

**Quang C. Tran D.D.S**  
5413-D Backlick Road  
Springfield, VA 22151  
703-256-4243

**CREDIT CARD AUTHORIZATION**

Patient Name: \_\_\_\_\_  
Last Name First Name Middle Initial

Card Holder Name: \_\_\_\_\_

Credit Card #: \_\_\_\_\_ Exp: \_\_\_\_\_

Type of Card: \_\_\_\_\_ Security Code: \_\_\_\_\_

I hereby request and authorize Dr. Quang C. Tran to charge this credit card for date of service \_\_\_\_\_, in the amount of \$ \_\_\_\_\_. I understand that this amount will be charged when this notice is received unless otherwise noted by me.

My signature below authorizes said charges to above-mentioned credit card.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date