WholeYou™

NEW CLIENT FORM

Name of Doctor: ______________________ Name of contact in office: ______________________

Name of Practice: ______________________ How did you hear about us? ______________________

Phone: ______________________ Fax: ______________________

Email Address: ______________________

Shipping Address: ______________________

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City: ____________ State: ____________ Zip Code: ____________

Billing Address (if different from above): ______________________

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City: ____________ State: ____________ Zip Code: ____________

PAYMENT INFORMATION: **We require that you send payment along with the impressions & bite!** Since we work within very tight profit margins and do not have an accounts department we are unable to allow invoices to build up. We do this to keep costs down and give you the best value! Any case that is sent without payment will be placed on hold until payment is received. We hope that you understand our position on this.

If you would like to keep a credit card on file, please fill in the information below:

Type of card: AMEX ☐ DISCOVER ☐ MASTERCARD ☐ VISA ☐

Credit card#

Exp. date:

M	M	/	Y	Y

* this card will be charged unless a check is sent with the case.

Cardholder name: ______________________ Signature: ______________________

By signing above, I hereby release and authorize the use of the above card to respire medical.

*We may use the personal information only to provide you with the services and products.
We do not share the personal information unless it's necessary to provide you with the services and products.

Please email, mail, or fax this completed form to Respire Medical. We look forward to doing business with you!

1-844-Live-Fully **www.wholeyou.com**

Manufactured by

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