7186 South Highland Drive, Suite 150
Salt Lake City, Utah 84121
(801) 733-9700
fax (801) 733-9970
www.prestigedl.com

ACCOUNT APPLICATION

1. Doctor Information

Name_____

Address_____

City/State/Zip_____

Phone_____

Email_____

Social Security No._____

Type of Business:

☐ Sole Proprietorship ☐ Corporation

☐ Partnership ☐ LLC

Corporate Officers

Name_____

Phone_____

2. Business References

Name_____

Account No._____

Address_____

City/State/Zip_____

Phone_____

Name_____

Account No._____

Address_____

City/State/Zip_____

Phone_____

3. Credit Card Authorization

(If you wish to pay by Credit Card)

☐ Visa ☐ Master Card

☐ Discover ☐ American Express

Card No._____ Exp. Date_____

Name on Card_____

Billing Address_____

City/State/Zip_____

By signing below, I authorize Prestige Dental Lab to charge my credit card. Charges will be applied on the 10th of the month following the statement.

4. Agreement

The undersigned agrees to the following: Terms are NET 30 DAYS from the statement date. A 2% per month finance charge will be charged on all past due accounts. Cases will be shipped COD prior to credit approval. In the event that an account is not kept current, the undersigned agrees to pay all legal fees and court costs involved in collection activities, and agrees for the hearing to be held in the state of Utah.

Signed_____

Date_____