

Surgery Center _____ **Customer Number** _____

Billing Address

First Name _____
Last Name _____
Street Address _____
Suite/Floor _____
City _____
State/Province _____
Zip/Postal Code _____
Phone _____
Fax _____

Shipping Address

Same as Billing Address

First Name _____
Last Name _____
Street Address _____
Suite/Floor _____
City _____
State/Province _____
Zip/Postal Code _____

Payment Information

- Check
- Charge to my credit card on file
- Charge to my Tesla Medical acct
- Charge to my credit card below:

Card Number: _____ Exp. Date: _____ Security Code: _____

Cardholder Signature: _____

Zip Code on Card: _____