

# Credit Card Authorisation Form



Please complete all fields.

You may cancel this authorisation at any time by contacting us.

This authorisation will remain in effect until cancelled.

A.B.N 55 43 2482 977

Toll Free: 1800 653 439

Ph: (03) 9720 6700

Mail: P.O Box 972, Bayswater VIC 3153

6/51 Jersey Rd, Bayswater VIC 3153

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Credit card payments will be processed by our team as follows:

- **Pay On Order Account (Pay as you go):** Payment will be processed for each order placed before despatch
- **30 Day EOM Credit Account (Approved):** Payment will be processed before due date according to Statement – We may contact you to still to request approval before processing.

<b>Credit Card Information</b>
Durodent Account Name:
Cardholder Name (as shown on card):
Card Type: <input type="checkbox"/> MasterCard (16 Digits) <input type="checkbox"/> VISA (16 Digits) <input type="checkbox"/> AMEX (15 Digits)
Card Number: _____ <i>** Full Card details may be provided over phone if you prefer, but this form must be provided showing last 4 digits of card and expiry date before calling.</i>
Expiration Date (mm/yy): ____ / ____
Cardholder Postcode Code (from credit card billing address): _____

### Information Storage Authorisation:

I, \_\_\_\_\_, authorise **Durodent Dental Supplies** to store my credit card details provided above to be used for agreed purchases we place with Durodent Dental Supplies. I understand that my information will be securely stored for future transactions on my account and will only be securely disposed once out of date or I cancel this authorisation by contacting Durodent.

### Direct Debit Authorisation:      YES / NO

I, \_\_\_\_\_, authorise **Durodent Dental Supplies** to charge this credit card for the full invoice value for each purchase I or my authorised employees place with Durodent Dental Supplies.

\_\_\_\_\_  
Authorised Customer Signature

\_\_\_\_\_  
Date

RETURN FORM TO: [office@durodent.com.au](mailto:office@durodent.com.au)