



Credit Application

Bristol Chiropractic Centre, PC
5098 W. Bristol Rd.
Flint, MI 48507

Provider ID#: 74294

Phone: 810-733-1261

Fax: 810-733-1274

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

Applicant Information *(The primary 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#
*Street Address (Include Apt.#)		*City	*State	*Zip
TOTAL GROSS MONTHLY HOUSEHOLD INCOME: \$ _____ Residential Status: <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Live with others <input type="checkbox"/> Other(Clarify): _____				
SOURCE OF INCOME: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Self Employed <input type="checkbox"/> Spouse <input type="checkbox"/> None <input type="checkbox"/> 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

For Co-applicant use only (if applicable)

*First Name		*Middle Initial	*Last Name	
*Social Security # - -	*Date of Birth / /	Home Phone#:		Other Personal phone#
*Street Address (Include Apt.#)		*City	*State	*Zip
TOTAL GROSS MONTHLY HOUSEHOLD INCOME: \$ _____ Residential Status: <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Live with others <input type="checkbox"/> Other(Clarify): _____				
SOURCE OF INCOME: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Self Employed <input type="checkbox"/> Spouse <input type="checkbox"/> None <input type="checkbox"/> Other(Clarify): _____				
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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.

Married Wisconsin Residents: We are required to ask you to provide the name and address of your spouse:

Name of Spouse _____ Address of spouse _____

APPLICANT Signature

Date

CO-APPLICANT Signature

Date

Fax this form to (888)519-6222 for processing