

# AMENDMENT OF PATIENT DETAILS

(block capitals please)

14400



Please use this form to notify DPAS of any changes of information relating to the members of your plan(s).  
Please allow at least 7 days for the information change to take effect

**Dental Practice Name**.....

**Practice Address**.....

**Patient Name** ..... **Patient No.**.....

**Do you wish to cancel this patient? (Please circle) YES / NO**      **Effective Date** .....

## Change Of Address

**Old Address**.....

**New Address**.....

## Change of Other Details

Change of Name - Previous Name(s) ..... New Name(s).....

Change of Plan - From Plan ..... @ ..... To Plan ..... @ .....

Change of Dentist - From Dentist ..... To Dentist .....

Effective Date ..... (Signature of Practice Owner:) .....

## Change of Bank Details

### Instruction to your Bank or Building Society to pay Direct Debits



Please fill in the whole form and send it to:

DPAS Limited,  
Place Farm Courtyard, Tisbury, Salisbury, SP3 6LW

1. Name and full postal address of your Bank or Building Society branch

To: The Manager	Bank or Building Society
Address :	
Postcode :	

2. Name(s) of account holder(s)

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*Banks and Building Societies may not accept Direct Debits for some types of account.*

Originators Identification Number

9	4	2	2	1	6
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3. Branch sort code (from the top right hand corner of your cheque)

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4. Bank or Building Society account number

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5. Reference number (For office use only)

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6. Instruction to your Bank or Building Society:

Please pay **DPAS Limited** Direct Debits from the account detailed on this Instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this instruction may remain with DPAS and, if so, details will be passed electronically to my Bank/Building Society.

**14400**

Signature(s) :

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Date :