



CREDIT CARD AUTHORIZATION FORM

Date: _____

Type of Card: mastercard visa others please specify: _____

Credit Card Number

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Expiration Date: _____ Card Security Code *

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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