



Azure Ortho Order Form

Please Check One: Dr's Office: _____
Laboratory : _____

Billing Info:

Name (First, Last, M.I.): _____

Company Name: _____

Address: _____

Phone Number: (____) _____ Extension: _____

Email Address: _____

Shipping Address: [] Check if same as billing

Name / Company: _____

Address: _____

Phone Number: (____) _____ Extension: _____

Email Address: _____

Product:

VECS 10MM EXPANDER \$39EA: _____ VECS 14MM EXPANDER \$39EA: _____

LAB KIT \$15EA: _____ ACTIVATION KEYS \$20EA: _____

BROCHURE: _____ INFO SHEET: _____ COPY OF INV: _____ CREDIT APP: _____

Shipping Option: (Circle) UPS Ground: \$14 UPS 2nd Day: \$23 UPS Next Day: \$45

Use own UPS/FED EX Acct (**\$5 FOR HANDLING FEE**) : _____

CALIFORNIA ORDERS: MUST ADD TAX OR RESALE CERT REQUIRED

Payment Method: Account Number: _____ or

(Circle) **Visa** (3 Digit on Back) **Master Card**(3 Digit on Back) **AMEX**(4 Digit on Front)

Card Number: _____

Expiration Date: _____ Security ID _____



Azure Ortho Order Form

Total Amount Charged: \$ _____ **Date:** _____ **Initials:** _____