Dental Advantage Plan Enrollment Form

The Dental Advantage Plan is an in-house, discount plan designed to provide greater access to affordable quality dental care. For a small fee, you and your family will enjoy substantial savings on dental care. Please review the Dental Advantage Plan brochure for further information on cost savings and benefit details.

Plan includes: New patient or comprehensive examination, 2 periodic exams/yr, 1 full mouth set of xrays and panoramic xray/3-5 yrs, 1 set bitewing xrays/yr and 2 basic cleaning/yr. Discounted rate on emergency exams, fluoride, sealants, 3D xrays and periodontal maintenance. Additional services will be provided with a 15% discount with cash or check, 12% with credit card.

Member	Yearly Rate	Value
Individual	$299	$348
Child	$269	$380 with fluoride

APPLICANT INFORMATION (Please print clearly)

LAST NAME	FIRST NAME	INITIAL	BIRTHDATE ____/____/________
ADDRESS	PHONE #	GENDER	☐MALE ☐FEMALE
CITY	STATE	ZIP	
BILLING ADDRESS(IF DIFFERENT)	CITY	STATE	ZIP
DRIVERS LICENSE #	STATE		

Once you enroll, your membership will be activated within 24 business hours. *By submitting your enrollment form, you acknowledge that you have read, understand and agree (on your own behalf and the behalf of your dependents) to adhere to the following terms and conditions:*

- The Advantage Plan is honored only at Cold Spring Family Dentistry.
- Patient's portion of the bill is due the day of service.
- No refund of premiums will be issued at any time.

The Advantage Plan is NOT a dental insurance plan and cannot be used in the following situations: in conjunction with another dental plan/dental insurance, for services/injures covered under Worker's Compensation, for dental care costs covered under automobile or medical insurance or services using financing (Lending Club/Care Credit). By signing this form, I agree to all the above terms and conditions.

_______________________________ Name

_______________ Date

_______________________________ Signature

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When paying by ACH or Credit Card, please complete the section below.

☐ Please automatically charge my credit card the following yearly fee in amount of $_______________.
(Complete the credit card information and sign the Automatic Payment Authorization below to activate this payment method.)

Credit card type: ( )Visa ( )Mastercard ( )Discover

Credit card number: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Security code: ☐ ☐ ☐ Expiration date (month/year): ☐ ☐/☐ ☐

Cardholder Name_______________________________ Cardholder Signature_____________________________________

Address____

AUTOMATIC PAYMENT AUTHORIZATION

I authorize Cold Spring Family Dentistry to initiate debit entries to my credit card account for my dental membership. I understand that this agreement will remain in effect until Cold Spring Family Dentistry has received written notice from me that my membership be terminated. I agree to notify Cold Spring Family Dentistry of any changes in my account information.

______________________________________	_______________	______________________________________
Membership Holder’s Name (Please Print)	Date	Membership Holder’s Signature