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DR. JOANNE PETERS
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WWW.WESTSTREETSURGERY.ORG.UK

WEST STREET SURGERY,
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Registration form for online services

www.weststreetsurgery.org.uk

Surname: _____

First Name(s):_____

Date of birth: _____/_____/_____

Address: _____
_____
_____
_____

Landline Phone number: _____

Mobile Phone number: _____

If you would like your password emailed to you, please tick here to give your permission, otherwise you will need to collect it from reception at the surgery. **Email address:** @	☐
We have a facility for sending blood results and appointment reminders by sms / text message. Our patients find this to be a useful service, and it is our hope to reduce our failed attendances for forgotten appointments. Please tick here if you agree to receiving text messages for this purpose.	☐

I would like to apply to use online services at West Street Surgery. I am aware missing appointments booked online may result in my online services privileges being revoked.

Signed: _____

Please allow 3 working days to process your application before collecting your UserID and password from reception