New Customer Information

STUDIO ARTS
A PROFESSIONAL DENTAL LABORATORY

Name: _____

Shipping Address: _____

City: _____ **State**: _____ **Zip**: _____

Phone:(___) _____ **Fax**:(___) _____

Contact Information (name and e-mail):

Technical: _____

Shipping: _____

Billing: _____

Payment Options

☐ Check with each case ☐Credit Card charged with each case

☐ Statement (paid by check on or before 30th) ☐Statement (paid by credit card on or before 30th)

Studio Arts Dental Laboratory requires a credit card on file for all accounts.
For customers paying by check, bounced checks will be subject to a $25 bounced check fee. Bounced checks or missed payments will result in a phone call from Studio Arts Dental Lab to the Billing contact listed above. If payment is not resolved within 30 days of the statement date, the credit card listed below will be charged for the amount due including any applicable fees.

For customers paying by credit card, this card will be charged for each case prior to each shipment, or by the 30th of the month following the statement date as selected above.

By providing this credit card number, the laboratory and cardholder agree to be liable for any and all debts incurred with Studio Arts Dental Lab. The laboratory and cardholder agree to allow Studio Arts Dental Lab to conduct a credit check. Bill cycles end on the last working day of the month. Any unpaid balances will be subject to a minimum 1.5% per month financing fee. By signing below, the cardholder and laboratory agree to these terms and conditions.

Credit Card Information Type of Card: ☐ Mastercard ☐ Visa ☐ Discover ☐ American Express

Name on Card: _____

Card Number: _____ **Exp Date**: _____ **Sec. Code**: _____

Billing Street Address: _____

City: _____ **State**: _____ **Zip**: _____

Signature: _____

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