**MARKINCH MEDICAL PRACTICE**

**PATIENT ACCESS APPLICATION FORM**

Patient to Complete

|  |  |
| --- | --- |
| **Name** |  |
| **Date of Birth** |  |
| **Address** |  |
| **Tel No:** |  |
| **Mobile No:** |  |

I have read and understood the Patient Access Terms and Conditions. I understand that failure on my part to adhere to the guidelines may result in my access rights being removed. I also understand that this will in no way affect my registration with the Practice. I also acknowledge that I agree to receive reminders for appointments and other medical reviews via text message.

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

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

**Practice Staff Use**

Photographic ID confirmed Y/N

Registration Letter Issued/Sent on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(date)