ORIGIN
Dental Solution

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# NEW CUSTOMER ACCOUNT INFO

## Business Information Form

## Contact Information

### Company

Name : _____ Fax : _____

E-mail : _____ Phone : _____

Shipping Address : _____

Billing Address : _____
(If different from shipping address)

Federal Tax ID # / State : _____

### Primary Contact

Name : _____

Title: _____

Phone : _____

E-mail : _____

### Purchasing Manager / Accounting

Name : _____

Title: _____

Phone : _____

E-mail : _____

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### Client Agreement

I agree to pay within 30 days of receipt of the invoice for the merchandise or services rendered by Origin Dental Solution.

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### Your Company Authorization

I certify that the information provided in this form is accurate and fully understand the terms set forth by Origin Dental Solution.

Date : _____ Signature : _____