



Doctor or Practice Name: _____

Patient's Name: _____

Is the Patient the primary applicant? Yes (If yes, please enter the same information in the Primary Applicant Section)
 No (If no, please enter the person applying for credit in the Primary Applicant Section)

Loan Amount Request: \$ _____ Tentative Procedure Date: (mm/dd/yyyy): _____

Preferred Term: Revolving 24 Months 36 Months 48 Months 60 Months

Applicant Information (If applying with a Co-Applicant, please fill out a second form with the Co-Applicant's Information)

Check One: Primary Applicant Co-Applicant

Email Address: _____

First Name: _____ Last Name: _____

SSN: _____ - _____ - _____ Date of Birth (mm/dd/yyyy): _____

Driver's License Number: _____ State: _____ Mobile Phone: _____

How is your credit? (Check One)

- Excellent (740 - 850 FICO) Good (700 - 739 FICO) Fair (650 - 699 FICO)
 Ok (600 - 649 FICO) Not so good (Less than 600 FICO) I don't know

Gross Monthly Salary: \$ _____ Additional Monthly Income: \$ _____ Source: _____

Current Employer: _____ Position: _____

Work Status (Check One)

- Full Time Part Time Self Employed Retired Unemployed Student Homemaker

Street Address: _____ City: _____ State: _____ Zip Code: _____

Business Phone: _____ Ext. _____ Time With Employer: _____ Years _____ Months

(If at current employer < 2 yrs, please provide your previous employer below)

Previous Employer: _____ Position: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Business Phone: _____ Ext. _____ Time With Employer: _____ Years _____ Months

Housing Status: Own Rent Monthly Payment: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Duration at Address? _____ Years _____ Months

(If at current residence < 2 yrs, please provide your previous residence below)

Previous Residence: Own Rent Monthly Payment: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Duration at Address? _____ Years _____ Months

If applying with a Co-Applicant, please fill out another form with the Co-Applicant's Information.

eMedical Lending Patient Application Consent

By signing below, I agree to the following: I hereby: (1) apply for the loan indicated; (2) certify that all information I have provided on this application herewith is true, correct and complete; (3) authorize eMedical Lending (EML) Inc and/or any of its lending partners (the EML Network) to make credit inquires about my current and past creditors and to consumer reporting agencies; (4) authorize my current and past consumer reporting agencies to furnish the EML Network with regular investigative reports about me; (5) authorize the EML Network to verify my employment history; (6) understand that EML in acting as an intermediary and will relay all my submitted information to their lending network (7) authorize EML to receive all loan decisions associated with this application from their lending partners on my behalf (8) authorize my provider's staff to submit a loan application on my behalf through the EML lending platform (9) authorize my provider's staff and EML's agents, affiliates or contractors to receive information related to the processing, decisioning, and funding of my loan application including items such as name, address, decision, rate, and loan terms (10) give my consent that all disagreements arising as a result of this application, processing of the application, or funding of the loan shall be resolved by binding arbitration, in Los Angeles County, California, in accordance with Commercial Arbitration Rules of the American Arbitration Association.

I agree to and accept eMedical Lending's [Privacy Policy](#), [Terms of Use](#) and [Consent for Electronic Disclosures](#). I acknowledge that I have read and understand these documents. (Please print these documents for your records.)

IMPORTANT

IT IS VERY IMPORTANT THAT YOU UNDERSTAND THAT eMEDICAL LENDING AND OUR LENDING PARTNERS DO NOT GUARANTEE THAT YOU WILL BE SATISFIED WITH THE OUTCOME OF YOUR PROCEDURE. REGARDLESS OF THE OUTCOME, YOU MUST COMPLY WITH THE TERMS THAT YOU AGREED TO IN YOUR FINAL LOAN DOCUMENTS.

eMEDICAL LENDING IS AN INDEPENDENT COMPANY, SEPARATE FROM YOUR DOCTOR'S/DENTIST'S OFFICE. WE ARE ONLY AFFILIATED WITH DOCTOR'S/DENTIST'S OFFICES TO PROVIDE A SERVICE FOR YOU THE PATIENT.

Applicant's Name: _____
Applicant's Signature: _____
Date: _____

Co-Applicant's Name: _____
Co-Applicant's Signature: _____
Date: _____