DISCOVERY PEDIATRIC DENTISTRY
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Credit Card Payment by Mail or Fax

Parent's Name (Please Print): _____

Patient's Full Name (Please Print): _____

Patient's Date of Birth: _____

BANK CARD PAYMENT AUTHORIZATION

I authorize Discovery Pediatric Dentistry to charge $ _____ to my credit card account.

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PLEASE CHECK WHICH CREDIT CARD TO USE

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CARD ACCOUNT NUMBER (MC, Visa, Discover have 16 digits and AMEX has 15 digits)

☐☐☐☐ _____/_____/_____

SECURITY CODE (MC, Visa, Discover have 3 digits on BACK and AMEX has 4 digits on FRONT) **EXPIRATION DATE**

_____

CARDHOLDER NAME (EXACTLY as shown on credit card)

_____ _____

CARDHOLDER SIGNATURE **DATE**

_____ _____

Address **Apt. #**

_____ _____ _____

City **State** **ZIP**

I understand that this form is valid for **ONE** transaction. Discovery Pediatric Dentistry does **not** keep records or copies of this form. This form will be **immediately shredded** after processing to protect your account information. To reduce security risk we highly recommend calling in the information to our office.

Please complete entire form and return it by mail:
1700 California Street, Suite 200
San Francisco, CA 94109
or by fax:
(415) 441-1919