**CUSTOMER DATA**

Please fill out and send this form back to us via e-sign or post with your first case.

INVOICING DETAILS - Practice data (\*mandatory fields)

Practice Name & Group name if any:\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_        \_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor's Full Name:\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_        \_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Address:\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_        \_\_\_\_\_\_\_\_\_\_\_\_\_

City:\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_        \_\_\_\_\_\_\_\_\_\_\_\_\_

State (if any) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_        \_\_\_\_\_\_\_\_\_\_\_\_\_

Country \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_        \_\_\_\_\_\_\_\_\_\_\_\_\_

Postcode:\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_        \_\_\_\_\_\_\_\_\_\_\_\_\_

License/GDC Number:\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_        \_\_\_\_\_\_\_\_\_\_\_\_

Doctor's Email Address:\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_        \_\_\_\_\_\_\_\_\_\_\_\_\_

Practice Website: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_        \_\_\_\_\_\_\_\_\_\_\_\_\_

The SmileShoppe Dental Lab | +1(248)-716-0146 | smileshoppelab@gmail.com | www.SmileShoppeLab.com

**To Receive Statements:**

We run paperless statements that are sent out via email on the last working day of each month. It is the Doctor's responsibility to ensure an online account has been set up for their surgery to receive their statement. To set up an online account, go to www.SmileShoppeLab.com and select 'My Account'.

**What You Should Know:**

• Payment terms are 15 days from the statement date.

• Statements are sent on a monthly basis. The practice is responsible to insure that the payment is received in a timely manner.

• All requested services require an online account with us to receive updates on your case progress, as well as monthly updates on your financial data with SmileShoppe.

I hereby accept the payment and delivery conditions.

I hereby declare under my responsibility that the data provided is correct, and I will inform SmileShoppe about any variation.

This document implies the acceptance of the mentioned terms and conditions.

The personal data on this document will be used exclusively by SmileShoppe and will be used to provide information regarding the products, services, or for promotional purposes.

(To be signed and dated by the named Doctor)

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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