HUNSAKER DENTAL

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Credit Card Authorization Form

I authorize Hunsaker Dental to charge my credit card as detailed below:

❑ Please keep this signature on file for any estimated patient portion due at the time of service

❑ Please keep this signature on file for any estimated patient portion due at the time of service and any unpaid balance after insurance payment.

Patient Name: _____

Responsible party name: _____

Address: _____

City : _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone#: _____

Credit Card: ❑ Mastercard ❑ VISA ❑ American Express

Account #: _____ Exp.: _____ Sec. Code: _____

Card Holder Signature: _____ Date: _____

Print Name: _____

Staff Initials: _____