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

18 Bridge St, Suite 4J. Brooklyn, NY 11201
Phone 718-643-7326
Fax 718-643-7322

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