PRECISION DENTAL LABS LLC
Innovative Dental Crafters
Panama City , FL

CUSTOMER INTAKE FORM

PRACTICE NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

EMAIL CONTACT: _____

BILLING CONTACT (NAME): _____

BILLING EMAIL for statements: _____

HOURS: _____

POINT OF CONTACT FOR LAB QUESTIONS: _____

EMAIL: _____ **PHONE:** _____

PRACTICE EIN: _____

PREFERRED PAYMENT TYPE (Please indicate): _____
(Credit Card – 3.0% processing fee) | Check – No Charge | ACH – No Charge
CC: Please provide card information to keep on file for payment processing:

CC: | EXP: | 3 DIGIT:

NAME AND BILLING ADDRESS FOR CC (INCLUDE ZIP CODE): Zip Code:

TERMS: NET 15
Precision Dental Labs LLC require FULL PAYMENT of statement/invoice within 15 days from billing date. Any outstanding balances unpaid beyond 15 days will be charged a 3% late fee for each 15-day period.
Billing cycle frequency: Statements sent /processed weekly