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entire balance owing on this account will become due immediately payable and any credit limitation established will be withdrawn.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

1846 W. 169th Street, Suite B Gardena, CA 90247
866-517-2233 / 310-715-6424 / 310-715-2630 FAX
Email: contact@atlasdentallab.com
Website: www.atlasdentallab.com

GENERAL INFORMATION

Doctor's Name: First _____ Last _____ DDS or DMD

Practice Name: _____

Doctor's License #: _____

Email Address: _____

Address: _____

City, St, Zip: _____

REFERRED BY

❑ Website ❑ Current Client: _____

❑ Email Marketing ❑ Other: _____

OFFICE HOURS

M: __ / __ T: __ / __ W: __ / __ TH: __ / __ F: __ / __ S: __ / __

Emergency #: _____

CONTACT INFORMATION

Scheduling Questions:

Name: _____

Email: _____

Technical Questions:

Name: _____

Email: _____

Can we email or text the dentist with technical questions? ❑ Yes ❑ No

If so, please provide:

Cell #: _____

Email: _____

BILLING INFORMATION

Main Contact: _____

Phone #: _____ Fax #: _____

Email: _____

Billing Address (if different): _____

City, St, Zip: _____

BACKGROUND INFORMATION

Why are you looking for a new lab?

❑ Looking for a higher quality product.

❑ Looking for more consistent product:

❑ Occl. Contact ❑ Interprox. Contacts

❑ Shade ❑ Margins

❑ Other _____

❑ Looking for better comunication:

❑ Technical ❑ Due Date

❑ Willing to pay a higher fee for a higher quality product. Quality is my main focus.

❑ Need more reliable turnaround time than what I am currently receiving.

Do you have a digital Impression Scanner? ❑ Yes ❑ No

If yes, which one? _____

FIXED PREFERENCES

What are your usual preferences? (* indicates lab default)

Alloy Preference (PFM)

❑ a. Precious-White
❑ b. Semi-Precious-White
❑ c. Yellow Ceramic-Med. Yel.
❑ d. Non-Precious-White

Crown Design

❑ a. Full Porcelain Coverage
❑ b. Lingual Collar* ____mm
❑ c. Mesial Collar ____mm
❑ d. Distal Collar ____mm
❑ e. Metal Occlusal (3/4 Occ)
❑ f. Metal Occlusal (Full Occ)
❑ g. Metal Island
❑ h. Metal Lingual-Anterior Tooth

Occl. Contact

❑ a. Out (0.5mm sub)
❑ b. Light* (0.3mm sub)
❑ c. Contact (Touching Opp)

Inter. Prox. Contact

❑ a. Light*
❑ b. Medium
❑ c. Heavy (Scrape Cast)

Occlusal Stain

❑ a. None*
❑ b. Light
❑ c. Heavy

If Occlusal space is needed:

❑ a. Adjust Opposing Tooth*
❑ b. Make Metal Island
❑ c. Make Metal Occlusal
❑ d. Adjust Prep and Mark Die

If questions present, I'd prefer:

❑ a. Call to discuss specific case in question
❑ b. Follow my preferences above, call if needed
❑ c. Follow my preferences above, I prefer no call

REMOVABLE PREFERENCES

Denture Tooth Preference

❑ Premium ❑ Economy*

ADDITIONAL INFORMATION / SPECIAL INSTRUCTIONS

_____

_____

_____

_____

Atlas Dental requires each case to be accompanied by a signed labslip which is a binding work order agreement and acceptance of our Terms and Conditions. Invoices are billed by statement with payment due by the end of the subsequent month from statement date. 2% Service Charge will be billed on all past due balances.
For complete details of T&C, visit www.atlasdentallab.com

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