Dr. David R. Bowser III
Cosmetic & Family Dentistry

Credit/ Debit Card Authorization Form

Print and complete this authorization and return. All information will remain confidential.

I, _____, hereby authorize
(Please print name)
Dr. David R. Bowser III Cosmetic & Family Dentistry to charge my credit card for the amount deemed by my insurance carrier as "patient responsibility" or in the event I do not have insurance, any outstanding balance owing and/or charges for services rendered this date. (You will be contacted again for approval before each and every individual charge to your credit card.)

Name on Card: _____

Billing Address: _____

_____ PO Box: _____

City/State/Zip _____

Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Credit/ Debit Card Number: _____

Expiration Date: _____

Card Identification Number: _____ (last 3 digits on back of credit card)

Telephone: ( ) _____ Alternative Phone ( ) _____

Email: _____

** Phone or email required

_____ _____
Cardholder's Signature Date

Your completion of this authorization form helps us to protect you, our valued patient, from credit card fraud. Dr. David R. Bowser III Cosmetic & Family Dentistry will keep all information on this form strictly confidential.

_____ _____
Corporate acceptance by: Date