



Aim-Fx Dental Arts
New Doctor Information Form
MUST BE FILLED OUT AND RETURNED WITH FIRST CASE!

Doctor Name: _____ Dental Practice License # _____

Ownership: _ Corporation _ Partnership _ Proprietorship _ Other (please explain) _____

Billing address: _____

Phone Number: _____ Fax Number: _____ Email address _____

Practice Related Information

- 1. Please designate a contact person in your practice that will handle the ongoing relationship with Aim-Fx Dental Arts: (Name) _____ (Title) _____
2. Please indicate the practice's business hours by designating the times the practice is open during a normal work week: (Mon) __, (Tue) __, (Wed) __, (Thu) __, (Fri) __, (Sat) __
3. In case we need to reach you about a specific case, and you are not in your office, please designate two alternate telephone numbers where you may be reached. We will only use this contact method as a last resort: (home#) _____ (cell#) _____
4. Please indicate the company you prefer to ship your cases with from the following options: Airborne Express Federal Express US Priority Mail _____
5. Please indicate if your shipping address is different from your billing address. If this does not apply to you please skip to the next question. _____

I/We affirm that the foregoing information contained in this application is presented for purposes of establishing credit and is true, complete, and correct. Aim-Fx Dental Arts is authorized to make any investigation of my credit or employment status whether directly or through any agency employed by Aim Fx Dental Arts for that purpose. You may also disclose to any interested parties or agencies your experiences with this account. I/We agree to inform Aim-Fx Dental Arts immediately of any matter that will cause significant change in my financial condition on existing or new orders. I understand that Aim-Fx Dental Arts will retain this credit application whether or not it is approved. If this application is accepted by Aim-Fx Dental Arts, I/We agree to the following terms:

a) Please provide below the credit card which you want to use to guarantee payment of all charges:
Credit Card Type _____ Card #: _____ Expiration Date : __ / __ / _____

Credit Card Billing Address _____

- b) Any invoice, which is not paid when due, will accrue interest of one and one half percent (1.5) per month on the unpaid balance from the invoice until payment in full is received
c) In the event the account becomes delinquent after 45 days, Aim-Fx Dental Arts is authorized to satisfy the outstanding balance by credit card which will be provided by applicant below, until such time that a notice is received by Aim-Fx Dental Arts canceling the authorization
d) In the event the company is a corporation, I understand and agree that by signing below I personally Guarantee payment of any and all monies owed.
e) In the event that it becomes necessary to file an action to recover any amounts due under this agreement, I understand and accept that the court shall award prevailing party in such actions all costs, including reasonable attorney's fees.
f) This agreement shall be governed by and consulted and enforced under the laws and judicial decisions of the State of California. Any and all actions to enforce this Agreement shall be commenced in the County of Los Angeles.
g) This agreement shall act as a revolving Agreement and shall apply to any and all future orders placed with Aim-Fx Dental Arts by applicant
h) This agreement shall be binding on and shall insure to the benefit of heirs, executors, administrators, successors, or assigns of respective parties .

Signature of Applicant: _____ Date: __ / __ / _____