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## HIGHLANDS SURGERY

### SystemOne Online – Patient Registration Form

If you would like to register for SystemOne online services, please verify your identity by completing the information below and providing Photo ID. Please tick the boxes below for what you wish to access.

Repeat Prescriptions		Test Results	
Medical Records		Book/cancel Appointments	

Patient Details			
Patient Forename			
Patient Surname			
Date of Birth			
Email Address*			
Mobile Number			
I would like to receive my pin by <i>*Please tick only one option*</i>	SMS		E-mail
	Print Out		
Office use only			
Staff members name			
Photo ID (passport/drivers' licence)			
Signature		Date	

\* This email address will be used by your practice to send you notifications, only one email address can be used per patient

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To use this service, you require a PIN. Patients over the age of 13 will each receive their own pin. Children under the age of 13 will be given access via their parent's pin. Please allow one week for us to complete your request and generate a PIN for you. We will contact you when ready for collection.

**You will need to bring proof of identity when you collect your PIN, this MUST include photo ID. No one else can collect the PIN for you. All details of how to use the service will be provided with your PIN.**

CHILDREN 13 YEARS AND OVER. You are able to register to use this service for your children, although this will be reviewed when your child becomes 13 years old. At that age the young person can contact us and inform us whether they would like to register for themselves or continue to allow their parent / guardian to access this service on their behalf. If the child agrees for the parent / guardian to continue to have access, we will request annual consent until the patient becomes 18 years old when the access by the parent / guardian will automatically cease and the 18 year old will need to register to use the service him/herself.

If this request is for a young person between the ages of 13 and 18 and the parent / guardian is requesting the access for the online service would the young person, please sign the declaration below.

**I ..... (please name)**

**give consent for my parent/guardian (please name)**

**..... to have access to book / cancel appointments, order repeat prescriptions and have access to my medical records on my behalf. I understand I can cancel this arrangement at any time.**