BANK STREET MEDICAL GROUP
THE HEALTH CENTRE
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APPLICATION TO REGISTER FOR ONLINE APPOINTMENTS

Date of Birth (dd/mm/yy)	
Name	
Address	
Postal Code	
Telephone Number	
Email Address	
Signature of Applicant*	

**By signing this application form you are giving authority to the Practice to store the above personal information on a secure database. No details will be released to any third party at any time.*