**Manage My Health Registration Form**

Please Print Details Clearly – 16+ Years

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| --- | --- | --- |
| Name: |  | |
| Address: |  | |
| Date of Birth: |  | |
| Email address: |  | |
| **IMPORTANT**  **Each family member needs their own individual email address.**  **Please write clearly to avoid a delay in the registration process.** | | |
|  | | |
| Previously Registered to Manage My Health | Yes / No (Circle one) | |
| Name of previous medical centre |  | |
|  | | |
| Photo Identification included | |  |
| I agree to the patient portal terms and conditions | |  |
|  | | |
| Today’s Date | | |
| Patient signature | | |

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