Online Form

Date: ____ / ____ / _____
Day Month Year

Party Responsible for Payment | Email

Mailing Address

County | City | State | Zip Code

Phone | Fax (optional) | Hygiene License Number | Issuing State

Name of Hygiene School | Year Grad.

Credit Card Information to be charged per order, initial here _____.

Name on Credit Card

Billing Address | City | State | Zip Code

Phone | Type of Card: ☐ MC/Visa ☐ Amex | Card # | Exp. Date / (Month / Year) | Security Code

This application is submitted for the purpose of obtaining an account from Simply Hygiene (supply fulfillment through Atlanta Dental Supply Company). Regardless of whether the signature(s) on this application indicate(s) a representative capacity, the individual(s) signing this application agree(s) to be personally responsible for payment of the account. I authorize Simply Hygiene / ADS to verify the information on this application and to receive information about me, including requesting reports from consumer reporting agencies. I further authorize Simply Hygiene to contact theses sources for information at any time. I represent that all purchases here under shall be for business or commercial purposes only. I understand that the payment terms are "due upon receipt" of goods. I further understand that Simply Hygiene / ADS may impose a service charge of up to 1-1/2% per month on amounts delinquent beyond the specified terms on the invoice(s). In the event of default, the undersigned agrees to pay all costs of collection including a reasonable attorney's fee and court costs.

I HAVE READ THIS AGREEMENT AND AGREE WITH ITS TERMS.

_____ ____/____/_____ _____ ____/____/_____
Customer Day Month Year Sales Representative Day Month Year

Thank you for your order!

Please Fax to: 678.584.4601 or email setup@atlantadental.com
Questions? Call 1-844.471.7814