

first dental studio
2nd floor
10709 107 street NW
edmonton alberta
T5H2Y9



phone 780 421 1890
toll free 888 747 4051
fax 780 421 1892
info@firstdental.ca
www.firstdental.ca

date

time

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information

Card Type: MasterCard VISA AMEX Other _____

Cardholder Name (as shown on card): _____

Card Number: _____

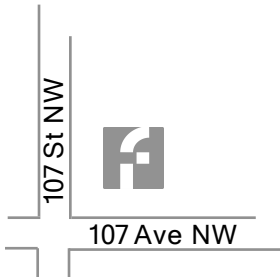
Expiration Date (mm/yy): _____ CVV: _____

Cardholder's Postal Code (from credit card billing address): _____

I, _____, authorize First Dental Studio to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

signature

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