2833 Smith Ave., Suite 135 • Baltimore, MD 21209 240.423.6765

New Client Information

Please return this form with the first case you send us or email it to us at crowndoctor@gmail.com

| Doctor Name: | | | |
|--|-----|----|--|
| Office Name: | | | |
| | | | |
| Address: | | | |
| Phone Number: | | | |
| Email Address: | | | |
| Would you like your monthly statements emailed to you? | Yes | No | |
| Preferred Payment Method: Check | | | |

Credit Card



3300 Tray Lane • Baltimore, MD 21208 240.423.6765

Payment Authorization Form:

Your completion of this authorization form helps us protect your private information. This information will be kept confidential. The purpose of this form is to collect monthly or overdue dues related to Crown Doctor Dental Laboratory.

| Name on Card |
|-----------------|
| Billing Address |
| City |
| State |
| Zip Code |
| Card # |
| Exp Date |
| |
| |
| Signature |
| Date |

Your signature on this form authorizes Crown Doctor Dental Laboratory to charge this credit card for any overdue fees. We will notify you through email or phone call before charging this credit card.

*If your bill is overdue by 90+ days we reserve the right to charge your credit card

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