# Vision Online – Three Harbours Medical Group

To register for online services please complete this form and return it to your practice by the email below or post/put through the letter box. Please do not come into the practice. Once you are registered, you will get an email with the next steps.

**NHSH.GP55323-ADMIN@NHS.SCOT**

**Our practice policy is to not approve of shared accounts for any of our patients**. Your medical information is personal and should not be shared. Each patient is responsible for the security of their own information. If you choose to share your information with anyone else, this is at your own risk.

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| Patient details | | | Please complete in BLOCK CAPITALS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient forename | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient surname | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of birth | | |  | |  | | | | / | | |  | | |  | | | / | | | |  | | | | | |  | |  | | |  | | |  | |
| Email address  This email address will be used by your practice to send you notifications and reminders. | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mobile number | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
| I wish to have access to the following **online** services (please mark ‘X’ in all that apply): | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | | | | | | | | | |
| 1. Booking appointments | | | | | |  | | 1. Requesting repeat prescriptions | | | | | | | | | | | | | | |  | | | | 3.SMS communication | | | | | | | | | |  |
| Signature |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date |  |  | | | / | | | | |  | | |  | | | / | | |  | | | | | |  | | | |  | | |  | | |  | | |
| Completing the form on behalf of the patient? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Print forename | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Print surname | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Relationship to patient | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Signature |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date |  | | |  | | | / | | | |  | | |  | | | / | | |  | | | | | |  | | |  | |  | | |  | | | |
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