

NEW CUSTOMER INFORMATION FORM

Company Name*	
ACN /ABN*	
Business Trading Name*	
Registered Address	
Delivery Address*	
Contact Name (Purchase)*	
Telephone No.*	
Contact Name (Accounts Payable) *	
Telephone No.*	
Email Address *	
Ownership * (tick appropriate):	<input type="checkbox"/> Sole Trader <input type="checkbox"/> Partnership <input type="checkbox"/> Trust <input type="checkbox"/> Proprietary / Ltd Co.
Type of Business *	<input type="checkbox"/> Wholesaler <input type="checkbox"/> Retailer <input type="checkbox"/> Catering <input type="checkbox"/> Other: _____
How did you hear about us?	<input type="checkbox"/> Facebook <input type="checkbox"/> Google <input type="checkbox"/> Local Retail Shops <input type="checkbox"/> Word of Mouth <input type="checkbox"/> Other: _____

Signature: _____

Date: _____

* Required