

# New ACCOUNT FORM

**T** Name \_\_\_\_\_  
**O** Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Credit Mgr \_\_\_\_\_  
Phone \_\_\_\_\_

**F** The Phoenix Dental Laboratory \_\_\_\_\_  
**R** 6505 218th St Sw #1 \_\_\_\_\_  
**O** Mountlake Terrace, WA 98043 \_\_\_\_\_  
**M** 888-546-6450/425-670-2080 \_\_\_\_\_  
Fax 425-670-2099 \_\_\_\_\_

Business Type:  Sole Proprietor  Partnership  Corporation: State \_\_\_\_\_

How long in business: \_\_\_\_\_ D&B Number: \_\_\_\_\_

Credit References		
Company: _____	Phone: _____	Acct No: _____
Address: _____		
City: _____	State: _____	Zip Code: _____

Name of Person to Contact Regarding Purchase Orders and Invoices, Title. _____ _____
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Credit Card Authorization	Account Number, Contact, Title, and Phone Number
Name of Cardholder: _____	Card Type: Visa Mastercard _____
Card #: _____	Exp Date (MM/YY): _____ 3-Digit Security Code: _____
Bill Address: _____	

Payment terms will be net 30 days from date of invoice. It is agreed that I will pay a service charge of 1.5% per month on the total amount past due. Hower, to open a account at Phoenix Dental Lab credit card is required. _____
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The above information is submitted for the sole purpose of opening an account and I hereby certify the information to be true.	SIGNED _____ TITLE _____ DATE _____
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