CREDIT REPORT APPLICATION

Date:_____ Patient Name_____PR#_____

Guarantor – the ADULT person(s) who is financially responsible for the treatment.

THIS WILL NOT REFLECT ON YOUR CREDIT REPORT

___I give my permission to process my credit, so that I may qualify for your payment plan.
*****Credit will be denied unless this form is completed and returned**

Guarantor's
Full Name _____
Last First MI
Guarantor's
Current Address _____

City _____ State _____ Zip _____

Home Phone # _____-_____-_____ Guarantor's Relation to Patient _____

SS #_____ - _____ - _____ Number of Years at Current Address _____ Date of Birth_____

Guarantor's
Previous Address _____

City _____ State _____ Zip _____

Number of Years at Previous Address_____
Current Employer _____

Business Address _____

City _____ State _____ Zip _____

Guarantor's
Occupation _____ Work Phone (_____) _____

Guarantor's Signature _____Date _____

By signing above, the applicant: 1) **authorizes the UMFDSP Assoc., PA to obtain any information that it may require relative to this application from any source**, as permitted by applicable law, and 2) agrees that this application shall remain the property of the UMFDSP Assoc., PA whether credit is granted or not.-

THIS WILL NOT REFLECT ON YOUR CREDIT REPORT

FOR OFFICE USE ONLY
Credit Status _____
CredApRev 11/13rbj