Credit Card on File Authorization

Please complete this form if you would like ***McCracken Family Dentistry*** to keep your credit card on file for future payments. You may elect to provide us with credit card information separately for each payment.

Information to be completed by the card holder:

Cardholder Name: _____

Card Number: _____

Card Type: ❑ Visa ❑ MasterCard ❑ American Express ❑ Discover ❑ Care Credit

Expiration Date: _____

Security Code: _____ (3 digit code on back)

Billing Zip Code: _____

E-mail: _____

I, _____, authorize ***McCracken Family Dentistry*** to charge the above credit card account for payments owed to my account for services rendered at their office. I agree to update any information regarding this account. The above information is complete and correct to the best of my knowledge.

Cardholder Signature _____ Date_____