



Payment Form
Gwinnett Medical Center Foundation
(Tax ID # 58-1828486)

Date: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Dental Office Name: _____

Name of Dentist: _____

Payment to: Gwinnett Medical Center Foundation

Amount: _____

Circle Payment type:

Cash Check Visa MasterCard American Express Discover

Credit Card users PLEASE NOTE: All credit cards will be processed through Gwinnett Medical Center. When you receive your credit card statement in the mail, the line item will read "Gwinnett Medical Center Foundation".

Cardholder: _____

Card #: _____ - _____ - _____ - _____ **Expires:** _____

Signature: _____

Gwinnett Medical Center Foundation Contact Number: 678-312-8500

Please submit payment and forms to: Gwinnett Medical Center Foundation
1755 North Brown Road, Suite 100
Lawrenceville, GA 30043

Gwinnett Medical Center Foundation