

Authorization for Credit Card Use

PRINT AND COMPLETE THIS AUTHORIZATION AND RETURN.
All information will remain confidential

Name on Card: _____

Billing Address: _____

Credit Card Type: _____ Visa _____ Mastercard _____ Discover _____ AmEx

Credit Card Number: _____

Expiration Date: _____

Card Identification Number: _____ (last 3 digits located on the back of the credit card)

Amount to Charge: \$ _____ (USD)

I authorize _____ to charge the amount listed above to the credit card provided herein. I agree to pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder – Please Sign and Date

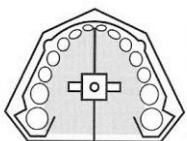
Enroll in Automatic Payment (ACH) Yes No

Signature: _____

Date: _____

Print Name: _____

Return the completed and signed form to the following:



**ROQUE ORTHODONTIC
LABORATORIES INC.**

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(949) 581-9711 • FAX (949) 581-9712