2240 Cross Timbers Road, Suite 100
Flower Mound, TX 75028
voice: 972-355-8500
fax: 972-691-9549
www.DFWDentalAssistingSchool.com

I, _____, authorize DFW Dental Assisting School to charge
(Full Name)

my credit/debit card for the full tuition payment of $3,500.00 for _____.
(Student Name)

Name on card: _____ Date: _____

Student's Name: _____

Amount: ___$3,500.00_____

Credit Card Number: _____-_____-_____-_____

Expiration Date: _____/_____ (MM/YY) Card Verification Digits: _____

Billing Address: _____
Address City State Zip

Email Address for Receipt: _____