Koren Dental Management, Inc.

Credit Card Authorization Form

Date: _____

Type of Card: Discover

Credit Card Number: _____ Expiration Date: _____ V#:_____

Name on Card: _____

Billing Address: _____

City, State Zip:_____

Phone Number: _____ Fax Number: _____

Patient Name: _____

Relationship to Patient:_____

Charge Amount: _____

I, _____, certify that I am the authorized holder and signer of the credit card reference above. I certify that all information above is complete and accurate. I hereby authorize my credit card to be charged the above listed charge amount payable to Smithfield Family Dentistry for services rendered. A new authorization form is required for each separate charge amounts.

Please sign and return by fax along with a copy of a picture id.

_____ _____

Card Holder's Signature Date

Thank you for choosing Koren Dental Management for all your dental needs.

Change your Smile today!

Smithfield Family Dentistry Fax#(919)934-4748
Creedmoor Family Dentistry Fax#(919)528-2211
Pittsboro Family Dentistry Fax#(919)542-0904

Roxboro Family Dentistry Fax# (336)322-3776
Leland Family Dentistry Fax#(910)371-5667