PRE-AUTHORIZED DENTAL CARE FORM

Dental Payments

I authorize Dr. Liliana J. Hernandez D.D.S. Pa to keep my signature on file and charge my:

Credit Card as indicated below:

Check One: Master Card____ Visa____ Discover____ Other____

Balance of charges not paid by insurance within 90 days and to exceed $________

For (indicate one):

_________ this visit only

_________ all visits this year.

Recurring charges (on-going treatments) of $________ every _________ from_____ to __________

(AMOUNT) (FREQUENCY) (DATE)

Patient Name ____

Cardholder Name____

Card Billing Address ____

(STREET)

____

(CITY) (STATE) (ZIP CODE)

Account Number____________________________________MO____________YR____________ CVC__________

Cardholder Signature____ Date

All information will remain confidential

Please complete, print and return with cardholder's picture ID.