



## CREDIT CARD DEPOSIT

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Dental Office: \_\_\_\_\_ Date of Procedure: \_\_\_\_\_

A deposit of \$1000 is due at the time the appointment is made. This will be applied to the final bill for anesthesia services. Full payment for the remaining balance is due the day of treatment prior to anesthesia.

CREDIT CARD INFORMATION	
Card Type: (circle one)    MasterCard    Visa    Discover    Amex    Other:	
Cardholder Name (as shown on card): _____	
Card Number: _____	Exp. Date (mm/yy): _____
Cvv Code (3 digit number on back of card): _____	
Billing Address: _____	Zip Code: _____
<b>Amount: \$</b>	

I, \_\_\_\_\_, authorize DreamGuard Anesthesia to charge my credit card referenced above for the amount indicated. Any additional balance due after the procedure may be charged as indicated unless other arrangements have been made.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature