



Products • Services • Technology

### NEW Account Set-Up Form

Date: \_\_\_ / \_\_\_ / \_\_\_  
Day Month Year

Full Business Legal Name	Estimated Monthly Purchases
<input type="text"/>	<input type="text"/>

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

Mailing Address

County	City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Business Phone	Business Fax	Email
<input type="text"/>	<input type="text"/>	<input type="text"/>

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

How Long in Business	Type of Business	Dental License Number
<input type="text"/>	<input type="text"/>	<input type="text"/>

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)		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
Mailing Address	City	State	Zip Code	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Dental School	Year Grad.			
<input type="text"/>	<input type="text"/>			
<b>Or Credit Card Information To Be Charged Per Order, Initial Here _____.</b>				
Name on Card	Type of Card:	Card #	Exp. Date	Security Code
<input type="text"/>	<input type="checkbox"/> MC/Visa <input type="checkbox"/> Amex	<input type="text"/>	___ / ___	<input type="text"/>
			Month / Year	
Billing Address	City	State	Zip Code	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	

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 these 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: 678.584.4601 or email to: setup@atlantadental.com.**