Aesthetics Account Opening / Amend Form

Please note Photo I.D with signature is needed for all new account holders e.g. driving license, passport

PERSONAL DETAILS

Title: Name:

Existing Account Code: Company Name:

Correspondence Address:

Postcode:

Invoicing Address *(If different from above)*:

Postcode:

GDC Number: Prescriber: YES NO

Email Address:

Telephone: Mobile:

Delivery Address *(If different from above)*:

Postcode:

PARTNER PRESCRIBER DETAILS

(To be completed by associated Prescriber or Medical Director for Dental Hygienist or Dental Therapist)

(Photo ID required to process application)

Name:

Correspondence Address:

Postcode:

Home Address *(If different from above)*:

Postcode:

GDC Number: Email Address:

Telephone: Mobile:

Medical Director declaration: (Please tick to confirm)

☐ I hereby declare I am responsible and indemnified for medicines stocked, stored and used at the premises

Associated Prescriber declaration: (Please tick to confirm)

☐ I hereby declare I am responsible for seeing all prescription patients face to face for this account and have the appropriate indemnity, and product and procedure knowledge

Signature: Date:

Account Conditions and Acknowledgements

Prescriptions	I undertake that private prescriptions will be sent to you by mail the same day for receipt within 72 hours, otherwise I will be re-invoiced including VAT. I understand that the pharmacist has the right to use his/her discretion to decide whether to authorise prescription orders. I agree to provide any further information or clarification as requested, to support this right
Account	I confirm that I am appointed as agent to take delivery and am the authorised signatory on the account. I bear the responsibility for any unauthorised access to my account. I have read the terms and conditions at www.dental-directory.co.uk/Terms/
Products	I am fully responsible for all aspects regarding the prescribed medication at the address on behalf of patients. I confirm that I have the appropriate training and techniques to administer each product. I confirm that I have professional indemnity insurance. I take full responsibility for any products that I prescribe outside of their SPC including dosage and indications
Patients	I confirm that the prescribed item(s) will only be used for the treatment of the named patient on the prescription and that I have undertaken a FACE TO FACE consultation with the named patient. I confirm that I have the consent of the patient to receive the delivery of prescribed products on his/her behalf and that the patient has consented to Med-Fx pharmacy dispensing his/her prescription with the full understanding of his/her choice to use alternative pharmacies.
Privacy	I confirm that the patient has given consent for their personal details to be given to us for the purposes of processing their prescription to comply with a legal and regulatory obligation. I have read the Dental Directory Privacy Policy at cdn2.dental-directory.co.uk/Assets/pdfs/GDPR-Dental-Directory-Privacy-Policy.pdf and consent for my details to be used by Dental Directory according to the policy

Account Holder declaration: (Please tick to confirm)

☐ I hereby declare I agree with the Account Conditions and Acknowledgements

Signature: _____ Date: _____

PAYMENT INSTRUCTIONS

Please make payments to:

Bank Account Number: 10951129
Sort Code: 20-97-65
Bank: Barclays
Account Name: Billericay Dental Supply Co Ltd
IBAN: GB66 BARC 2097 65109511 29

Please return completed from to: contactcentre@DDGroup.com **or call 0800 585586**

Internal Use

TO BE COMPLETED BY SUPERVISOR

ORDER ATTACHED	Y / N
CHECK REGISTER	Y / N
PHONE BACK	Y / N
ADDRESS CHECK	Y / N
PHOTO WITH SIGNATURE I.D	Y / N
BANK DETAILS REQUESTED	Y / N
REFER TO SUPERVISOR	Y / N
OKAY TO PROCEED WITH ORDER	Y / N
INFO UPDATED ON CRM	Y / N

AUTHORISED BY:……

SPECIAL REQUIREMENTS: