Dynacare®

Payment Authorization Form

Patient Information

Last Name: ______________________________

First Name: ______________________________

Date of Birth: ______________________________
Date (YYYYMMDD)

Referring Physician: ______________________

Address: ________________________________
No. Street Apt
____
City. Province Postal Code

Tel (home): ______________________________

Tel (daytime): ____________________________

Test Information

Genetic Tests

Test Code	Test Name	Price

Payment

☐ VISA ☐ Certified cheque (No personal cheques accepted)

☐ MasterCard

☐ AMEX

Credit Card Number: __ __ __ __ / __ __ __ __ / __ __ __ __ / __ __ __ __

Expiry date: _____ / _____ Security Code: _______
MM YY (3 digits)

Cardholder: ______________________________ ______________________________
Name Signature

Date: ______________________________
(Year/Month/Day)

INTERNAL USE

Date: ______________________________ Lab#: ______________________________