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### Credit Card Payment Authorization Form

Sign and complete this form to authorize Penn-Tex Dental Laboratory to keep this credit card on file and to make payments on your credit card listed below, when authorized by you each month.

By signing this form you give us permission to debit your account for the amount indicated on the statement or other amount indicated by you after verbal authorization is given by phone or in person. This is permission for a single transaction only when authorized by you and does not provide authorization for any additional unrelated debits or credits to your account.

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#### Please complete the information below:

I \_\_\_\_\_ authorize Penn-Tex Dental Laboratory to charge my credit card  
(full name)  
after verbal authorization is given by me or someone authorized by me. These payments are for service or products provided by Penn-Tex Dental Laboratory.

Billing Address \_\_\_\_\_ Phone# \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ Email \_\_\_\_\_

Account Type: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> AMEX <input type="checkbox"/> Discover <input type="checkbox"/> Other _____
Cardholder Name _____
Account Number _____
Expiration Date _____
CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_