GARDNER Family Dentistry

Dental Savings Plan Application Form

Effective Date: _____
(office use only)

Primary Plan Holder:

First Name _____ Last Name _____ Middle Initial _____ Social Security _____-_____-_____

Address _____ City _____ State _____ Zip Code _____

Cell Phone Number_____ Work Phone Number _____

Email _____ Date of Birth _____

Additional Family Members to be Covered:

Adult Patient with Healthy Gums **Add $325**
Add a child under 12 years of age family member **Add $285**
Periodontal Program *(Individualized plan will be created)* **$450 - $550**

Primary Annual Membership

Cost $ **$325.00**

Name _____ Relationship _____ DOB _____ Cost $_____

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Name _____ Relationship _____ DOB _____ Cost $_____

***Total Amount Due: $_____**

*Annual fee is required at enrollment and cannot be financed. Membership fees for Dental Savings Plan are NON-REFUNDABLE. Gardner Family Dentistry reserves the right to modify, change, or discontinue the Dental Savings Plan, terms, fees, and services at the company's discretion upon written notice from Gardner Family Dentistry prior to you anniversary renewal date.

Payment Method:

❑ Cash (cash accepted in office only, please do not mail)

❑ Check (check number_____)

❑ Credit Card #:_____ Exp. Date: _____/_____ CVC: _____

Please mail this completed application with appropriate payment (check or credit card information) to our dental location:

Gardner Family Dentistry,107 Marsheutz Avenue, Huntsville, AL 35801

By signing below. I acknowledge that I have read the Dental Savings Plan brochure and understand the plan details, benefits, and limitations.

Member Signature: _____ **Date:** _____