

Confidential
VIP Express Checkout
Authorization

Patient Name: _____
Cardholder Name: _____
Card: Visa () Mastercard () Discover() American Express()
Card Number: _____ Exp Date: _____
Name on Card: _____
Address: _____
City: _____ Zip Code _____
Telephone #: _____

The Dental Practice of:

Dr. Bruce W. Small
Dr. Kaitlin C. Small
133 Franklin Corner Road
Lawrenceville, NJ 08648
609-896-0529

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

_____ Cardholders initials

Is authorized to keep my signature on file and to issue a charge memo to my credit card account for any outstanding balance for services. Charges in excess of \$300.00 will be pre-authorized by telephone.

_____ Cardholders initials

Date: _____

Authorized: _____
Responsible Party

Date: _____

Authorized: _____
Dental Concierge