New England Dental

Family Dentistry • Se Habla Espanol • Falamos Portuguese

Credit Card Authorization Form

Name: _____

FAX #: _____

I, the undersigned, authorize New England Dental LLC to debit my credit card for my outstanding balance.

Type of card: **VISA MASTERCARD AMEX DISCOVER CARECREDIT**

Credit Card Number: _____

CCID: _____

Expiration Date: _____

Name as it appears on Credit Card: _____

Address as it appear on Billing Statement: _____

_____

Authorized Signature: _____ **Date:** _____

Printed Name: _____

****

FOR NED USE ONLY

Requested By: _____ **Approved By:** _____

Processed By: _____ **Reviewed By:** _____

Date Processed: _____ **Date Funds Received:** _____

Authorization Number: _____

Customer # _____ **Payment** _____

NOTES

***** **Please sign and fax back to (203) 797-0822.** ***If you have any questions please call (203) 790-0111***

Danbury Location: 54 Main St., Suite F, Danbury, CT 06810 • Phone: 203-790-0111 Fax: 203-797-0822
Brookfield Location: 246 Federal Rd., Suite B-11, Brookfield, CT 06804 • Phone: 203-790-0111 Fax: 203-797-0822
Web: www.newenglanddentalllc.com • Email: info@newenglanddentalllc.com