APPLICATION FOR IN-HOUSE WELLNESS PLAN

Member Information:

Name_______________________________________ DOB ____________ Sex _____ SS# __________________

Home Address ____
(Street) (City) (State) (Zip)

Home Phone___________________ Cell________________ E-Mail _____________________________________

Plan Cost: *Individual Adult Coverage - $495* *Individual Child Coverage (Under 13)-$375*

Enrollment fees must be paid prior to any dental care procedures

If the participant does not utilize the services, the plan is non-refundable and offers no additional benefits.

Membership is for one year beginning on the enrollment date.

In order to receive the membership discount, full payment is due at the time of service. Any service not paid in full will be billed at the customary fee.

This plan is a savings plan, not an insurance plan. No claims are filed and no payments are made to any other healthcare provider. It cannot be combined with another dental plan, insurance, or any other discounts. This plan is solely for your treatment with Shallotte Family Dentistry. If treatment cannot be completed at Shallotte Family Dentistry, discounts are not applicable at other offices.

There will be a $75 fee if plan lapses and requires reinstatement at any time.

Payment Type: ☐ Cash ☐ Check ☐ Credit Card (An additional $20 processing fee applies for credit card payments.)

Credit Card Type: Discover Visa MC Name on Card: ____

CC Number: ____ CVR Code: _________ Exp. Date: ____________

Cardholder Signature: ____ Date: ____________________

Check information: (Signed check must be enclosed to complete enrollment)

Check Number: ____________________ Bank Branch: ____

Terms and Agreement: By signing below I understand and accept the above terms and information regarding the enrollment process for the Shallotte Family Dentistry In House Dental Plan. My signature below confirms the enrollment for the member listed above (myself or minor family member). I understand the enrollment will be effective beginning the date of this signed form and will end one year from the enrollment date. I understand reenrollment will not be automatic for the following year and will be the responsibility of the member or their representative to initiate. I understand this form is only effective for the member listed above and each enrollee will require their own agreement even if enrollment fee is paid in full.

Member/ Representative signature____**Date**________________

WELLNESS PLAN

At Shallotte Family Dentistry, we believe everyone should receive the quality dental care they need. Our wellness plan is designed to make keeping up with your dental care easy, manageable and affordable.

Benefits

- No deductible or co-pays
- Pre-existing conditions are covered
- No pre-authorizations
- No waiting periods
- No annual maximums
- Discounts on services

Our wellness plan includes the following:

- Two (2) dental examinations
- Two (2) dental cleanings
- Oral cancer screening
- Bitewing radiographs at semi-annual visits
- Two (2) fluoride treatments if needed
- One (1) limited/emergency examination

15% off additional procedures that are performed in office including: Dental sealants, fillings, core build-ups, crowns, veneers, extractions, bone grafting, root canals, implants, implant restorations, full and partial dentures and Invisalign. Excludes Whitening or take home products.

Plan Cost: *Individual Adult Coverage - $495* *Individual Child Coverage (Under 13)-$375*

Membership

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To sign up for this wellness plan please complete the application as directed on the reverse side of this page. Please return fully completed and signed form for each member directly to our office. If you have any additional questions, please feel to contact our office at (910)755-7645.