CREDIT CARD AUTHORIZATION FORM

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until canceled.

CREDIT CARD INFORMATION

Card Type: ◯ MasterCard ◯ VISA ◯ Discover ◯ AMEX ◯ Other

CARDHOLDER NAME (AS SHOWN ON CARD)

CARD NUMBER

EXPIRATION DATE (MM/YY) CVV

CARDHOLDER ZIP CODE (FROM CREDIT CARD BILLING ADDRESS):

I, ________________________________ , authorize ________________________________ to charge my credit card above for agreed dental work or missed appointment. I understand that my information will be saved to file for future transactions on my account.

CUSTOMER SIGNATURE DATE

RAYMOND DENTAL GROUP
FAMILY DENTISTRY & SEDATION CARE

Your Comfort. Your Smile. Our Priority.

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