EXQUISTE DENTAL STUDIOS INC.
NEW CLIENT AGREEMENT
(Required for all new accounts)

Doctor Name _____**Dental Practice License#**_____

Address _____ **Phone**_____

City _____ **State** _____ **Zip** _____

Years established _____

Ownership (Check one): Corporation _____ **Partnership**_____ **Proprietorship**_____

Other (explain) _____

Other Doctor's in your practice: _____

_____

_____

My/Our signature(s) will affirm that the foregoing information contained in this application is true, complete and correct. I/We agree by signing below to the terms set forth in this document by *Exquisite Dental Studios, Inc*.

1) All invoices will be paid on a net 15 day basis by automatic American Express Card payment using the card information provided. I agree that Exquisite Dental Studios will automatically charge my card for each prior month's billing on the 15th of the following month
2) Any invoice that is not paid due to lack of funds, will accrue interest until payment in full is received.
3) In the event the company is a corporation, I understand and agree that by signing below I personally guarantee payment of any and all monies owed.
4) In the event that it becomes necessary to file an action to recover any amounts due under this agreement, I understand and agree that any and all court costs, including reasonable attorney fees will be my responsibility.
5) This Agreement shall be governed by and consulted and enforced under the laws and judicial decisions of the state of Pennsylvania. Any and all actions to enforce this agreement shall be commenced in the county of Northampton.
6) This Agreement shall act as a revolving Agreement and shall apply to any and all future orders placed with *Exquisite Dental Studios, Inc.* by applicant.
7) This Agreement shall be binding on and shall insure to the benefit of heirs, executors, administrators, successors or assigns of the respective parties.

Signature _____ **Title** _____ **Date:** _____

American Express Card #_____ **Exp. Date**_____

THIS FORM MUST BE COMPLETED AND FAXED TO
610-614-1997 BEFORE SENDING US A CASE