



Credit Card Payment Form

Account # _____

Date _____

PATIENT INFORMATION

First Name _____ Last Name _____

Street _____

City _____ State _____ Zip _____

Home Tel. (_____) _____ Cell. (_____) _____

CARD HOLDER INFORMATION

Name as it appears on card _____

Card Type: VISA Mastercard Discover AMEX

Card Number _____ Exp. Date ____ / ____ CSV Code _____

Amount Total \$ _____

Billing Address _____

City _____ State _____ Zip _____

Cardholder's contact number (if different from patient) (_____) _____

I agree to pay the total amount as entered above according to the card issuer agreement. I hereby authorize First Coast Endodontics to charge the above credit card for this amount.

Cardholder's Signature _____

DATE _____

THANK YOU!