

Pre-Authorization Health Care Form

I authorize Carlsbad Open 7 Days Dental/ Thomas Davies, DDS, Inc. to keep my signature on file and to charge my:

VISA MASTERCARD AMEX DISCOVER

* Balance of charges not paid by insurance within 90 days and not to exceed \$ _____

this visit only

all visits this year

* Recurring charges (on-going treatments) of \$ _____

every _____ from _____ to _____

I assign my insurance benefits to the provider listed above. I understand that this form is valid unless I cancel the authorization through written notice to the health care provider.

Patient Name

Cardholder Name

Cardholder Address

City

State

Zip

Credit card account number (card type)

CVU# (back of card)

EXP. date

Cardholder Signature

SS#

DOB

**All credit cards will be ran for a "Pre-Approval" dollar amount indicated above. This HOLD will be in effect for 5-7 business days, unless card is charged before that time.