Credit Application

Provider ID#: 56122

Phone: 540-465-3980 **Fax:** 540-465-1810

Patient Tracking # ________

Thomas Family Dentistry, P.C. - Strasbur
33820 Old Valley Pike Ste. 1
Strasburg, VA 22657

Please fill out all information completely. If you already have a ChaseHealthAdvance Revolving Account or have questions please call (888) 519-6111.

Applicant Information *(The applicant is the patient, or parent/guardian if patient is a minor)*

*First Name	*Middle Initial	*Last Name	
*Social Security #	*Date of Birth / /	Home Phone#	**Other Personal phone#
*Mailing Address (including Apt #) – *required*			
*City	*State	*Zip	Email address
Street Address (including Apt #) – *Complete this section if the mailing address above contains a PO Box.*			
City	State	Zip	

TOTAL GROSS MONTHLY HOUSEHOLD INCOME: $________

Residential Status: ☐ Own ☐ Rent ☐ Live with others ☐ Other (Clarify):________
SOURCE OF INCOME: ☐ Employed ☐ Unemployed ☐ Self Employed ☐ Spouse ☐ None ☐ Other (Clarify):________

Alimony, child support, or separate maintenance income need not be revealed if you do not wish to have it considered as a basis for repaying this obligation. Married Wisconsin Residents: If you are applying for an individual account or a joint account with someone who is not your spouse, combine your and your spouse's information on this application.

Present Employer	Present Employer Phone #:	Present Occupation
Personal Reference or Relative not living with you	Relationship	Telephone

I hereby authorize Chase Bank USA, N.A. to obtain and use information about my credit history and all information on this Application, and I authorize the release of such information to Chase Bank USA, N.A. Each applicant certifies that he/she is 18 years of age or older (19 in NE, AL). By signing this Application, I authorize any doctor or other medical provider to release to Chase Bank USA, N.A. any information and records regarding my medical or dental procedures, treatments, devices, implants and other medical or dental services and products financed by means of the ChaseHealthAdvance Revolving Account (issued by Chase Bank USA, N.A.). We comply with Section 326 of the USA Patriot Act. This law mandates that we verify certain information about you while processing your Account application. 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 the other information provided for this purpose. *This information is required to process your Application. The Provider (the seller of goods or services) is responsible for delivering to each applicant the ChaseHealthAdvance Revolving Account Agreement which sets forth your payment and other obligations relating to the financing of your procedures and/or purchases. **You agree that we may contact you about your account, including for customer service or collection at any address or telephone number as well as any cellular telephone number you provide us. **Ohio Residents:** The Ohio laws against discrimination require that all creditors make credit equally available to all credit-worthy customers, and that credit reporting agencies maintain separate credit histories on each individual upon request. The Ohio civil rights commission administers compliance with this law.

Name of Spouse ________ Address of spouse ________
Married Wisconsin Residents: *We are required to ask you to provide the name and address of your spouse.*

Applicant Signature: ________ **Date:** ________

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