In-Office Discount Dental Plan

Enrollment Application

Name: ____

Date of Birth:______________________ SSN#:______________________

Address:____

____

Phone Number:

Home:______________________ Cell:______________________

Work:______________________

Dependents:	Name	Date of Birth	Relation

Enrollment Fee:

Member	$340	X______	$_______
Spouse/Domestic Partner	$280	X______	$_______
Dependents	$180	X______	$_______
Periodontal Patient	$560	X______	$_______

Effective Date:______________________ Auto-Renewal Date______________________

I,______________________________, do hereby understand the polices and limitations the of Dental Care of Frisco In-Office Discount Plan. Furthermore, I understand the office polices of Dental Care of Frisco and agree to them.

Signature:______________________________ Date:______________________