

# Aesthetics Account Opening / Amend Form

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

Title:       Name:         Existing Account Code:       Company Name:         Correspondence Address:       Postcode:         Invoicing Address (// different from above):       Postcode:         GDC Number:       Prescriber: YES       NO         Email Address:       Telephone:       Mobile:         Delivery Address (// different from above):       Postcode:       Postcode:         Correspondence Address (// different from above):       Postcode:       Postcode:         Delivery Address (// different from above):       Postcode:       Postcode:         Correspondence Address (// different from above):       Postcode:       Postcode:         Mame:       Postcode:       Postcode:       Postcode:         Correspondence Address:       Postcode:       Postcode:       Postcode:         Home Address (// different from above):       Postcode:       Postcode:       Postcode:         Correspondence Address:       Postcode:       Postcode:       Postcode:       Postcode:         GDC Number:       Email Address:       Postcode:       Postcode:       Postcode:         GDC Number:       Email Address:       Postcode:       Postcode:       Postcode:       Postcode:         Elephone:       Mobile:       Postcode:       Postcode	-	PERSONAL DETAILS	
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Email Address:   Telephone:   Mobile:   Delivery Address (If different from above):   Postcode:   PARTNER PRESCRIBER DETAILS Ito 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): Email Address: GDC Number: Email Address:	Postcode:		
Telephone: Mobile:   Delivery Address (If different from above): Postcode: <b>PARTNER PRESCRIBER DETAILS</b> Correspondence Address: Vehoto ID required to process application)   Name:   Correspondence Address: Postcode:   Home Address (If different from above): Postcode:   GDC Number: Email Address:	riber: YES NO	Prescriber: YES	GDC Number:
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Postcode:   PARTNER PRESCRIBER DETAILS Correspondence Address:   Correspondence Address:   Postcode:   Home Address (If different from above):   Email Address:	Mobile:		Telephone:
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):   GDC Number:			Delivery Address (If different fr
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<i>Medical Director declaration:</i> (Please tick to confirm)		ick to confirm)	Nedical Director declaration
I hereby declare I am responsible and indemnified for medicines stocked, stored and used at the premises	since stacked, stared and used at the previous	e and indemnified for medicines stock	I hereby declare I am r
Associated Prescriber declaration: (Please tick to confirm)	lines stocked, stored and used at the premises	ease tick to confirm)	Associated Prescriber decla
I hereby declare I am responsible for seeing all prescription patients face to face for this account and have the ap indemnity, and product and procedure knowledge	Lines stocked, stored and used at the premises	,	
Signature: Date:		e for seeing all prescription patients fa	I hereby declare I am r

#### 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:		