



CLIENT APPLICATION

285 LIBERTY STREET NE
SUITE 350
SALEM, OR 97301
PHONE: 503-581-8645
TOLL FREE: 888-669-4553
FAX: 503-371-3347

Fax: (503) 371-3347

DOCTOR INFORMATION

Doctor Name: _____ DMD DDS
Home Street Address: _____
City, State, Zip: _____ Home Phone: (____) _____
Dental School Attended: _____ Year Graduated: _____
Dental License #: _____ Area of Specialty: _____
Social Security #: _____ E-Mail Address: _____
Is Your Practice: Incorporated Partnership Sole Proprietor Tax ID#: _____
Legal Business Name: _____

PRACTICE INFORMATION

Assumed Business Name/Doing Business As: _____
Office Street Address: _____ County: _____
City, State, Zip: _____ Off. Mgr. Name: _____
Office Phone #: (____) _____ Fax #: (____) _____
Avg. Monthly Production: \$ _____ Avg. Mo Collection %: _____
Accounts Receivable: \$ _____ Software: _____
Do you currently have access to the internet? Yes No
Are you the owner of the accounts receivable? Yes No
Are your accounts receivable used as security? Yes No
Are payroll and income taxes current? Yes No
How did you hear about American Financial Services? _____

MISCELLANEOUS INFORMATION

Please select one of the four banks listed below according to your preference or proximity

Bank of America US Bank Washington Mutual Wells Fargo

PRACTICE GOALS

What goals would you like to achieve in the next 6-12 months? _____

American Financial Services, Inc. is authorized to contact lending institutions and consumer agencies for information on any accounts.

Doctor's Signature

Date