CREDIT CARD DEPOSIT/PAYMENT FOR ANESTHESIA

Patient Name: _____ DOB:_____

Dental Office:_____ Date of Procedure: _____

A deposit of $1200 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:_____
Amount: $

I, _____, the parent or guardian of _____ 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.

_____ _____

Parent/Guardian Name Date

_____

Parent/Guardian Signature