

For office  
use only  
PIF\_\_\_\_  
SL\_\_\_\_  
SPST\_\_\_\_  
EPW\_\_\_\_  
FILE\_\_\_\_  
RENEWAL  
DATE:  
\_\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ EMPLOYER AND TITLE \_\_\_\_\_

List Covered Dependents:

(Eligible dependants include only spouses, children under the age of 18 and full-time students 25 and younger. Proof of student status required.)

Name	Birth Date	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Quality Dental Plan - Total Amount Due \_\_\_\_\_  
(\$338 for first member plus \$256 for each additional dependant)

Payment Method:

Cash \_\_\_\_\_

Check \_\_\_\_\_

Credit Card # \_\_\_\_\_ Exp Date \_\_\_\_\_ Billing Zip Code \_\_\_\_\_

Card Type: MC / Visa / Discover

Signature \_\_\_\_\_

Please read and sign below:

Quality Dental Plan offers significant discounts on dental services. I understand the benefits, limitations exclusions and requirements of this plan and agree to the following:

Fee for dental services are due when rendered. Fees for prosthodontic (dentures) and cast restorations (crowns, inlays, onlays, veneers) are due at the preparation/impression visit. Use of Care Credit for payment will result in a service fee. If you choose not to pay at the time of service you will billed our usual and customary fees for such services.

VIP patients may still use their additional discount. Member benefits may not be used with any other offers.

Signature \_\_\_\_\_ Date \_\_\_\_\_