

# The Digital Dental Record

PHONE: 800-243-4675 FAX: 414-276-2186  
www.dentalrecord.com

**BILL TO: PLEASE USE THE ADDRESS OF WHERE YOUR CREDIT CARD STATEMENT IS MAILED. AN INCORRECT BILLING ADDRESS WILL DELAY YOUR ORDER.**

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Office Phone No. \_\_\_\_\_ Office Fax No. \_\_\_\_\_ \*E-Mail Address \_\_\_\_\_

**PAYMENT METHOD:**

CHECK ENCLOSED  
Order will be Processed only after receipt of check.

CHARGE MY CREDIT CARD  
Your order will be billed immediately.  
Master Card, Visa, American Express & Discover only.

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Credit card number.

Expiration Date \_\_\_\_\_ Cardholder Name: \_\_\_\_\_

Signature: \_\_\_\_\_

**SHIP TO: DUE TO THE SENSITVIE NATURE OF OUR PRODUCTS, WE SHIP ONLY TO THE ADDRESS PRINTED ON THE RX PAD, ADDRESS OF RECORD ON EITHER YOUR STATE LICENSE OR YOUR DEA LICENSE. WE CANNOT SHIP TO P.O. BOXES ONLY PHYSICAL LOCATIONS.**

STREET ADDRESS: \_\_\_\_\_

PERSONS AUTHORIZED TO RECEIVE SHIPMENT: \_\_\_\_\_

**By Completing and Signing this form, I acknowledge that I am a Representative and Authorized Purchaser for this Practice/Physician.**

Printed Name: \_\_\_\_\_

Authorized Purchaser Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Sales Tax will be added for Texas State Customers**

Please Select One	One Part #Pads	Cost	Please Select One	Rx Paper 8.5 x 11 for printing	Cost
	5 (100 scripts / pad)	\$105.17		100 Sheets	\$22.00
	10 (100 scripts / pad)	\$142.07		250 Sheets	\$50.00
	20 (100 scripts / pad)	\$171.43		500 Sheets	\$90.00
				1,000 Sheets	\$150.00

Please Select One	Two Part #Pads	Cost			
	5 (50 scripts / pad)	\$120.47			
	10 (50 scripts / pad)	\$180.77			
	24 (50 scripts / pad)	\$299.52			

# The Digital Dental Record

PHONE: 800-243-4675 FAX: 414-276-2186  
www.dentalrecord.com

PLEASE TYPE OR PRINT WORDING EXACTLY AS YOU WISH TO APPEAR ON RX PAD.

Practice Name: \_\_\_\_\_

Do you want this included on the Pad: Yes                      No (please circle a choice)

Alternate Line: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Pad Starting # \_\_\_\_\_

## PRESCRIBER INFORMATION.

Prescriber Name: \_\_\_\_\_ Degree: \_\_\_\_\_

License # \_\_\_\_\_ Do you want Lic# printed on pad:      Yes      No (please circle a selection)

Would you like a blank line for your License # instead:      Yes      No (please circle a selection)

DEA# \_\_\_\_\_ Do you want your DEA# printed on the pad:      Yes      No (please circle a selection)

Would you like a blank line for DEA# instead:      Yes      No (please circle a selection)

DPS# \_\_\_\_\_ NPI#: \_\_\_\_\_

\*\*\*We are required by Law to confirm all License, DEA, NPI and DPS information. If any information is inaccurate, we will contact you to receive correct information. Rx Pads will not be printed or shipped without correct information. \*\*\*

## Florida and Kentucky Prescription Pads – Signature Release Form

All prescription pad orders for the State of Florida and Kentucky must be accompanied by the signature, printed name, date, and DEA# number of the licensed medical prescriber authorizing the order.

Please note we cannot process your order until this is received.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

DEA# \_\_\_\_\_

This number will not be printed on your script unless requested by you. It is for verification purposes only.

Signature release forms may be returned by fax, e-mail, or mail.