CREDIT CARD AUTHORIZATION FORM

Thank you for your continued partnership. Please complete this form to authorize payment to our lab.
Note: Payments will appear under our previous name, New Age Dental Lab. This is our same company — 6X6 IMPLANT CENTER — and no action is needed on your end. Payment will be rendered upon submission.

Company Name:

Cardholder Name:	
Billing Address:	
City, State, ZIP:	
Phone Number (for receipt):	
Email (for receipt):	
Credit Card Type (Visa / MC / Amex):	
Card Number:	
Expiration Date (MM/YY):	
CVV:	
Cardholder Signature:	
Date:	

By signing above, I authorize 6X6 Implant Center (formerly New Age Dental Lab/ZBL Lab) to charge my credit card for the agreed-upon amount. I understand this authorization will remain in effect until I provide written notice to cancel.