Garden City Surgery

Online Services- Registration form

Patient's title and full name:	
Patient's full address:	Postcode:
Patient's Date of birth:	
Patient's Email address (this require verification):	
Patient's Contact Mobile and Landline phone number:	
Details of Parents/ Guardian/Carer, requesting Proxy access including Full name and relation to the patients of under 16years old: ***Full name :*** ***D.O.B:*** ***Relationship with the patients:*** ***Parents/ Guardian/Carer***	
Please note that we will require to see original copies of your ID documents (Passport, Full Driving Licence) to confirm your identity.	
Once you complete and emailed this form, Please give 48/72 hours for the practice to get in touch with you.	