Repeat Prescription Registration Form

Branch Copy

Providing NHS Services

Your Details (Please complete)

Title:	First Name:
Surname:	
Address:	
	Postcode:
Preferred Contact No:	D.O.B: DD/MM/YY

Additional Person(s)

Please complete the following sections for any other person(s) in your household who would like to register:

Full Name:	D.O.B: DD/MM/YY
Full Name:	D.O.B: DD/MM/YY

I would like Ringmer Pharmacy to:

Collect my prescription from my GP's surgery and then deliver my medication to me

I agree that Ringmer Pharmacy will make arrangements for all my future prescriptions to be dispensed this way. This may include electronic transfer of my prescription, where the service is available.

If I wish to change this arrangement I will inform Ringmer Pharmacy.

Signature:

If signing on behalf of someone else, please state their relationship to you:

Date:

Please tell us your doctor's surgery (Please fill details)

Surgery Name:	Postcode:
Address:	

Please tick the services you are interested in (Please tick all that apply)

Microsuction Ear Wax Removal	☐	Hepatitis B Vaccination	☐
Travel Vaccinations	☐	Ear Infection	☐
Malaria Medication	☐	Impetigo	☐
Stop Smoking Clinic	☐	Travellers Diarrhoea	☐
Period Delay	☐	Erectile Dysfuntion	☐