Cloud Provider Count Change Form

Fax Signed Copy to (480) 924-1974

Account Change Requested By:

Contact Name: _____

Practice Name: _____

Phone Number: _____

Email Address: _____

Add or Remove (Check One)	Provider License Name (if Removing)
Add? ☐ Remove? ☐	
Add? ☐ Remove? ☐	
Add? ☐ Remove? ☐	
Add? ☐ Remove? ☐	
Add? ☐ Remove? ☐	

* Pricing will changed based on practice's provider count.

Total # of Providers in Practice Before Change: _____

Total # of Providers in Practice After Change: _____

By signing this Order Form, I acknowledge that I have read and agree to the terms and conditions of the application Terms of Service as well as the Service Level Policy, Support Policy, and System Requirements all of which can be viewed and accessed at http://dentimax.com/resources/files

Signature: _____ Date: _____