

MONTHLY HOUSEHOLD EXPENSES

GROCERIES: \$	AUTOMOBILE: \$
	GAS/OIL \$
	REPAIR & MAINTENANCE \$
RENT PAYMENTS: \$	CHILD CARE \$
MORTGAGE PAYMENTS: \$	TUITION: \$
INSURANCE:	OTHER: \$
AUTO: \$	\$
LIFE: \$	\$
MEDICAL: \$	\$
RESIDENCE: \$	\$

UNPAID BILLS

Name of Bank, Finance Co., Credit Card, Hospital, Individual, etc	Address	Original Amount	Unpaid Amount	Monthly Payments
		\$	\$	\$
		\$	\$	\$
		\$	\$	\$
		\$	\$	\$
		\$	\$	\$

PLEASE ATTACH COPIES OF YOUR LAST TWO (2) YEARS TAX RETURNS

COMMENTS:

I certify that all information listed is true and correct to the best of my knowledge. I understand that the information given is to be used to ascertain my ability to pay for services provided by E.C. Tyree Health & Dental Clinic, Inc. I also understand that after my review has been completed that I have 30 days to pay the remaining balance in full or I will not receive the discount offered and my account will be listed with an outside collection agency. I hereby grant permission to E.C. Tyree Health & Dental Clinic, Inc. to investigate the information contained herein.

Signature

Date