New Referring Dentist/Physician

Information/Referral Form

Please Download, Complete and Fax To 903-825-7155

Dentist/Physician Information

Referring dentist/physician_____

Specialty_____

Lic. #_____

Office Address/location_____

Office Contact_____ **Phone**_____
Fax_____

Please call 903-825-7400 to discuss specifics regarding Scan options, preferences and payment process.

For credit card billing, please provide the following:

Card Type_____ **Card Number**_____

Expiration Date_____**Security Code**_____

Name On Card_____

Referred Billing Date_____ **e-mail for invoices**_____

Being the cardholder or corporate officer by signing below I understand and agree to pay, and specifically authorize Healthier Smiles Imaging to charge my credit card, for all services provided by Healthier Smiles Imaging to me or my company. Healthier Smiles Imaging will provide me with an itemized monthly statement detailing all my charges. The authority for Healthier Smiles Imaging to credit to charge my credit card will continue until revoked by me in writing to Healthier Smiles Imaging. I further agree that in the event my credit card becomes invalid, I will provide Healthier Smiles Imaging with a new valid credit card upon request to be charged for the payment of any understood outstanding balances owed to Healthier Smiles Imaging,

Signature:_____

Printed name:_____

Date:_____

Please fax this form back to 903-825-7400