Credit Card Authorization Form

I, _____,
authorize **Melissa V. Rozas, D.D.S. Dentistry for Infants, Children and Teens, P.A.** to keep my signature on file and to charge my ***Visa, MasterCard, American Express or Discover*** account for:

- **A.** Dental charges incurred
- **B.** Balance of charges not paid by insurance within 60 days
- **C.** Deposit for in office or out-patient dental treatment

Patient/s Name:_____

Cardholder Name:_____
(As printed on actual credit card)

Cardholder Address:_____

City, State, Zip Code:_____

Circle Credit Card Type: Visa / MasterCard / American Express / Discover

Account Number:_____

*Expiration Date:_____ 3-4 Digit Code:_____

Cardholder Signature:_____

Date:_____

Staff Member Witness:_____ Date:_____