Membership Registration

Full Name :_________________________________ Birthday:____/____/______

Home Address:____

City:________________________ State:____ Zip code:____________

Additional Family Members:

Name	Birthday	Relation

Method of Payment (check): ❑ Cash ❑ Check ❑ Credit Card

I understand the benefits, limitations, exclusions, and requirements of the membership and I agree to the following: **I will remain in the plan and pay membership fees for a minimum of 12 months.** Payment of less than 12 months membership fees may result in my being charged the usual and customary fees for all services, including those already provided. Fees for dental services are due as the services are rendered. Failure to comply may result in my being charged the usual and customary fees for those services. A late fee may apply to accounts when there are not sufficient funds available in your account to clear your check payment when paying for services and/or initial yearly fees. I agree to pay any and all costs in collecting all charges including, but not limited to, attorney fees and court costs. Coverage must be continuous. Late fees must be made up for uninterrupted service. Fees are nonrefundable.

Signature:______________________________________ Date:____/____/______

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OFFICE USE ONLY

Start Date:____/____/______ End Date:____/____/______

Adults: _____ x $359 = $________

Children: _____ x $299 = $________

Perio: _____ x $719 = $________

Total: = $________