New Customer Information

Customer Business Name: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Contact Information: (name and email)

Technical: _____

Shipping: _____

Billing: _____

Payment Options: (please check one)

☐ Check for Full Statement Balance - Due 10th Calendar fo Month

☐ Credit Card Auto Billed for Full Statement Balance on 5th Calendar Day of Month

Apex requests all customers to keep a valid credit card on file. Open invoices not settled within 60 days of invoice date and not in dispute will be charged to the credit card on file. Returned checks will incur a $35 bounced check fee.

Customers agree to liability for all work completed by Apex Dental Milling. Unpaid balances are subject to a 2.0% per month fee. By signing below, the customer agrees to these terms and conditions.

Credit Card Information

Card Type: ☐ Mastercard ☐ Visa ☐ Discover ☐ American Express

Name on Card: _____

Card Number: _____ Exp Date: _____ CV: _____

Billing Street Address: _____

City: _____ State: _____ Zip: _____

Signature: _____

Please email or fax completed form to:
Email: newcustomer@apexdentalmilling.com
Fax: 734 623 1861

apexdentalmilling.com
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(734) 623 4236