

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 <input type="checkbox"/>	Partnership <input type="checkbox"/>	Private Company <input type="checkbox"/>	Public Company <input type="checkbox"/>
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TRADE REFERENCES (Please include three)

Company Name	Contact Details

Monthly Credit Required

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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)	Number of Treatment Units	Number of Practitioners
General <input type="checkbox"/> Endodontics <input type="checkbox"/> Hygienist <input type="checkbox"/> Oral Surgery <input type="checkbox"/> Orthodontics <input type="checkbox"/> Paediatrics <input type="checkbox"/> Periodontics <input type="checkbox"/> Other <input type="checkbox"/>		