



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:	<input type="text"/>	Name:	<input type="text"/>		
Existing Account Code:	<input type="text"/>	Company Name:	<input type="text"/>		
Correspondence Address:	<input type="text"/>				
	<input type="text"/>	Postcode:	<input type="text"/>		
Invoicing Address (If different from above):	<input type="text"/>				
	<input type="text"/>	Postcode:	<input type="text"/>		
GDC Number:	<input type="text"/>	Prescriber: YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Email Address:	<input type="text"/>				
Telephone:	<input type="text"/>	Mobile:	<input type="text"/>		
Delivery Address (If different from above):	<input type="text"/>				
	<input type="text"/>	Postcode:	<input type="text"/>		

PARTNER PRESCRIBER DETAILS

(To be completed by associated Prescriber or Medical Director for Dental Hygienist or Dental Therapist)
(Photo I.D required to process application)

Name:	<input type="text"/>				
Correspondence Address:	<input type="text"/>				
	<input type="text"/>	Postcode:	<input type="text"/>		
Home Address (If different from above):	<input type="text"/>				
	<input type="text"/>	Postcode:	<input type="text"/>		
GDC Number:	<input type="text"/>	Email Address:	<input type="text"/>		
Telephone:	<input type="text"/>	Mobile:	<input type="text"/>		

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:	<input type="text"/>	Date:	<input type="text"/>
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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.dd.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 form 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
SPECIAL REQUIREMENTS:	

AUTHORISED BY: