



Credit Card Authorization Form

CREDIT CARD TYPE: (Check One)

- VISA
- MASTERCARD
- AMERICAN EXPRESS

CREDIT CARD NUMBER: _____

EXPIRATION DATE: ____/____ CVC CODE: _____

(VISA & MC-3 LAST DIG ON BACK, AMEX 4 DIG ON FRONT)

CARDHOLDER'S BILLING ADDRESS (Required):

NAME as it appears on card: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PROVINCE: _____ COUNTRY: _____

PHONE NUMBER: _____

The cardholder agrees that his/her signature on this form constitutes his/her signature on file and becomes his/her agreement to pay all charges as signed by the cardholder and that **Modern Dental Technology Laboratory** is authorized to charge the identified account of Cardholder.

Open invoices are payable according to the terms on each account. Past due balances are subject to monthly finance charge and a \$25 service charge will be assessed for any returned check. Payment Options: Visa/ Master Card/ Discover/ American Express, and Cheque.

CARDHOLDER AUTHORIZED SIGNATURE

DATE

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