

Customer Set Up Form



OPTICAL PRODUCTS & ACCESSORIES

BILLING INFORMATION

Company/Name: _____
Owner: _____
Address: _____

City: _____
Province: _____ Postal Code: _____
Phone1: (____) _____
Phone2: (____) _____
Fax: (____) _____
Email: _____

ACCOUNTS PAYABLE INFORMATION

Contact: _____
E-mail: _____

Payment Method*

VISA MASTERCARD CHECK

Credit Card #: _____
Expiry Date(mm/yy) : _____

BUSINESS INFORMATION

Optometrist
Optician
Lab
Other

Specify: _____

PURCHASING INFORMATION

Contact: _____

E-mail: _____

BUYING GROUP

YES N/A

Specify: _____

Member #: _____

** The first order requires payment in advance. \$250.⁰⁰ credit limit will be assigned to all new approved accounts. Payment terms are Net 30 days. There is a delivery charge on orders less than \$100.⁰⁰
We also offer automatic current monthly balance payment with VISA and MASTERCARD*

I authorize automatic current monthly payments on our credit card

Authorized Signature: _____ Date: _____

TRADE REFERENCES

Name : _____ Phone #: (____) _____
Name : _____ Phone #: (____) _____
Name : _____ Phone #: (____) _____

BANK REFERENCES

Name: _____ Contact: _____
Branch: _____ Address: _____
Account#: _____ Phone #: (____) _____

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