Texas Society of Oral and Maxillofacial Surgeons

CREDIT CARD PAYMENT AUTHORIZATION FORM

Member Name: _____

Address _____

_____

Phone Number _____

Payment = $_____ **To: TSOMS**
MasterCard/Visa/Discover/American Express

#_____ Expiration Date: _____ CVS Code:_____

Billing Zip Code: _____ Personal Credit Card? Y / N

Cardholder Name: _____

If Business Credit Card, Legal Entity Name: _____

Signature: _____ Date:_____

PLEASE FAX YOUR COMPLETED CREDIT CARD AUTHORIZATION TO:
210-614-5234

-OR- EMAIL YOUR COMPLETED CREDIT CARD AUTHORIZATION TO:
kellyannshy@alamoOMS.com

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