Atlantic Dental
Implant Seminars

CREDIT CARD AUTHORIZATION FORM (PLEASE KEEP ON FILE)

_____	_____	_____/ _____
Credit Card Number	(3/4 digit code)	Expiration Date

I authorize ADIS keep this credit card on file for pre-payment on services rendered. I take full responsibility and understand that I am obligated to pay the amount charged in full.

Company Name: _____

Card Holder Name: _____

Card Holder Signature: _____

Date: _____

Billing Address: _____

_____

Phone Number for Card: _____

Business Ph. Number: _____

Confirmation Email Address: _____

FAX <u>ONLY</u> TO 973-807-0514 PLEASE!

ADIS
400 Broad Street Clifton, NJ 07013 Voice: 551-655-1909