TRIAD DENTAL STUDIO, INC

NEW ACCOUNT/CHANGE FORM

◯ **NEW ACCOUNTS:** The following information is required prior to or with the first case you submit to our laboratory. Missing information may cause a delay in shipment.

◯ **EXISTING ACCOUNTS:** Please complete only the information changed.

Dentist Name (please print):.....

Billing Address:.....

City: ..... State: ..... Zip Code:.....

Contact for Accounting:.....

Contact Phone:..... Contact email:.....

Please choose one of the following payment options:

Card Type: ◯ Mastercard ◯ Visa ◯ American Express

Name on Card:.....

Address for Card: .....

Card Number:.....

Expiration Date:..... Verification code:.....

* Credit card will be charged semi-monthly

I request that fees owed to Triad Dental Studio be charged to the credit/debit card above. I understand that if I cancel an order after work has begun, I am responsible for those charges, as well as any charges rejected by my credit card company.

Signature of Cardholder:..... Date:.....

A copy of each invoice will be sent with each case.
A monthly statement of account activity (invoices and payments) will be sent at the beginning of each month for the prior month's activity.
Please note that 1.5% penalty per month will apply on any outstanding balances more than 30 days from the first statement date on which the charge appears. Accounts with past due amounts may be placed on C.O.D status.

PLEASE CONTACT ACCOUNTING WITH ANY QUESTIONS:
Phone: 800.318.6684 Fax: 336.812.9656 Email: Jennie@TriadDentalStudio.com