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Request to Charge Credit Card

To help keep costs down and provide more cost effective health care, we will be obtaining credit card information on all patients. This information will be kept on file in our office to use in the event that a balance is due and payment is not received within 30 days. Your card will only be used for outstanding balances and receipts will be mailed to you. If you have any questions, please contact our office at (979)776-1660.

Please complete the information below: (print legibly)

Patient Name: _____

Name on Card (if different than above): _____

Address: _____

MUST include credit card billing address & zip code

Type of credit card: MC AMEX DISCOVER VISA

Credit Card Number: _____

3 – Digit Code from back of credit card (CVS): _____

Expiration Date: _____

Patient Signature: _____

OFFICE USE ONLY

Amount Charged to card: _____

Date card was charged: _____

Signature of person running card: _____

Staple credit card receipt to this paper.