The Dental Record

PHONE: 800-243-4675 FAX: 262-644-6902
www.dentalrecord.com

BILL TO: PLEASE USE THE ADDRESS OF WHERE YOUR CREDIT CARD STATEMENT IS MAILED. AN INCORRECT BILING 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. CVV Code_____

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		500 Sheets	$90.00
	10 (100 scripts / pad)	$142.07		1,000 Sheets	$150.00
	20 (100 scripts / pad)	$171.43			

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			

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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.