

ESCHENBACH OPTIK CUSTOMER INFORMATION FORM



*Business Name: _____ Date: _____

*Bill-To: _____ _____ _____ _____	*Ship-To: (If multiple locations, please add separate sheet) _____ _____ _____ _____
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How did you hear about Eschenbach/Ash Technologies? _____

*Tel: _____ *Fax: _____

*E-Mail address: _____ Web Page: _____

Person dispensing Low Vision Product: _____

License No. (primary L.V. Provider): _____ *Federal Tax ID# _____

*Do you have a certificate that exempts you from tax? Yes ___ (# _____) No ___

-If yes, you must include a copy of the Certificate with this form

*Accounts Payable contact person: _____ Ext: _____

*Do you prefer your invoices/statements emailed or faxed to you instead of mailed?

Please check choice: email ___ fax ___ regular mail ___

***Type of Business (please check one):**

- | | | |
|---|--|--|
| <input type="checkbox"/> Ophthalmology (MD) | <input type="checkbox"/> Optometry (OD) | <input type="checkbox"/> Optician (OP) |
| <input type="checkbox"/> Agency (AG) | <input type="checkbox"/> School/University (SL) | <input type="checkbox"/> Library (LB) |
| <input type="checkbox"/> Veterans Administration (VA) | <input type="checkbox"/> Occupational Therapy (OT) | <input type="checkbox"/> Retail (RT) |
| <input type="checkbox"/> Durable Med. Equipment (DM) | <input type="checkbox"/> Government [non-VAMC] (GO) | |
| <input type="checkbox"/> Video Dealer /Adaptive Equip. Dealer | <input type="checkbox"/> Other (please specify): _____ | |

***Supplier Credit References**

1. Name: _____ Acct#: _____ Fax #: _____

2. Name: _____ Acct# _____ Fax#: _____

3. Name: _____ Acct# _____ Fax #: _____

*** These fields must be filled in to complete the account set up !**