



# *Southwest Society of Oral and Maxillofacial Surgeons*

*est October 24, 1929*

## CREDIT CARD PAYMENT AUTHORIZATION FORM

Member Name: \_\_\_\_\_

Address \_\_\_\_\_  
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Phone Number \_\_\_\_\_

**Payment = \$ \_\_\_\_\_ To: SWSOMS**

**MasterCard/Visa/Discover/American Express**

Card # \_\_\_\_\_ Expiration Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

CVV Code: \_\_\_\_\_ Billing Zip Code: \_\_\_\_\_

Cardholder Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**PLEASE FAX YOUR COMPLETED CREDIT CARD AUTHORIZATION TO:  
210-614-5234**

**-OR- EMAIL YOUR COMPLETED CREDIT CARD AUTHORIZATION TO:  
[kellyannshy@alamoOMS.com](mailto:kellyannshy@alamoOMS.com)**