4212 Artesia Blvd.
Torrance, CA 90504
800-548-3384
310-214-8007

www.gkydentalarts.com

ACCOUNT INFORMATION

GKY DENTAL ARTS

PLEASE RETURN COMPLETED FORM(S) TO:

GENERAL OFFICE INFORMATION

1. Company Name: _____

Billing Address: _____ Phone: _____

_____ Fax: _____

City, State and Zip: _____ Email: _____

2. Federal Tax ID or Social Security No. _____

3. Type of Business: ❑ Dental Office ❑ Dental Lab (If CA, provide Resale No. _____)

4. Years in Business: _____

5. Check which is applicable to you: ❑ Corporation ❑ Sole Proprietorship ❑ LLC
❑ General Partnership ❑ Limited Partners

6. Please list: Owner(s), Officer(s), Partner(s) _____

Please provide: License No. _____

7. Doctor/Account Holder's Name: _____

8. Accounts Payable Contact Name: _____

Phone: _____

Fax: _____

Email: _____

9. Requested Type of Account: ❑ COD ❑ Preauthorized Credit Card Payment ❑ Open Account (must fill in #10)

10. If Open Account, Amount of Credit Requested: $ _____ ($1,000, if not specified)

AGREEMENT

I have read and agree to the GKY Dental Arts, Inc. Terms and Conditions.

❑ Yes, I agree that my signature below authorizes GKY Dental Arts, Inc. to proceed with my lab work without a Dentist Signature on any paper prescription(s) submitted by my office.

❑ No, I do not authorize GKY Dental Arts, Inc. to process with my lab work if the paper prescription form(s) is/are not signed. I understand this will result to a delay of my case.

SIGNATURE ON FILE

Name of Company: _____

Authorized Signature: _____ Date: _____

Print Name and Title: _____

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AGREEMENT FOR OPEN ACCOUNT

DENTAL ARTS

PLEASE RETURN COMPLETED FORM(S) TO: GKY - ACCOUNTING DEPARTMENT
Email: accounting@gkydentalarts.com
Fax: (310) 214-0747

AGREEMENT

In consideration of GKY Dental Arts, Inc. supplying products on Open Account Credit Terms, it is understood the Statement Balance will be paid in full by the end of the subsequent month from the statement date.

I agree that, should I fail to fulfill any of the obligations under this credit agreement, fail to comply with payment terms or in the event any check be dishonored by our bank for any reason, then the entire balance owing on this account will become due immediately payable and any credit limitation established will be withdrawn. Amounts past due will be subject to a 2% service charge.

In the event my account goes out of terms, GKY Dental Arts has my authorization to apply charges on the following VISA or MasterCard Account:

❑ VISA ACCOUNT ❑ MASTERCARD ACCOUNT

_____
Card Number

_____
Name of Cardholder

_____
Expiration Date

_____
CVV2 - Credit Verification Value Code
(located on the back of the credit card)

SIGNATURE ON FILE

_____
Cardholder Authorized Signature

_____
Date