Registration Form

Patient Details

Surname		Contact Details	
First Name		Daytime	
Middle Name(s)		Evening	
Sex		Mobile	
Date Of Birth		Email	
Address			

Doctor's Details

Doctor		Surgery	
Address		Phone Number	

Chronic conditions, Allergies etc: (please supply information if applicable)			
Prescription Payment (please tick which applies)			
I pay for my prescriptions		I am exempt from charges for the reason stated below	
Exemption Reasons: (please tick which applies)			
A. Under 16		G. War pension certificate	
B. 16,17,18 in full time education		*H. Income support*	
C. 60 or over		*K. Income based job seekers allowance*	
D. Maternity Exemption Certificate		L. Named on a current HC2 charges certificate	
E. Medical Exemption Certificate		***M. Named on a working families tax credit NHS exemption certificate***	
F. Prepay certificate		***N. Named on a disabled persons tax credit NHS exemption certificate***	
For reasons H,K,M & N (indicated in italics above) please provide your national insurance number			

Declaration:
I declare that the information on this form is accurate and complete. I authorise staff of Drugmart Pharmacy to:
Sign prescription charge exemption forms on my behalf.
Collect (either in person or via postal service)
Should my status change I will inform Drugmart Pharmacy of this change and if necessary pay the prescription charges required.

Signed		Date	
Print Name			
I am the patient		I am the patients representative	

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