noble
PEDIATRIC DENTAL
Gentle Care From the Start

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# REFUND REQUEST

Please refund $__________.______, which is currently showing as a credit on my account. I agree to repay Noble Pediatric Dentistry if this credit is an error. I have been advised that in some instances insurance companies review accounts and determine they paid in error and request repayment from the dental provider. If this happens, I agree to repay *Noble Pediatric Dentistry*.

Patient(s) Name: ______________________________________________

Reason for Refund: ____________________________________________

Pay to: ________________________________________

Current Address: ______________________________________________

Name of Cardholder: *(Please print exactly as it appears on card)*

____________________________________________________________

Credit Card Number: __________-__________-__________-__________

Expiration Date: ______/_______

CVV Code (3-digit number): __________

___________________________ ___________________

**Parent or Guardian Signature** **Date**

OFFICE USE:

STAFF __________