CREDIT APPLICATION
FOR DENTAL OFFICE

2355 South Commerce Road
Wolverine Lake, MI 48390

FAX Completed Application to: (248)341-3641 **Account Inquiries CALL: (248)432-0136**

Credit Account-Applicant Information

Business Name: ____________________

Owner or Doctor's Name: ____________________

BILLING ADDRESS: ____________________

City ____________ State ______ Zip ______

Phone # ____________ Fax # ____________

EMail Address: ____________________

SHIPPING ADDRESS: (if different from above):

Contact Name: ____________________

Shipping Address: ____________________

City ____________ State ______ Zip ______

Phone # ____________ Fax # ____________

EMail Address ____________________

Social Security No*:

☐☐☐-☐☐-☐☐☐☐

✱ The Social Security number is required for all Net-30 & C.O.D. billing accounts

Tax ID # ____________________

Credit Card Information

Credit Card Type:

VISA ☐ MasterCard ☐ DISCOVER ☐ American Express

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

☐☐☐☐ ***Credit Card Security Code***
(3 Digits on back of credit card - American express is 4 digits.)

Please Print Cardholder Name ____________________

Signature ____________ **Card Exp. Date** ______

CREDIT CARD BILLING ADDRESS:

Address ____________________

City ____________ State ______ Zip ______

Current Suppliers

Company #1: ____________ Contact: ____________

Phone #: ____________ Fax: ____________

Address: ____________________

City: ____________ State: ______ Zip: ______

Company #2: ____________ Contact: ____________

Phone #: ____________ Fax: ____________

Address: ____________________

City: ____________ State: ______ Zip: ______

Net 30 Days Credit Information

Please Indicate Preferred Method of Payment

☐ **Due Upon Receipt** ☐ **Credit Card** ☐ **C.O.D.**

Shipping (freight) goes by weight, size, and zip code of packages. There is a $20.00 minimum for hazardous or heavy materials. Shipping: Most orders ship the day of order. Minimum Order: $20.00 before shipping charges. Returns: Within 30 days in original packaging. Returned Checks: Assesed $25.00 Processing Fee. Restocking Fee: 20% Free shipping: Orders of $500 or more, 20lb weight limit.

TYPE OF BUSINESS: (Please Check One):

☐ Proprietorship ☐ Partnership ☐ PC ☐ Tax Exemption ☐ Corporation

COD:

International orders must be prepaid via wire-transfer. *By signing below, you give Chase Dental Supply Company permission to request consumer reports from consumer reporting agencies to be used in considering this Application and subsequently for the purpose of any update, renewal, extension of credit, reviewing or collecting on the Account. Upon your written request, we will inform you of the name and address of each consumer reporting agency from which we obtain a consumer report relating to you. Proprietorships, Partnerships. or Corporations including professional corporations assume liability for ALL purchases made by any employee, or authorized agent employed when the order was placed. I hereby agree to pay interest on all overdue accounts at the rate of 1.5% monthly, and to pay all costs of collection including reasonable attorney's fees. I hereby certify that the information set forth above, together with all other information submitted in connection with this application, is true and correct.*

X ____________________ ____________

Authorized Signature **Date**

IF PLACING C.O.D. ORDERS

1) C.O.D. Orders have a $9.00 charge, plus the shipping charge.

2) C.O.D. Orders over $500 must be paid with a cashiers check or money order. (No Personal Checks)

PLEASE NOTE: WE WILL NOT SHIP TO P.O. BOXES

Complete this application in full. *We thank you for your application for credit with Chase Dental Supply. We will process your application quickly, and will notify you within 30 days. All application inquiries may be directed to our accounting office at (248)432-0136. All information you provide will be kept in strict confidence, subject to the terms stated above. Thank you.*

Please Sign Here: X ____________________ ***Today's Date:*** ____________