NHS
Nottingham West
Clinical Commissioning Group

SAXON CROSS SURGERY
PATIENT ACCESS APPLICATION FORM

Name	
Date of Birth	
Address	
Home telephone number	
Daytime telephone number	

- 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 and that this will in no way affect my registration with the practice.
- I understand that my Patient Access username and password should not be shared with anybody

☐ I am the patient
☐ I am the legal guardian of the patient if under 16 years old

I wish to be able to
☐ Book GP appointments online
☐ Request repeat prescriptions
☐ View my medical record (Not available for records of patients under 16)
☐ Update my personal details

Patient's signature……

Date……

FOR SURGERY USE ONLY

PRACTICE CHECK LIST FOR REGISTRATION

☐ Patient's date of birth checked
☐ Patient's identity confirmed with ID: Photo, signature, address(copy taken)
☐ Patient given practice Patient Access Guidance
☐ Patient understands registration process and next step to registration
☐ Patient's registration screen updated ☐