

ACCOUNT SET-UP

Date ____ / ____ / ____

Doctor's Name _____

Hospital Name _____

Phone Number (____) _____ Fax Number (____) _____

Email _____ Web Address _____

ORDERING INFORMATION

Approved Account Number *Office Use Only* _____

Purchase Order Number *If Applicable* _____

Number of **3-Packs** Ordered: _____

Number of **10-Packs** Ordered: _____

Shipping Address

Billing Address

Street _____

Street _____

City _____

City _____

State _____ ZIP _____

State _____ ZIP _____

PAYMENT INFORMATION

Credit Card Number _____

Name as Appears on Card _____

Expiration Date ____ / ____ / ____ Security Code _____