



CREATIVE DENTAL LABORATORY, INC

14201 N. 87th St. Scottsdale, AZ 85260 P: 480-948-0456 F: 480-443-7666 www.creativedentalaz.com

Practice Name: _____

Practice Owner: _____

Practice Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____ Cell: _____

Doctors authorized to send cases from this practice (If you add doctors to your practice in the future, you will need to fill out the Add Doctor form):

Primary Credit Card #: _____

Exp. Date: _____ CVV Code: (from the back of your card) _____

Name as it appears on credit card: _____

Billing Address for credit card: _____

Billing City, State, Zip: _____

Date of Auto Pay (please circle one): 5th 10th 15th or Prefer to pay by check

(When paying by check, payment is due by the 15th of the month, otherwise your credit card will be charged.)

Secondary Credit Card #: _____

Exp. Date: _____ CVV Code: (from the back of your card) _____

Name as it appears on credit card: _____

Billing Address for credit card: _____

Billing City, State, Zip: _____

This Agreement is between the Cardholder (above) and Creative Dental Laboratory, Inc. The Agreement shall become effective upon signature of Cardholder and a duly authorized agent of Creative Dental Laboratory, Inc.

I hereby certify the information provided on this Agreement is true, correct, and complete as of the date indicated below and I agree to promptly notify Creative Dental Laboratory, Inc. of any changes in the information provided.

I hereby authorize Creative Dental Laboratory, Inc. to charge my credit card indicated above on the day selected, or on a case by case basis to facilitate C.O.D. delivery with the amount of my invoices. This Pre Authorization Agreement shall remain in effect until I notify Creative Dental Laboratory, Inc. in writing of its cancellation.

Card Holder's Signature: _____ Date ____ / ____ / ____