Family & Cosmetic Dentistry
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THE DENTAL DISCOUNT PLAN APPLICATION

Date: ____________________ Name: ______________________________________

Address: ____

City: ____________________________ State:______________ Zip:________________

Home Phone:(_____) ______-_________ Work Phone:(______) _____ -________

Email: ____________________________ SS#: _________-_____-_____________

Additional members:

Name: ______________________________________ Relation: ________________

Name: ______________________________________ Relation: ________________

Name: ______________________________________ Relation: ________________

Name: ______________________________________ Relation: ________________

I would like to enroll in Dental Discount Plan. I understand the fee for this service is $299.00 for myself and an additional $99.00/year for anyone else in my family. I understand in order to keep my plan active, I must keep my six-month recall appointment or else I will lose the benefits. I understand that Scaling and Root planning are not included in the cleaning but I will receive a 20% discount on such procedures. The plan fee is non-refundable. I have received a copy of this page.

Signature of Applicant______________________________ Date__________________

Office Administrator Signature: ____

Amount Paid: ________________________________ Date: _______________________