



Center for Dental Anesthesiology

CREDIT CARD AUTHORIZATIONS

I authorize the Center for Dental Anesthesiology to charge the credit card listed below for services rendered.

Card member acknowledges receipt of good and/or services in the amount of the total shown heron and agrees to perform the obligations set forth by the card member's agreement with the issuer.

Signature of cardholder: _____

Cardholder's Name: _____

Cardholder's Address: _____

VISA ___ MC ___ AMEX ___ DISC ___ CARECRED ___ CAPTONE

Credit Card Number: _____

Expiration Date: _____

Security Code (on back in signature box): _____

Amount to be Charged: \$ _____