

# DOCTOR PROFILE ACCOUNT APPLICATION

Please email to [nyphoto@microdental.com](mailto:nyphoto@microdental.com) or return this with your first case.

## DOCTOR'S INFORMATION

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Alternate Phone

\_\_\_\_\_  
Fax

\_\_\_\_\_  
Email

\_\_\_\_\_  
Office Days (M/T/W/TH/F)

\_\_\_\_\_  
Hours

\_\_\_\_\_  
Office Contact Person

\_\_\_\_\_  
Dual Offices:  Yes  No

\_\_\_\_\_  
License #

\_\_\_\_\_  
State

## TYPE OF BUSINESS

Sole Proprietorship  Partnership  Corporation  LLC

\_\_\_\_\_  
FEIN #

## OWNERS/CORPORATE OFFICERS/PARTNERS

\_\_\_\_\_  
Name #1

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Email

\_\_\_\_\_  
Name #2

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Email

## ASSOCIATES

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## AUTOMATIC PAYMENT OPTION

(By entering this information, you are authorizing MicroDental to charge your credit card for the prior month's balance on the 10th day of each month.)

Visa  MasterCard  American Express  Discover

\_\_\_\_\_  
Card #

\_\_\_\_\_  
Exp. Date

\_\_\_\_\_  
Name (as it appears on card)

\_\_\_\_\_  
Billing Address (if different from shipping address)

## ACCOUNT AUTHORIZATION & AGREEMENT

*Customer shall pay for the products ordered pursuant to the payment terms of net 30 days from the date of the invoice or as otherwise stated on each invoice. Customer agrees to pay the amount of any taxes resulting from purchases. If payment is not made to MicroDental in accordance with the payment terms set forth, MicroDental may add a 1.5% finance charge per month for any unpaid balance and the Customer shall be liable to MicroDental for all reasonable attorney fees and costs incurred by MicroDental to effect collection of any invoice unpaid in whole or part. In addition, MicroDental reserves the right to suspend all future shipments until all payments have been received.*

*Applicant's signature attests financial responsibility, ability and willingness to pay invoices in accordance with the agreement terms and asserts authority to apply for this account.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Lab Use Only  
CUSTOMER #