

DR. KATHRYN A. FREEMAN  
DR. JOANNE PETERS  
DR. C. F. QUARTL Y  
DR. JANET E. BERRY  
DR. STEPHEN PRICE  
DR. BRUCE J. ELLA



WWW.WESTSTREETSURGERY.ORG.UK

WEST STREET SURGERY,  
89 WEST STREET,  
DUNSTABLE,  
BEDS.  
LU6 1 SF

TEL No. (01582) 664401  
FAX NO. (01582) 475766

## Registration form for online services

[www.weststreetsurgery.org.uk](http://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. <b>Email address:</b> _____ @ _____	<input type="checkbox"/>
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.	<input type="checkbox"/>

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