CREDIT CARD AUTHORIZATION FORM

I, _____, give permission for Chelsea Pediatric Dentistry & Orthodontics to charge my credit card without being present.
Patient's Name: _____
Name on credit card: _____
Credit Card number:_____
Expiration Date: _____ CID number:_____
Amount of the charge:_____
One Time Charge: _____ Recurring Charge: Date of recurring charge: _____ Effective Date:_____
Signature:_____ Date:_____