

## DENTALBANC, LLC CREDIT AUTHORIZATION

I hereby authorize DentalBanc, LLC, on behalf of Dr. R.J. Tippin to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options.

### PLEASE PRINT

Responsible Name \_\_\_\_\_  
First Middle Last

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Email \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

### JOINT APPLICANT

If applying for joint credit, please supply the following information on your spouse.

Full Name \_\_\_\_\_  
First Middle Last

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Email \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

### PATIENT INFORMATION

Patient Name \_\_\_\_\_  
First Middle Last

Responsible Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Required if joint

OID: of00002421