CREDIT CARD AUTHORIZATION FORM

Fax 310-393-8198

I, _____, agree to allow Pet Medical Center to charge services, prescription and product sales on this credit card. This card will only be used on my behalf for products and services received and/or provided to my pets by Pet Medical Center.

Client Name:_____
Address: _____
_____

Home Phone Number _____
Work Phone Number _____
Cell Phone Number _____

Social Security Number: _____

Driver's License Number _____ State _____
Please Circle One:

VISA MASTERCARD AMEX DISCOVER CARE CREDIT

Account #: _____

Exp. Date: _____

CVV: _____

Name as it appears on card: _____

Signature: _____ Date: _____

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