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CREDIT CARD AUTHORIZATION FORM

I _____ hereby authorize Dr. Wexler to submit electronic claims on my behalf and agree to assign the payment directly to Dr. Wexler. I understand that my insurance is an agreement between the insurance company and myself. I further understand that I am responsible for any service fees or balances that may not be covered by my dental benefits plan and any differences resulting from the amount billed and the amount covered by my plan. I authorize the following credit card to be billed for any outstanding balances.

Signature: _____

Patient Name: _____

Responsible Party (if different than patient): _____

Please circle credit card: Visa MasterCard Amex Discover

Date: _____

Phone #: _____

Card #: _____ Expiration Date: _____

Card holder signature: _____ CC security code: _____

Print name: _____ Date: _____

Staff Initials: _____