DENTX SOLUTIONS

NEW CUSTOMER FORM

CUSTOMER INFORMATION

Thank you for choosing DentX Solutions. Please fill out the following information pertaining to your practice, in order to set up your account. This form is based on individual information, please fill in one per doctor and practice.

Legal Name of Practice _____

Practice | Clinic Name
(If different from legal name of practice) _____

Dentist First Name _____ Dentist Last Name _____

Address _____

City _____ Province _____ Postal Code _____

Practice Telephone Number _____

If Applicable, ID and/or Name of Dental Service Organization (DSO) _____ ID # _____

Territory Sales Manager _____

PAYMENT INFORMATION

☐ Visa ☐ MasterCard ☐ Amex

Credit Card # _____ Credit Card Expiry date: (mm|yy) _____

Name as It Appears on Card _____

Please select one of the following:

☐ I consent to have my outstanding balance applied as an Automatic Payment on the credit card I have provided above, the following month in which the service / product was delivered. Please apply my balance on the 1st ☐ 10th ☐ or 15th ☐ day of the month.

☐ I'll make payments manually (either by phone, or online via dentxsolutions.com.) However, I understand this information is for legal purposes, and I won't be charged unless there is an overdue balance.

ADMIN INFORMATION

Billing Name: ☐ Legal Name ☐ Practice

Billing Address: ☐ Legal Name ☐ Practice

Email for statements _____ CC _____

Email for general communications _____ CC _____

How did you hear about DentX Solutions? _____

Signing Officer Name _____

Date (yyyy|mm|dd) _____ Signing Officer Signature _____

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