Ultimate Dental Customer Application

2099 Hillshire Circle | Memphis, TN 38133 | Local: (901) 683-6677 | Toll Free Fax: (866) 683-6679 | www.ultimatedental.com

Toll Free 800-388-7868

To open an account, please complete this application in full and fax to 866-683-6679. We will process your application and notify you when your account becomes active. If you have questions regarding this application or the status of your account, please call 800-388-7868. All information is strictly confidential.

Applicant Information

Practice Name

Doctor's Name

Billing Address

City, State, Zip Code

Phone Number

Fax Number

Doctor's License Number* (Required to open an Ultimate Dental Account)

DEA Number* (Required to open an Ultimate Dental Account)

*Due to state and federal laws, prior to your first purchase of any controlled substances (including needles, syringes, anesthetics, injectables, etc.) we must have your license numbers and/or DEA numbers for our records.

Communication Preferences

As a customer, you will receive communications about new products, special offers or upcoming events via fax and email. In accordance with the CAN-SPAM Act and Telephone Consumer Protection Act we must have your written approval authorizing these communications.

☐ **Yes, I want to receive promotion information via Email.**

Email Address*

** For Ultimate Dental's internal use only. Not for sale or distribution.*

Please add me to these email groups:

(Please select which type of emails you would like to receive.)

☐ Order Updates and Tracking Information

☐ Product and Account Information from your Account Manager

☐ Special Offers and New Product Announcements

☐ No, exclude me from all email communications.

☐ **Yes, I want to receive faxes via the number listed above.**

☐ No, exclude me from all fax communications.

Signature

Date

You may request to not receive future faxes from Ultimate Dental/Endoco, Inc. To stop receiving such faxes, please do one of the following: call (901) 683-6677 or (800) 388-7868, or send a fax to (901) 683-6679, or send an email to sales@endoco.com at any time. Your fax or communication must include the specific telephone number of the fax machine(s) at which you do not wish to receive faxes from us. We will remove your fax number from our lists and will not send you additional faxes. Failure to comply with your request within 30 days is unlawful. If you wish to receive such faxes from us after you have requested to be removed from our lists, you must provide express consent to receive such faxes at the fax number, telephone number, or e-mail address listed above.

The following is to be completed by Credit Department:

Date Received

Credit Manager

Shipping Information

☐ **Check if same as billing address.**

Business Shipping Address (No Post Office Boxes)

City, State, Zip Code

Payment Information

How do you prefer to be billed? (Please check one.)

☐ **Net 30 Days*** (Credit check required)
Freight charges will apply.
Payment is due upon the receipt of your monthly statement.

Social Security Number (Required to open an Ultimate Dental Net 30 Account)

☐ **Credit Card***
We accept Visa, MasterCard, American Express and Discover.
There is no charge for freight.

Credit Card Type:

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Credit Card Number (If preferred, you may call with number)

Card Expiration Date

Name (As Printed on Card)

Card Billing Address

City, State, Zip Code

☐ **C.O.D.***
Freight charges will apply.
A C.O.D. charge will be added to your order as regulated by UPS.

* There is no minimum order; however, all orders under $50.00 are subject to a $6.95 small order fee. Orders over $50.00 will have a $4.95 handling fee.

Credit Information

By signing below, you give Ultimate Dental, A Division of Endoco, Inc. permission to request a consumer report to be used in considering this application and subsequently for the purpose of any update, renewal, extension of credit, reviewing or collecting on the account. Proprietorships, Partnerships or Corporations, including professional corporations, and/or the undersigned assume liability for ALL purchases made by any employee, manager, office, doctor or pharmacist employed when the order was placed.

I hereby agree to pay interest on all overdue accounts at the rate of 1.75% monthly, and to pay all costs of collection including reasonable attorney's fees. I hereby certify that the information set forth above, together with all other information submitted in connection with this application, is true and correct. Any fees associated with NSF checks will be the responsibility of the customer.

Signature Required (Owner/Dentist)

Date

Please Print (Owner/Dentist)

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