Please email this form to
AR@midwaydental.com
or fax to 248-919-5709

Sales Representative Name:
_____

New Customer Account Application

Office Name: _____

Doctor's Name: _____

Office Address: _____

City: _____ State: _____ Zip: _____ County: _____

Billing Address: _____

Phone: _____ Fax: _____ Email: _____

State License No.: _____ State: _____ Expiration Date: _____

A/P Contact: Name: _____

Phone: _____ Email: _____

Billing Instructions

□ AutoPay By Bank Account (ACH Payments) **SIGN UP FOR ACH AUTOPAY TODAY & RECEIVE $100 INSTANT ACCOUNT CREDIT!!**

Accountholder Name: _____

Bank Name: _____

Bank Address: _____

Routing Number: _____

Account Number: _____ □ Checking □ Savings

Special Payment Notes/Instructions _____

□ AutoPay By Credit Card

Cardholder Name: _____

Billing Address: _____

_____

Credit Card Number: _____ Exp. Date: ___/___ Security Code: _____

I agree that I am liable for any written or verbal orders that are invoiced upon receipt. I will inspect orders upon delivery and contact Midway Dental Supply to report any discrepancies, missing items, and/or damaged items within 7 days of receipt. In the event any balance is not paid within the terms stated and any suit or action is brought to enforce or interpret any of the terms of this Agreement, I agree to pay all actual costs of collection, including actual attorney's fees and court costs and interest charged at the annual rate of 18% whether or not litigation is commenced or prosecuted to final judgment. In the event I sell, transfer or change the ownership or legal structure of our business, I agree to provide written notice thereof delivered to the accounting department of Midway Dental Supply, which notice must actually be received. Until I provide such notice, I agree to be liable for all purchases made on the account(s) established in my name. I understand that Midway Dental Supply reserves right to change my discount pricing should my account become delinquent over 90 days. I hereby authorize Midway Dental Supply to charge my credit card or withdraw from my bank account provided above upon shipment of each order. By providing email address above, Customer agrees to receive monthly statements via email. Customer must contact AR@midwaydental.com to receive paper statements instead.

Customer's Signature attests financial responsibility, ability, and willingness to pay our invoices in accordance with our terms.

Customer Signature: _____ Title: _____

Name: _____ Date: _____