EMIS ONLINE – Patient Registration Form

Please tick forms of photo ID provided:
Passport
Driving Lic
ID Card
Statement
Council Tax
Other:

If you would like to register for this online service, please complete the form below and return to reception. After you have given this form to the Patient Coordinator, they will then activate your account and produce a Registration Letter that enables you to register for this service. You will need to provide 2 separate forms of ID, including one that must be photo ID and one that has your current home address (must be no older than 3 months unless a Council Tax Statement) – see the small box to the right for ID that we accept – and these must be up to date with the correct information. We cannot process your application if you provide incorrect ID, or no ID at all.

If you are a new patient, please return this form with your registration documents. You will then receive an email (this is automatically generated therefore will not come from us) with a Registration Letter to enable you to register for this service.

In accordance with Article 8 of the UK GDPR[1], from the age of 13 young people must provide their own consent and will be able to register for online services.

Patient Details	**Please complete in BLOCK CAPITALS**
Patient Full Name	
Date of Birth	
Email address	
This email will be used by the practice to send you notifications and reminders	
Mobile Number	
Patient Home Number	

Registering on behalf of another patient - For those patients who are under 13, or elderly, or unable to complete themselves due to lack of capacity (lack of capacity will be discussed with patient's GP)	
Please complete above patient information as well as this section if you are completing this on behalf of another patient	
Name of Proxy	
Date of Birth	
Email Address	
Mobile number	
Relationship to patient	

This person acts as my carer and should therefore be noted as such on my medical notes. *(Somebody who looks after a sick, elderly, or disabled person)*	**YES**	**NO**
I consent to this person to have online access to my medical information through *Patient Access*, (**appointment booking, repeat prescriptions**)	**YES**	**NO**
I consent to this person to have online access to my medical information through *Patient Access*, (**test results and medical records**)	**YES**	**NO**

I consent to Alchester Medical Group giving me access to my medical records via Patient Access Electronic Records Viewer and, if applicable, I authorise the above-named person to have Proxy access to my medical records.

Patient Signature: …… **Date:** ……

If signing on behalf of a child (under13) or patient with lack of capacity ……

[1] Article 8 UK GDPR