Scally McDaid Roarty Medical Practice

REGISTRATION FOR ONLINE BOOKING

NAME OF PRIMARY USER:_____

DATE OF BIRTH: _____

ADDRESS: _____

_____

MOBILE NO: _____

EMAIL : _____

I give permission to Scally McDaid Roarty Medical Practice for my data to be stored and used for the purposes of online appointment booking & prescriptions □

I give permission to Scally McDaid Roarty Medical Practice to contact me via phone, text message and email □

I have permission from the members of my family listed below, to share their data (name & date of birth) with Scally McDaid Roarty Medical Practice for the purposes of online appointment booking & prescriptions □

Should there be any change to the above, I will contact Scally McDaid Roarty Medical Practice □

Signed:_____ Date:_____

ADDITIONAL FAMILY MEMBERS

NAME:_____ DATE OF BIRTH_____

NAME:_____ DATE OF BIRTH_____

NAME:_____ DATE OF BIRTH_____

NAME:_____ DATE OF BIRTH_____