



ALLIANCE DENTAL P.C.



84-11 Northern Boulevard
Jackson Heights, NY 11372
Phone: (718)424-7100

CREDIT CARD CHARGE AUTHORIZATION FORM

DIRECTIONS

1) Fill out and print, or print the blank form and complete the entire form legibly with a dark pen. Card holder must sign on the line indicated. We reserve the right to verify the provided information with your Credit Card Issuing Bank.

2) Include a photocopy of the front and back of the signed credit card and your driver license or state issued ID.

3) Fax to (718) 424-7898 or scan and email to info@alliancedentalny.com, the completed form and the photocopies of the credit card and ID to complete your order.

PATIENT NAME:

ACCOUNT #

DESCRIPTION

AMOUNT:

BILLING INFORMATION

Name

Address

City

State

Zip Code

Phone

E-Mail

CREDIT CARD INFORMATION

Credit Card #

Exp. Date

CVV#

* CVV is the last 3 digits on the back of your card. For AmEx it's the 4-digit code on the front side.

I, _____, understand the charges and hereby authorize ALLIANCE DENTAL P.C. to charge my credit card account in the amount of \$_____ and agree to be bound by ALLIANCE DENTAL P.C. policies, terms and conditions, and instructions for this transaction.

SIGNATURE

DATE: