CREDIT CARD AUTHORIZATION FORM

I, _____, authorize Heights Pediatric Dentistry and Orthodontics to keep my signature on file and charge my Mastercard/Visa/AmEx account for attached and signed treatment plans as agreed on during my child/children's dental appointment.

PATIENT(S)' NAME:_____

CARDHOLDER'S NAME: _____

CARD NUMBER: _____ EXPIRATION DATE: _____

CVC CODE: _____ ZIP CODE: _____

CARDHOLDER'S SIGNATURE: _____