

# Dr Devinder Bansi DM FRCP

## Personal Details

Mr/Mrs/Ms/Other .....  
First Name .....  
Family Name .....  
DOB .....  
Address  
.....  
.....  
.....  
Post code .....

## Contact Numbers

Home .....  
Work .....  
Mobile .....  
Email .....

## GP Details

GP Name .....  
Address  
.....  
.....  
.....  
Post code .....

## Payment Detail

Self Pay Y  (skip next section) N   
Insurance Company .....  
Address  
.....  
.....  
.....  
Post code .....  
Policy Number .....  
Pre-authorisation Number .....

I, being the patient or duly authorised by the patient, confirm by my signature below that I accept responsibility for all uninsured and auxiliary charges in respect of professional medical services provided to the patient.

Signature of the patient or representative \_\_\_\_\_  
Date \_\_\_\_\_