MEDICAL CONCEPTS

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NEW/CHANGE CUSTOMER INFORMATION FORM

CUSTOMER INFORMATION

Name _____ **TAX ID**_____

DBA _____

Website _____

SHIP TO Address:

Contact _____ **Phone 1** _____

Address _____ **Phone 2** _____

_____ **Email** _____

City _____ **Email Confirmation?** ☐ **YES** ☐ **NO**

State _____ **Fax** _____

ZIP Code _____

Country Code _____

BILL TO Address:

Contact _____ **Phone 1** _____

Address _____ **Phone 2** _____

_____ **Email** _____

City _____ **Email Invoice?** ☐ **YES** ☐ **NO**

State _____ **Fax** _____

ZIP Code _____

Country Code _____

Requested by (print) _____

Signature _____

Date _____

OFFICE USE ONLY

CUSTOMER ACCOUNT # _____

Payment Terms_____

Approved by _____

_____

Signature