PAYMENT PLAN CREDIT APPLICATION

If you are interested in making payments for your dental treatment services, please fill this out to help us determine approval.

1. APPLICANT INFORMATION

Name (First-Mid-Last)	Date of Birth	Social Security # _____ - ____ - _____	Home Phone # (_____) _____
Mailing Address Apt# City State Zip			Cell/ Other Phone #
* If the above address is a PO Box, you MUST provide a street address for yourself or a contact person Contact Person Name Street Address City State Zip Email Address:			
Housing Information ☐ OWN ☐ RENT ☐ OTHER Monthly Pmnt: $_____ How Long: Yrs: Mo:	Drivers License: #_____ Exp. Date: / /	Monthly Net Income From All Sources: $ _____ Source: _____	Checking or Savings Account? _____ How long has account been open? _____
Annual Gross Income: _____ Pay Period: _____ Next Pay Date: _____		Employer: _____ Phone: (____) _____ Position: _____ How Long: _____	

2. CO-APPLICANT INFORMATION

Name (First-Mid-Last)	Date of Birth	Social Security #	Home Phone # ( )
Mailing Address Apt# City State Zip			Cell/ Other Phone #
* If the above address is a PO Box, you MUST provide a street address for yourself or a contact person Contact Person Name Street Address City State Zip			
Housing Information ☐OWN ☐RENT ☐OTHER	Nearest Relatives Phone # ( )	Employer Name	Employers Phone # ( )
Monthly Net Income From All Sources $_____		Email Address	
Co-Applicant ID Type / Number #_____ Drivers License State Issued	Exp. Date	Co-Applicant 2nd ID Type Issuer Exp. Date	

3. NEAREST RELATIVE INFORMATION

Name (First-Mid-Last)			Home Phone # ( )
Mailing Address Apt# City State Zip			Cell/ Other Phone #
* If the above address is a PO Box, you MUST provide a street address. Street Address City State Zip			
E-Mail Address:			

4. TWO REFERENCES

1.) Name (First-Last)	Phone # ( )
2.) Name (First-Last)	Phone # ( )

5. BANKING INFORMATION

Name of Bank:
Account Number:
Routing Number:

PLEASE COMPLETELY FILL OUT THE BACK OF THIS PAGE.

3. APPLICANT & CO-APPLICANT: We need your signatures(s) below

I am providing the information in this application to Jose Arthur Mirelez, Jr., DDS, Inc, to CareCredit LLC, to Chase Financial and other credit program agencies that will assist me with my dental related financial obligations. By applying for this, I authorize and agree that:

*Dr. Mirelez may furnish this and other information about me (even if application is denied) and my account to credit agencies)

*Dr. Mirelez may make inquiries it considers necessary (including requesting reports from consumer reporting agencies and other sources) in evaluating my application, and for purposes of reviewing, maintaining or collecting my account.

*If my application is approved, the credit agencies agreements will be sent to me and will govern my account.

*Among other things, the Agreement: (1) INCLUDES AN ARBITRATION THAT MAY LIMIT MY RIGHTS UNLESS I REJECT THAT PROVISION UNDER THE AGREEMENT'S INSTRUCTIONS; and (2) makes each applicant responsible for paying the entire amount of credit extended; and (3) grants the credit agency a security interest in the goods purchased on the account as permitting by law.

*This application and the Agreement are governed by federal law and the credit agency state law (to the extent that state law applies).

Federal law requires us to obtain, verify and record information that identifies you when you open an account. We will use your name, address, date of birth, and other information for this purpose.

If I have been pre-approved, I request you open the type of account for which I was pre-approved. We reserve the right to refuse to open an account in your name if we determine that you no longer meet our credit criteria.

Signature of Applicant	Signature of Co-Applicant (if applicable)
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(Please Do Not Print)	(Please Do Not Print)
Date :	Date: