Preferred/Corporate Client Registration Form

ARTISTE STUDIOS
premier dental specialists

Personal Details

Title | Date of Birth

Last Name

Given Name(s)

Home Address

Postcode

Telephone (H) | Mobile

Email (H)

Employer Details

Company Name

Address

Postcode

Telephone (W) | Dental Insurance Plan

Email (W)

Preferred Appointments

	AM	PM
Mondays	☐	☐
Tuesdays	☐	☐
Wednesdays	☐	☐
Thursdays	☐	☐
Fridays	☐	☐

We recommend that you arrive 10 minutes ahead of your appointment for pre-treatment preparations and to enjoy our Nespresso® bar. We strive to provide you with individualised care; that means reserving ample time and ensuring your team is fully prepared for your case on the day. If you do need to cancel, please kindly provide 48 hours' business day notice to avoid being charged for the consultation or treatment planned for that day.

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How did you hear about us?

What types of treatment are you interested in?

☐ Orthodontics ☐ Invisalign® ☐ Implants ☐ Cosmetic Dentistry ☐ Other Specialisation ☐ Facial Rejuvenation ☐ Teeth Whitening

Please elaborate

Your signature below is an agreement to Artiste Studios' terms and conditions. You acknowledge that all electronic communications such as emails constitute formal written communications. Submission of this form via email (if applicable) constitutes an electronic signature for data transmitted. We will maintain the confidentiality of your records in accordance with practice protocol and will not release information about you to any third party including your employers without your express permission, unless required by law. You agree that we may use information, records and photographic images obtained from you for patient care, academic research and marketing purposes including seminars and advertising. Your identity will be kept confidential unless you agree to a release in customer testimonials. We will send you specific marketing materials occasionally that you may opt-out. Guardians of under 16s are required to submit a separate registration form.

Signature

Date

Submit via Post

Submit via Email

4 Hammersmith Broadway
London W6 7AL
0208 563 2864
info@artistestudios.com

Credit Agreement (Regulated by the Consumer Credit Act 1974)

Made between us (the Creditor) and you (the Account Holder) named below

ARTISTE STUDIOS
premier dental specialists

Patient

Title ☐ Date of Birth ☐

Last Name ☐

Given Name(s) ☐

Account Holder Details (if different from the Patient)

Name (on card) ☐

Billing Address ☐

☐

☐ Postcode ☐

Telephone ☐ Dental Insurance Plan ☐

Email ☐

Credit/Debit Card Number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Card Verification Code ☐☐☐ Last 3 digits on signature stripe

Card Type

☐ Visa ☐ MasterCard ☐ Switch/Maestro ☐ Others (state below) | ☐ Credit ☐ Debit

Name of Issuing Bank ☐

Start Date ☐☐ ☐☐ Expiry Date ☐☐ ☐☐ Issue Number (if applicable) ☐☐

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Membership/Treatment Details (official use only)

Membership Enrolment ☐ Preferred Corporate ☐ Preferred Client ☐ Access

Treatment Description ☐ *Invoice (or Quotation) Date* ☐☐ ☐☐ ☐☐

Total Amount £ ☐ *Less Payment* £ ☐ *Number of Instalments* ☐☐

Payment per Instalment £ 0 *usually taken on or around the 8th of each calendar month*

First Instalment Due 0 1 ☐☐ ☐☐

I, the Account Holder, confirm the above information is correct and agree to the Terms of Membership Agreement and Terms of Credit Agreement which I have had an opportunity to read and discuss with the Practice. I acknowledge that the membership of the Club is at least for the minimum term, and agree to pay/authorise you to charge my card in full amounts for any membership, treatment or late re-booking and cancellation fees. I understand that you will keep the details provided on file for these purposes only.

Cardholder's Signature _____ Submit via Post

Date _____ Submit via Email

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