Atlanta Dental

Products • Services • Technology

NEW Account Set-Up Form

Date: ____ / ____ / _____
Day Month Year

Full Business Legal Name | Estimated Monthly Purchases

Please check: ☐ General ☐ Endo ☐ Oral/Max ☐ Ortho ☐ Pediatric ☐ Perio ☐ Prosthodontics

Mailing Address

County | City | State | Zip Code

Business Phone | Business Fax | Email

☐ Please check if you like to receive monthly statements via email listed above.

How Long in Business | Type of Business | Dental License Number

☐ Proprietorship ☐ Partnership ☐ Corporation ☐ Sales Tax Exempt (Must provide Sales Tax exempt Certification) | Fed I.D. #

Party Responsible For Payments:

Name | Title | S.S. # *(For Open Terms)*

Mailing Address | City | State | Zip Code

Dental School | Year Grad.

Or Credit Card Information To Be Charged Per Order, Initial Here _____.

Name on Card | Type of Card: ☐ MC/Visa ☐ Amex | Card # | Exp. Date / (Month / Year) | Security Code

Billing Address | City | State | Zip Code

This application is submitted for the purpose of obtaining an open credit account from Atlanta Dental Supply Company (ADS). Regardless of whether the signature(s) on this application indicate(s) a representative capacity, the individual(s) signing this application agree(s) to be personally responsible for payment of the account. I authorize ADS to verify the information on this application and to receive information about me, including requesting reports from consumer reporting agencies. I further authorize ADS to contact theses sources for information at any time. I represent that all purchases here under shall be for business or commercial purposes only. I understand that I will receive statements monthly and that the payment terms are "due upon receipt" of statement. I further understand that ADS may impose a service charge of up to 1-1/2% per month on amounts delinquent beyond the specified terms on the invoice(s). In the event of default, the undersigned agrees to pay all costs of collection including a reasonable attorney's fee and court costs.

I HAVE READ THIS AGREEMENT AND AGREE WITH ITS TERMS.

_____ ____/____/_____ _____ ____/____/_____
Customer Day Month Year ADS Sales Representative Day Month Year

Please Fax to: 678-584-4523 or email to: setup@atlantadental.com.