ATLAS DENTAL
1846 W. 169th Street, Suite B
Gardena, CA 90247
Toll-Free: 866-517-2233
Phone: 310-715-6424
Fax: 310-427-7184
E-mail: accounting@atlasdentallab.com

PLEASE RETURN COMPLETED FORM(S) TO:
ATLAS DENTAL - ACCOUNTING DEPARTMENT
Email: accounting@atlasdentallab.com
Fax: 310-427-7184

ACCOUNT INFORMATION FORM

GENERAL OFFICE INFORMATION

1. Company Name: _____

   Billing Address: _____ Phone: _____

   _____ Fax: _____

   City, State and Zip: _____ Email: _____

2. Federal Tax ID or Social Security No. _____
3. Type of Business: ❍ Dental Office ❍ Dental Lab (If CA, provide Resale No. _____)
4. Years in Business: _____
5. Check which is applicable to you: ❍ Corporation ❍ Sole Proprietorship ❍ LLC
   ❍ General Partnership ❍ Limited Partners
6. Please list: Owner(s), Officer(s), Partner(s) _____

   Please provide: License No. _____
7. Doctor/Account Holder's Name: _____
8. Accounts Payable Contact Name: _____

   Phone: _____

   Fax: _____

   Email: _____
9. Requested Type of Account: ❑ Open Account ❑ Preauthorized Credit Card Payment ❑ COD
10. If requesting an "Open Account", I approve Atlas Dental to pull any credit information as needed, included but not limited to personal credit reports, in order to determine appropriate credit limit.
11. I agree that my signature below authorizes Atlas Dental to proceed with my lab work without a Dentist Signature on any prescription(s) submitted by my office.
12. I have read and agree to the Atlas Dental Terms and Conditions.

SIGNATURE

Name of Company: _____

Authorized Signature: _____ Date: _____

Print Name and Title: _____

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AGREEMENT FOR OPEN ACCOUNT

AGREEMENT

In consideration of Atlas Dental supplying products on Open Account Credit Terms, it is understood the Statement Balance will be paid in full by the end of the subsequent month from the statement date.

I agree that, should I fail to fulfill any of the obligations under this credit agreement, fail to comply with payment terms or in the event any check be dishonored by our bank for any reason, then the entire balance owing on this account will become due immediately payable and any credit limitation established will be withdrawn. Amounts past due will be subject to a 2% service charge.

In the event my account goes out of terms, Atlas Dental has my authorization to apply charges on the following VISA or MasterCard Account:

❍ VISA ACCOUNT
❍ MASTERCARD ACCOUNT

_____
Card Number

_____
Name of Cardholder

_____
Expiration Date

_____
CVV2 - Credit Verification Value Code
(located on the back of the credit card)

SIGNATURE ON FILE

_____
Cardholder Authorized Signature

_____
Date