CONFIDENTIAL
Credit Card Authorization

Patient Name: ______________________________

Cardholder Name: ______________________________

Card: □ Visa □ Mastercard □ American Express

Card Number: ______________________ Exp: __________

Address: ______________________________

City: ______________________ Zip Code: __________

Telephone: ______________________________

The Dental Practice of:

Shelby J. Smith, D.D.S., M.S.
2213 Buchanan Road, Suite 112
Antioch, CA. 94509
(925) 755-5115

Is authorized to keep my signature on file and to issue a credit memo to my credit card account for any over payment for services. Credits in excess of $300.00 will be pre-authorized by telephone.

____Cardholder initials

Is authorized to keep my signature on file and to issue a charge memo to my credit card account for any outstanding balances for services. Charges in excess of $300 will be pre-authorized by telephone.

____Cardholder initials

Date:______________ Authorized:______________________
Responsible Party

Date:______________ Authorized______________________
Office Manager/Business Manager