Application to register at St Paul's Medical Centre

[ ] I have fully completed the application form and new patient questionnaire and have provided the following:

Photographic Identification (specify) _____ _____

Proof of address (specify type) _____

Parental responsibility (children only) _____

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[ ] I have read and understood the practice Terms and Conditions and agree to be bound by them. This is a condition of registration.

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[ ] I nominate the following pharmacy to receive my repeat prescriptions by electronic means (should I need them). I can change this nomination at any time by informing the practice.

_____ (pharmacy name and address)

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[ ] I wish to be able to use online services such as booking appointments and ordering repeat prescriptions and therefore require a Patient Access account using the following email address:

_____ (write email address clearly & legibly)

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[ ] I consent to information about my medications, allergies and adverse reactions, illnesses and health problems, operations and vaccinations, how I would like to be treated (such as where I would prefer to receive care), what support I might need and who should be contacted for more information about me being shared across different healthcare organisations and systems that need the information to provide me with the best possible care and who work within strict NHS permissions and confidentiality rules (Enriched Summary Care Record).

[ ] I consent to only information about my medications, allergies and adverse reactions but no other information being shared as above (basic Summary Care Record).

If you do not wish to have any form of Summary Care Record, https://www.nhs.uk/your-nhs-data-matters

I understand that if no selection is made a basic Summary Care Record will be created and that I can change my decision at any time by informing the practice.

Signed: _____ DOB: _____ Date:_____

Print name: _____

**FOR SURGERY USE ONLY**

**Checked by: _____ Date: _____**