Address:
Phone:
Email:
Website:

NEW CUSTOMER FORM

Business Name:

Doctor's Name:

Primary Billing Address:

City: State: Zip:

Telephone: Fax:

Email:

SHIPPING DESTINATION(S)

Street Address:

City: State: Zip:

Telephone: Fax:

STATE LICENSE #: EXPIRATION DATE:

GLN: Accounts Payable Name:

Corporation ☐ Proprietorship ☐ Partnership ☐

Tax ID #:

You can complete this form on screen, then print, sign and date it. Return by fax to 847.806.0464, or apply online at optitrimmd.com/provider-application/

Do You Have Multiple Location Yes No **See Page 3**

NAME OF OFFICER	TITLE	HOME ADDRESS

Business Hours:

Number of Years in Business:

Approx. Number of Patients Seen:

Delivery Dates & Times:

Purchase Insurance:

Have you filed bankruptcy in the last 7 years?

Signature of Guarantor: Date:

Print Name:

For Office Use Only	Customer Number:
Primary Account	
Ship To Account	
Ship To Account	
Ship To Account	
Ship To Account	
Ship To Account	

For Additional Location Make Copy of This Page

Primary Account Location

Shipping Address:

City: State: Zip:

Telephone: Fax:

Email:

Additional Location

Shipping Address:

City: State: Zip:

Telephone: Fax:

Email:

Additional Location

Shipping Address:

City: State: Zip:

Telephone: Fax:

Email:

Additional Location

Shipping Address:

City: State: Zip:

Telephone: Fax:

Email: