NT DIGITAL DENTAL TECHNOLOGY

NEW CUSTOMER ACCOUNT INFO

Business Information Form

CONTACT INFORMATION

Company Name

Account Type

Dentist Laboratory Distributor

Milling Center Practice Lab Other

E-Mail

Phone

Fax

Shipping Address

Billing Address

(If diffrent from shipping address)

PRIMARY CONTACT

Name

Title

Phone

E-Mail

PURCHASING MANAGER

Name

Title

Phone

E-Mail

TAX EXEMPTION: CA, CT, IL, NC, NY ONLY

No

Yes: Resale/Exemption Certicate must be attached to this form in order for account to be setup as exempt.

YOUR COMPANY AUTHORIZATION

I certify that the information provided in this form is accurate and fully understand the terms set forth by NT-US, Inc.

DATE

SIGNATURE

NT DIGITAL DENTAL TECHNOLOGY

CREDIT CARD
Payment Authorization Form

PLEASE COMPLETE THE INFORMATION BELOW:

Name of Cardholder

Billing Address	City	State	Zip

Phone	E-Mail

I authorize NT-US, Inc. to charge my credit card indicated below for payments towards my statement balance.

CREDIT CARD INFORMATION

Cardholder Name (as shown on Credit Card)	Card Number
Expiration Date	CVV*

*3 digits on back of VISA/MasterCard/Discover & 4 digits on front of AMEX

By my signature above, I certify that I have signatory capacity with this credit card company to authorize charges on this credit card on behalf of my company. If the charges are declined, I personally and individually guarantee the payment of the above charges. I acknowledge that future orders may be authorized to this card – subject to the same terms and conditions as this authorization, and a confirmation provided if I request it.

DATE	**SIGNATURE**