Gorgeous DENTAL SMILE
PRECILYN B. SILVESTRE, DDS
5910 Thornton Ave. Suite B Newark, CA 94560

510.792.4525
510.792.4535

CREDIT CARD AUTHORIZATION FORM

Date: _____

Type of Card: mastercard visa ☐others please specify: _____

Credit Card Number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiration Date: _____ Card Security Code * ☐☐☐

Name on Card: _____

Billing Address: _____

City/State Zip: _____

Phone Number: _____ Fax Number: _____

Patient's Name: _____

Cardholder's Relationship to Patient: _____

Charge Amount: _____

I, _____ certify that I am the authorized holder and signee of the credit card reference above. I certify that all information above is complete and accurate. I hereby authorize my credit card to be charged the above listed charge amount payable to Precilyn Bondoc Silvestre A Dental Corporation for services rendered.

(A new Authorization form is required for each separate charge amount)

Please sign and return by Fax along with a copy of PICTURE I.D

_____ _____

Card Holder's Signature **Date**