REDMOND DENTAL GROUP

1765 SW Parkway Dr.

Redmond Or 97756

In the event that you may need to carry a balance on your account for dental treatment, please sign and date below to authorize Redmond Dental Group to obtain a credit Report.

___ I authorize Redmond Dental Group to obtain a credit report.

___ I decline. I will pay cash at the time of service.

Printed Name:___________________________________ SSN:__________________________

City: _________________________State ______ D.O.B. ____________

Signature:______________________________________ Date:________________