

**PRINT THIS ON YOUR PRINTER, FILL IT OUT AND  
SEND TO OUR OFFICE FOR  
AUTOMATIC CREDIT CARD CHARGES**

**DATE:** \_\_\_\_\_

**Your Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

**Patient's Name:** \_\_\_\_\_

**ID #** \_\_\_\_\_ (Found on coupons)

**I authorize Dr. David W. Johnson's orthodontic office to keep my signature on file to charge my credit card monthly. The monthly fee I want charged is \$ \_\_\_\_\_ for \_\_\_\_\_ months starting the 5th of \_\_\_\_\_, \_\_\_\_\_.**

(Month),(Year).

**Please check one: Mastercard** \_\_\_\_\_ **Visa** \_\_\_\_\_

**Credit Card Number:** \_\_\_\_\_ **Expires:** \_\_\_\_\_

**Cardholder Name:** \_\_\_\_\_ (Please Print)

**Cardholder Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Mail this form to the office at 2100 Otis Drive, Suite F, Alameda, CA 94501. Or you may FAX the completed form to 510-521-7016.**

**A COPY OF YOUR ACCOUNT STATUS IS AVAILABLE AT ANY TIME**