Credit Card Charge Authorization Form

I (we) hereby authorize Star Dental Supply, Inc to make charges to my Credit Card listed below, and, if necessary, initiate adjustments for any transactions credited/debited in error. This authority will remain in effect until Star Dental Supply, Inc is notified by me (us) in writing to cancel it in such time as to afford Star Dental Supply, Inc and Credit Card company a reasonable opportunity to act on it.

_____

(Name - PLEASE PRINT AS APPEARS ON CARD)

_____

(Billing Address - PLEASE PRINT)

_____

(Phone Number - PLEASE PRINT) (Email - PLEASE PRINT)

_____

(Shipping Address - PLEASE PRINT)

Please circle one: Visa / MasterCard / Amex / Discover

Account Number: _____CODE:_____

Expiration Date:_____

Charge Amount: $_____

Order Number#:_____

_____ _____

(Signature) (Effective Date)

Please return to:
Star Dental Supply, Inc
1201 W Artesia Blvd
Compton, CA 90220

T. 310-537-1500
F. 310-537-1502
Info@stardentalsupply.com
http://www.stardentalsupply.com