puredental
Holistic Dental & Wellness Center

Authorization for Credit Card Charges

By my signature below, I authorize Pure Dental Group to charge my credit card for the account balance that is on my account after insurance payment. I further state that I am the authorized signer for the credit card identified.

Credit Card Information Form

Name of Cardholder:_____

Credit Card Number (Visa/Mastercard):_____

CVV/Security Code:_____ Expiration Date (MM/YY):_____

Address of Cardholder:_____City:_____Zip:_____

Card Holder's Signature:_____