NORTHSIDE
FAMILY DENTISTRY

In-Office Dental Plan Enrollment

Effective Date: _____ Renewal Date: _____

Name: _____

Address: _____

DOB: _____ SSN: _____

Phone - Home: _____ Cell: _____ Work: _____

Email: _____

Additional Members:

Name	DOB	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Enrollment Fee: Individual: $407.00

Each additional family member $407.00 x _____ = _____

TOTAL: _____

**Checks made payable to Northside Family Dentistry **

I do hereby understand the policies and limitations of Northside Family Dentistry's In-Office Dental Plan. Furthermore, I understand the office policies of Northside Family Dentistry and agree to them.

Patient Signature: _____ Date:_____

NFD Staff Member: _____ Date:_____