Product or Seminar Purchased

Airway Mini - Residency Circle One: West Coast East Coast

Other Product:_____

Price:_____

Airway Focused Dentistry
32241 Crown Valley Pkwy Ste. 200
Dana Point CA 92629
Phone: 949-661-1006
Fax: 949-661-9454
www.airwayfocuseddentistry.com
markcruz@markacruzdds.com

CREDIT CARD AUTHORIZATION

Customer Information

Contact Name: _____
Telephone: _____
Email: _____
Address: _____
_____
_____
_____
Country: _____

Please fill out, scan and send completed form via:

Fax:
949-661-9454

Mail:
32241 Crown Valley Pkwy
Ste. 200
Dana Point CA 92629

Email:
markcruz@markacruzdds.com

Any information sent via E-Mail or Fax is not secure and is being transmitted at sender's own risk.

Credit Card Account

Account Type: __ VISA __ MASTERCARD __ DISCOVER __ AMEX
Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
Expiry Date: ☐☐☐☐☐☐☐☐
Security Code: ☐☐☐
Cardholder Name: _____
Address: _____
_____
_____
_____
Country: _____

It is the Customer's responsibility to inform AIRWAY FOCUSED DENTISTRY of any changes to the billing address, expiration date and/or changes to the card holder's name of credit card account provided.

Authorization
I authorize Airway Focused Dentistry to debit the credit card account provided above for the purchase of product by the above Customer. I also understand that this authorization will remain valid and continue until I cancel such authorization in writing.

Authorized Signature: _____ Date: _____