Credit Card Authorization

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information Card Type: ☐ MasterCard ☐ VISA ☐ Discover
☐ AMEX☐ Other _____

Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____ **CVV#:** _____

Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize Greater Essex Dental to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.