REQUEST FOR ONLINE REGISTRATIONS

The Mounts Medical Centre Date _____

Full Name: _____

Date of Birth _____ Mobile _____

Landline _____ Alternate _____

Address: _____ Post Code _____

Please write your email in Big/Large letters only To identify Corrrectly

Email Address:- _____

SMOKING QUESTIONS (Patients Age 14 and Over Only)

Are you a smoker Yes ☐ No ☐ Cigarette ☐ Cigar ☐ Chew ☐ Vaping ☐

Ex Smoker ☐

If yes how many a day _____ Do you need any help in Quit Smoking Yes ☐ No ☐

FOR WOMEN Age 25 & OVER ONLY

Did you ever have a Smear Test done Yes ☐ No ☐

Any possible date of last Smear test or result _____ Outcome of result _____

Declaration

☑ I give my consent to the surgery to send my login details for online services through the email and I will be responsible if provided any wrong email address and the details may go to that incorrect email address.

Patient's Signature's _____

Please do not fill below this, for Mounts Medical Centre Only

Proof of ID Provided

Passport ☐ Driving Licence ☐ Resident Card ☐ Birth Certificate(For UK Births Only) ☐

Any Other ID _____

Staff Member's Name _____ Staff Signature _____

The ID should only be government issued , examples are Passport, Driving License, Birth Certificate & similar