TOTAL CARE DENTAL

Delivering caring , comfortable dentistry to our community.

Your Savings Plan Application Form

I, _____, authorize **TOTAL CARE DENTAL** to make recurring charges to my Credit Card listed below, and, if necessary, initiate adjustments for any transactions credited/debited in error. This authority will remain in effect until TOTAL CARE DENTAL is notified by me (us) in writing to cancel it in such time as to afford TOTAL CARE DENTAL and Credit Card Company a reasonable opportunity to act on it.

_____

(Name - PLEASE PRINT AS APPEARS ON CARD)

_____

(Billing Address - PLEASE PRINT)

_____

(Phone Number - PLEASE PRINT)

_____

(Email - PLEASE PRINT)

Please circle one: Visa / MasterCard

Account Number: __ __ __ __ - __ __ __ __ - __ __ __ __ -__ __ __ __

Expiration Date: _____ (MM/YY)

VCC #__ __ __ (the three numbers in the back by the signature)

Frequency (please circle one or fill out your own schedule):

Monthly Yearly

Starting Date: ___/___/_____(MM/DD/YYYY)

_____

(Signature) (Date)