OAK VALE MEDICAL CENTRE

Please bring two forms of Identification when you have completed the new patient forms. (Photo Identification and Proof of Address)

<u>Please Circle appropriate answer</u>

Agree to Patient Access (Online Access) an email address is required for this

Yes No

Email Address - _____

Would you like us to Email or for you to collect documents from Reception?

Email Collect

<u>SMS TEXTING</u>

DO YOU CONSENT TO COMMUNICATION BY SMS TEXTING YES NO

PLEASE BE AWARE THAT YOU SHOULD NOT SHARE YOUR MOBILE NUMBER WITH ANYBODY ELSE AND KEEP YOUR PIN CODE SECURE TO MAINTAIN CONFIDENTIALITY

<u>Nominated Chemist</u>

If you have a nominated chemist and wish to change please enter the full name and postal address of the chemist you would like us to change it to below –

_____

_____

_____