CREDIT CARD AUTHORIZATION FORM

Candace M. Opon D.D.S. Ltd.
College Hill Professional Building
690 N Route 31, Suite G
Crystal Lake, IL 60012

CREDIT CARD INFORMATION

Card Type: ☐ MasterCard ☐ VISA ☐ Discover

Payment Amount: $_____

Cardholder Name (as shown on card): _____

Card Number:_____

Expiration (mm/yy):_____

CVV Code: _____

BILLING ADDRESS OF CARD HOLDER

Street:_____

City_____State_____Zip_____

I authorize Candace M. Opon D.D.S. to charge my credit card for agreed upon services.

_____ _____
Patient Date

PLEASE FAX OR EMAIL PAYMENT INFORMATION TO:
815-477-8671
candaceopon@ymail.com

WOULD YOU LIKE A RECEIPT MAILED: ☐ YES ☐ NO