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 $375**
Add a child under 12 years of age family member **Add $335**
Periodontal Program *(Individualized plan will be created)* **$505 - $605**

Primary Annual Membership Cost $ **$375.00**

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:** __________________________