PERFECT SMILE
DENTAL CERAMICS

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NEW DOCTOR – OPEN ACCOUNT

Dental Office: _____

Name of Doctor / Doctors: _____

Dental Office Address: _____

Contact Person: _____

Phone: _____ Fax: _____

Email: _____

Perfect Smile Dental Ceramics, Inc. requires a credit card number to be given when opening an account. This credit card will only be charged if any invoices / statements are past due 30 days from statement date. We accept all major credit cards. The cardholder / doctor agrees to be held financially responsible for all and any debts incurred at Perfect Smile Dental Ceramics, Inc. even if the dental office is presently incorporated or should incorporate in the future. The billing cycle ends the last business day of each month. The entire account balance will be charged to the credit card on the 10th business day of the following month.

Credit Card Authorization

Name on Card: _____ Credit Card Number: _____

Expiration Date: _____ CVV#: _____

Billing Address: _____

Signature: _____

Automatic Bill Pay

☐ Please enroll me in Auto-Pay and charge my card on the 5th or on _____ of each month.

☐ Card same as above.

Name on Card: _____ Credit Card Number: _____

Expiration Date: _____ CVV#: _____

Billing Address: _____

Signature: _____

I hereby certify the information provided in this application is true, correct, and complete as of the date indicated below. I agree to promptly notify Perfect Smile Dental Ceramics, Inc. of any changes in the information provided.

_____

Print Doctor's Name Date License#

_____

Signature of Doctor