SUMMIT SMILES

Dental Membership Plan Enrollment Form

This Plan is valid for one year from the date this agreement is signed and premium is paid.
This Plan is only honored at Summit Smiles. It cannot be used at any other dental office.

- □ **$399 per Adult Family Member for the plan year**, includes: (2) Prophy (2) Exam (1) Emerg. Exam (1) Pan/fmx (1) Bwx (1) Virtual video consult
- □ **$310 per Child Family Member for the plan year**, includes: (2) Prophy (2) Exam (1) Emerg. Exam (1) Pan/fmx (1) Bwx (2) Fluoride Treatment (1) Virtual video consult
- □ **$750 per Adult Family Member for the plan year,** includes: (1) Perio Eval (1) Gross Debridement (4) Perio Maint. (1) Periodic Exam (1) Emerg. Exam (1) Pan/fmx (1) Bwx

All other treatment 15% off

Member Information:

First Name _____ Last Name_____
Date of Birth (month/day/year) _____
Street Address_____
City, State, Zipcode_____
SSN_____
Cell Phone _____
Email Address_____

Annual Renewals are managed through **auto-debit** and will be charged to the member on the 1st day of _____ for continuous coverage.
Please circle one: VISA MasterCard Amex Discover
Credit Card # _____
Exp (month/year) _____
CVV _____
Card Holders Signature _____

Terms and Limitations of the Plan:

- ✓ This is an In-House dental membership plan and is NOT dental insurance.
- ✓ This plan cannot be combined with any other dental insurance.
- ✓ This In-House Plan is good only for Summit Smiles.
- ✓ This Plan is NON-Refundable.
- ✓ No refunds will be given if patient chooses not to use their membership plan.
- ✓ No refunds if patient picks a dental plan through their employer or any other means.
- ✓ Payments for services are due at the time of service. If you choose to pay with Care Credit, the discount will be reduced to 10% due to merchant fees.
- ✓ This Plan covers Dental Services only. Products are not included.

Printed Name of Member _____
Signature of Member/Legal Guardian _____
Relationship to minor _____
Date_____