SPIO®

Order Form

Date: _____

Customer Account #:

Bill To: _____

_____

_____

_____

_____

Phone #: _____

Email: _____

Customer Account #: _____

Phone Order: Y☐ N☐

Contact Person: _____

Ship To: _____

_____

_____

_____

_____

Phone #: _____

Patients Name: _____

Diagnosis: _____

Date of Birth: _____

Referred By: Name:_____

Clinic: _____

Quantity	Size / Item #	Color	Short or Long	Description	Unit Price	Discount	Total

Subtotal	
Shipping	
WA State Tax	
Balance Due	

Visa ☐ Master Card ☐ Am Ex ☐ Discover ☐

Card #: _____

Exp. Date: _____ 3 digit CID: _____

Name on Card: _____

Address for Card: _____

_____

_____

Purchase Order No. _____

Enclosed is a check in the amount of $_____

Return within 90 days for a full refund if you are not completely satisfied

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