orion
Dental Solutions

1769 NY RT 52 Fishkill, NY 12524
Tel: 845-764-2324
info@oriondentalsolutions.com
www.oriondentalsolutions.com

New Doctor Account Activation Form

Practice Name: _____ Sales Rep: _____

Doctor: _____ License #: _____

Office Manager: _____ Account Manager: _____

Address: _____

City: _____ State: _____ Zipcode: _____

Phone: _____ Cell #: _____

Email [For Case]: _____ Email [For Billing]: _____

Fax: _____ Courier/ Pickup Time: _____

Office Hours

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Payment Preference [Please choose one of the following]

- ☐ I will submit payment for the full statement amount*
- ☐ I authorize Orion Dental to charge the below credit card for the full statement monthly on the _____ of each month.

Card Type: ☐ Visa ☐ Master Card ☐ American Express ☐ Discover

Credit Card Number: ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ - ☐☐☐☐ Expiration Date: _____ / _____

Name On The Card: _____ CVC: _____

Billling Address: _____

Terms & Conditions

☐ I agree to Orion Dental's Terms & conditions. I acknowledge that full payment is due at the time of receipt of the monthly statement. Failure to pay within 30 days may result in a 2% monthly sevice charge.

Signature: _____ **Date:** _____

*Please make checks payable to Orion Dental. For other payment options (ie ACH, Etc), Please contact billing at (212) 302-3860