

# ACCOUNT APPLICATION FORM

Company Name			
Dentist Name		Contact	
Invoice Address			
Delivery Address			
Email			
Telephone (inc. area code)		Fax (inc. area code)	
Contact			
Ark Health Rep			

## TYPE OF BUSINESS (Please tick)

Sole Trader ☐ Partnership ☐ Private Company ☐ Public Company ☐

## TRADE REFERENCES (Please include three)

Company Name	Contact Details

Monthly Credit Required

Premises (Please tick)	Owned <input type="checkbox"/>	Leased <input type="checkbox"/>
Company ABN	Bankers Name	Bankers Address
Proprietor (s)/Director (s) Name & Address		I have read your Trading Terms as set out in your website www.arkhealth.com.au, a copy of which is attached and by checking the following box agree to abide by them. <input type="checkbox"/>

Signed		Date	
Print name of signatory			
Title			

## Specialties in the practice (Please Select)

General ☐ Endodontics ☐ Hygienist ☐ Oral Surgery ☐  
Orthodontics ☐ Paediatrics ☐ Periodontics ☐ Other ☐

Number of Treatment  
Units

Number of Practitioners