Leading Dental — Equipment solutions for the modern surgery

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APPLICATION TO OPEN CREDIT ACCOUNT

(All information offered will be treated in strict confidence)

APPLICANT DETAILS

Registered Business Name ____

Trading Name ____

Owners Name ____

Name of Proprietor(s)____

DELIVERY ADDRESS

Building: ____________________

St/Suite:____________________

City:____________________

State:__________Postcode:__________

POSTAL ADDRESS

Building:____________________

St/Suite:____________________

City:____________________

State:__________Postcode:__________

CONTACT DETAILS

Phone:____________________

Fax: ____________________

Mobile:____________________

Email:____________________

Would you like to receive emails from us? Eg Specials and Promotions, New Products, Dental News etc

Yes ☐ No ☐

BUSINESS DETAILS

How many years Trading? ____

ABN or ACN Number ____

Professional Registration Number ____

TRADE REFERENCE DETAILS

Please provide names and phone numbers of 3 suppliers.

1. ______________________________ Ph. ____________________
2. ______________________________ Ph. ____________________
3. ______________________________ Ph. ____________________

Please acknowledge that all information supplied above is true and correct. Payment Terms are 30 days from Invoice date. Thank you very much for supporting Leading Dental.

Signed, Owner/ Proprietor ……………………………………………… Date …………………….