MITCHELL M. STRUMPF, D.D.S., P.A.
PREVENTIVE • RESTORATIVE
COSMETIC DENTISTRY

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Date

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Dear ________________________,

This is to confirm that you will assume financial responsibility for dental services for _____________________________ who will be seen in this office.

To verify this, we need you to sign, and return the authorization form below.

Thank you.

I, the undersigned, promise to pay for the dental services rendered by Dr. Mitchell M. Strumpf for ____.

Form of Payment: ________________________Type of credit card
________________________Credit card number
________________________Expiration Date
________________________Zip Code

Date:____________________ Signature:________________________________

Printed Name:_____________________________

doc: word/office/guarante