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# CALCUTT FAMILY DENTISTRY

## DENTAL SAVINGS PLAN

### APPLICATION FOR IN-HOUSE DENTAL SAVINGS PLAN

#### Personal Information:

Name \_\_\_\_\_ E-mail Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

SSN \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

#### Spouse's Information:

Name \_\_\_\_\_ E-mail Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

SSN \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

#### Children's Information:

Name \_\_\_\_\_ M / F Birthdate \_\_\_\_\_

Name \_\_\_\_\_ M / F Birthdate \_\_\_\_\_

Name \_\_\_\_\_ M / F Birthdate \_\_\_\_\_

Name \_\_\_\_\_ M / F Birthdate \_\_\_\_\_

#### Annual Plan Cost:

Individual \$350.00

2<sup>nd</sup> Family Member \$250.00 = \_\_\_\_\_

Additional Family Member \$150.00 X \_\_\_\_\_ = \_\_\_\_\_

\*\* Periodontal Plan \$100.00 X \_\_\_\_\_ = \_\_\_\_\_

Total Annual Cost: \_\_\_\_\_

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Name: \_\_\_\_\_

**Payment Information:**

Check \_\_\_\_\_

Credit Card:

Visa

Mastercard

AMEX

Card Number \_\_\_\_\_ Exp Date \_\_\_\_\_ CVR Code \_\_\_\_\_

Zip Code for Card Holder \_\_\_\_\_

Card Holder Signature \_\_\_\_\_