

☐ Please open an Art Optical account for my office

Today's Date: \_\_\_\_\_ Have you ever ordered from Art Optical before?: ☐ Yes ☐ No

Individual completing request form: \_\_\_\_\_

Reasons for Choosing Art Optical?: \_\_\_\_\_

## ACCOUNT INFORMATION:

Account Name: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ ☐ OD ☐ MD ☐ Other: \_\_\_\_\_

Doctor's License #: \_\_\_\_\_

Name of Person or Corporation Legally Responsible for Account Balance (required):  
\_\_\_\_\_

Do you prefer to bill through a buying group? ☐ Yes ☐ No

If yes, please provide the name of your preferred buying group & your member #: \_\_\_\_\_

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

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

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

Phone Number: (\_\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_\_) \_\_\_\_\_

## Shipping Information (if different)

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

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

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

Phone Number: (\_\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

\*\*All requests to open a Direct Account will require an "Acceptable" Business Credit Inquiry/Report prior to granting credit.\*\*

For immediate processing, email your completed request to: [info@artoptical.com](mailto:info@artoptical.com)  
or fax your completed request to: **1-800-648-2272**

***Thank you!***

*We look forward to serving your custom contact lens needs!*



PO Box 1848 • Grand Rapids, MI 49501-1848

Toll-Free Ordering 1-800-253-9364 • Consultation Direct 1-800-566-8001

Online [www.artoptical.com](http://www.artoptical.com)