# Credit Application DAVIS DUEHR DEAN CENTER FOR REFRACTIVE SURGERY

## Applicant — Plan Option

| | | | | | |
|---|---|---|---|---|---|
| Name (First, MI, Last) | | | | | |
| Present Address | | City | State | Zip | Years/Months |
| Date of Birth | Social Security Number | Own ❒ Rent ❒ | Payment $ | Home Phone | |
| Former Address (if less than two years at current) | | City | State | Zip | Years/Months |
| Employed By | Employer's Address | City | State | Zip | Years/Months |
| Position | Monthly Salary | Work Phone | Former Employer (if less than two years at current) | | Years/Months |
| Other Income Source | | | Amount $ | | |
| Name of Nearest Relative Not Living with You | | | Relationship | Phone | |

## Co-Applicant

| | | | | | |
|---|---|---|---|---|---|
| Spouse's Name (First, MI, Last) | | | Date of Birth | Social Security Number | |
| Employed By | Employer's Address | City | State | Zip | Years/Months |
| Position | Monthly Salary $ | Work Phone | | | |

## Sign Here

By signing, Applicant(s) ("you"): (a) certify that the information provided above is true and correct; (b) acknowledge that this Application is subject to approval by Dean Health Systems; (c) agree that we may contact any source necessary to verify your credit responsibility.

X_____ _____ X _____ _____

Signature of Applicant — Date — Signature of Co-Applicant — Date

## Business Office Use Only

| | | | |
|---|---|---|---|
| Account Information | Place of Service | | Physician |
| Credit Search | Procedure | | Date |
| Credit Approval/Notification of Applicant | Finance Amount | Annual % Rate | Monthly Payment |