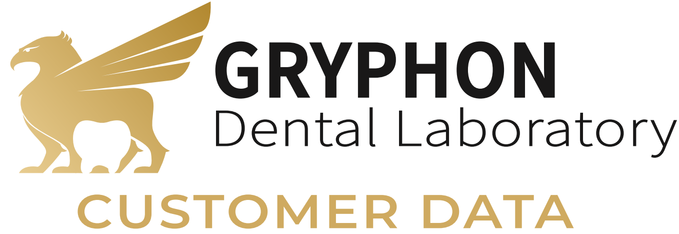

CUSTOMER DATA

Please fill out and send this form back to us via e-sign or post with your first case

INVOICING DETAILS*

Surgery data (*mandatory fields)

Field	
Surgery Name & Group name if any*	
Doctor Full Name*	
Surgery address*	
City*	
Postcode*	
GDC Number*	
Doctor Email Address*	
Doctor Mobile No.*	
Surgery website	

To receive statements:
We run paperless statements that are sent out via email on the last working day of each month. Please note that it is the Doctor's responsibility to ensure an account has been set up for their surgery to receive their statement.

What you should know (please refer to terms and conditions on the website):
Payment terms are 15 days from statement date.
Statements are sent on a monthly basis.
The dental surgery and the prescribing doctor are responsible for the payment.

I hereby accept the payment and delivery conditions.
I hereby declare under my responsibility that the data provided is correct and I will inform GryphonDental about any variation.
I hereby declare that I am able to pay for prescribed orders.

This document implies the acceptance of the terms and conditions as stated on the Gryphon Dental website. The personal data on this document will be used exclusively by Gryphon Dental, and will be used by Gryphon Dental to provide information regarding the products, services or for promotional purposes.

(to be signed and dated by the named Doctor)

Signature: ______________________________

Date: ______________________________