

## Patient Access Application Form

### Patient to complete

<b>Name:</b>	
<b>D.O.B:</b>	
<b>Address:</b>	
<b>Tel No:</b>	
<b>Mob No:</b>	
<a href="#">Practice Guidance read and understood:</a>	Delete as appropriate <b>Yes/No</b>

### Surgery Staff Only

Proof of photographic ID given e.g passport, driving license:	Yes/No
Identity confirmed:	Yes/No Signed

I have understood and will adhere to the [Practice Guidance for the use of Patient Access](#). I understand that failure on my part to adhere to the guidance may result in my Patient Access registration being terminated. I understand that this will in no way affect my registration with the practice. I also acknowledge that the practice will send me text reminders and request(s) for medical records updates.

**Signed** \_\_\_\_\_

**Date** \_\_\_\_\_