CUSTOMER CREDIT APPLICATION

Please fax back attn: ____________________
Fax: 866.545.3420

GENERAL INFORMATION

Practice Name ______________________________

Doctor/Owner ______________________________

Billing Address ______________________________
Street
____
City, State, Zip

Shipping Address ______________________________
Street
____
City, State, Zip

Phone: ______________ Fax: ______________

Email: ______________________________

M.D. ☐
O.D. ☐
Optician ☐
Distributor/Buying Group ☐

License # ____________________

Corporation ☐
Partnership ☐
Proprietorship ☐

SSN/Fed Tax ID# ______________

Years at location ____ Years in Business _______

CREDIT INFORMATION

Bank Reference

Bank Name ____________________ Account Number ____________________

Address ____________________ Phone ____________________
Street
____
City, State, Zip

Trade References

Supplier ____________________ Account Number ____________________

Address ____________________ Phone ____________________
Street
____
City, State, Zip

Supplier ____________________ Account Number ____________________

Address ____________________ Phone ____________________
Street
____
City, State, Zip

Supplier ____________________ Account Number ____________________

Address ____________________ Phone ____________________
Street
____
City, State, Zip

Office Use Only

Acct #
____

Rep ID: ______

PL: ______

Source: ______

Approval: ______

____________________ Signature of Owner/Doctor
____________________ Print Name and Title
__________ Date

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