Dynamic Dental Credit Card Authorization Form

I authorize Dynamic Dental to keep my signature on file and to charge my Visa/Mastercard account for the balance of charges not paid by my insurance company within 60 days of filing.

Patient Name:_____

Cardholder/Responsible Party Name:_____

Cardholder Signature:_____

Cardholder Address:_____

Phone Number: Home_____Work_____Cell_____

Credit Card (Please Circle): Visa Mastercard

Card Number:_____Exp Date:_____V-Code_____

Authorized Signature:_____Date:_____