Children's Dental Care

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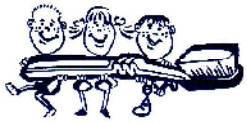

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DENTISTRY FOR CHILDREN AND YOUNG ADULTS
www.childrensdentalc.com

17510 DODD BLVD.
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PHONE: (952) 997-7100
FAX: (952) 997-2017

Credit/Debit Card Payment Consent Form

Patient Name: _____

Payee Name: _____
Print Last First Middle Initial

Name on the card if different: _____

I authorize Children's Dental Care to charge $_____ on the __15th__ day of each month until the balance is paid in full.
I will inform Children's Dental Care, if my credit/debit card number changes or a new card is issued to me before the balance on my account is paid in full.

Type of card: ☐ VISA ☐ MASTERCARD ☐ DISCOVER

Card Number: _____-_____-_____-_____

Expiration Date: _____/_____ **Security Number CVC** (on back of card)**: _____**

Card Holder's billing address:

_____
Street/apt City State Zip Code

Card holder's signature: _____ Date: ____/_____/_____