In House Discount Plan

Plan premiums - cost is annual

Individual Plan: $295

Family Plan –

- Primary $295
- Spouse/Other (over 18): $195
- Child (under 18): $145

Plan premium includes the following coverage:

Preventative services:

1 regular adult/child preventative care visit, complete exam, FMX, and a fluoride treatment at 100% off.

2nd preventative care visit of the plan year is discounted at 50% off.

All treatment during the plan year is discounted at 20% off our usual and customary fees.

The 20% discount includes:

Additional preventative care visits and fluoride treatments
Exams and x-rays
Sealants
Periodontal maintenance prophylaxis
Root planing and scaling
Endodontic treatment
Crowns, bridges, dentures, and implants
Occlusal guards
Emergency treatments

Limitations and exclusions:

Orthodontic procedures such as Invisalign braces are not a covered benefit.

If you have periodontal disease and require a periodontal maintenance prophylaxis, the usual fee of $89 will be credited towards your appointment, and you will owe the difference on your first visit that would be discounted at 100%. On your second visit you will receive the 50% discount off of your cleaning as per the plan provisions.

Enrollment Information

Patient name: ______________________________ Date of Birth: ____/____/_____

Address: ____ Apt/Suite #: ___________

City: _______________________ State: _________ Zip Code: ______________

Primary phone #: __________________________ Enrollment date: _____/_____/______

Patient signature: ____

Second Enrollee Information:

Patient name: ________________________________ Date of Birth: ____/____/_____

Address: ____ Apt/Suite #: ___________

City: ________________________ State: _________ Zip Code: _______________

Primary phone #: ____________________________ Enrollment date: _____/_____/______

Patient signature: ____

Third Enrollee Information:

Patient name: ________________________________ Date of Birth: ____/____/_____

Address: ____ Apt/Suite #: ___________

City: ________________________ State: _________ Zip Code: _______________

Primary phone #: ____________________________ Enrollment date: _____/_____/______

Patient signature: ____

Additional Enrollee Information:

Patient name: ________________________________ Date of Birth: ____/____/_____

Address: ____ Apt/Suite #: ___________

City: ________________________ State: _________ Zip Code: _______________

Primary phone #: ____________________________ Enrollment date: _____/_____/______

Patient signature: ____