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: $356.00

Each additional family member $356.00 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)	