

## In-Office Dental Plan Enrollment

Name: \_\_\_\_\_

Address: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Phone - Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_

Additional Members:

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

Enrollment Fee:

**Effective Date:** \_\_\_\_\_ **Renewal Date:** \_\_\_\_\_

Individual: \$392.00

Each additional family member \$392.00 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.

INCLUDED:            Prophy-                    BWX-                    Pan/FMX-  
                                 Exam-                        FL2-                      Emergency Exam-

(under age 16)