Dental Benefits Plan Form

OFFICE USE ONLY:	
INITIALS	DATE

PATIENT INFORMATION

FULL NAME	DATE OF BIRTH	DATE
ADDRESS	CITY	ZIP
EMAIL	PHONE	ALT PHONE

FAMILY INFORMATION

FULL NAME #1	RELATIONSHIP	DATE OF BIRTH
FULL NAME #2	RELATIONSHIP	DATE OF BIRTH
FULL NAME #3	RELATIONSHIP	DATE OF BIRTH
FULL NAME #4	RELATIONSHIP	DATE OF BIRTH

PLAN SELECTION

SELECT ONE:	◯ INDIVIDUAL	◯ DUAL	◯ FAMILY (3)	◯ FAMILY (4)

PAYMENT TYPE

SELECT ONE:	◯ CASH	◯ CHECK	◯ CREDIT CARD	*PLEASE FILL OUT THE INFORMATION BELOW IF PAYING WITH CREDIT CARD

NAME ON CARD	TYPE OF CARD	
CARD NUMBER	EXP DATE	
ADDRESS	CITY	ZIP

AUTHORIZATION

THE FEES OUTLINED IN THE DISCOUNT PLAN OPTIONS OR OTHER ESTABLISHED FEES BY HILLCREST DENTAL ARE NON-REFUNDABLE. ALL PLAN FEES ARE DUE AT THE TIME OF ENROLLMENT. AN ADDITIONAL FEE MAY BE CHARGED FOR ANY MISSED, CANCELLED OR BROKEN APPOINTMENT WITHOUT 24 HOURS PRIOR NOTICE. THIS PLAN IS NON-TRANSFERABLE BY PATIENT. THIS PLAN DOES NOT INCLUDE ANY WORK IN PROCESS OR RE-TREATMENT. THIS PLAN CANNOT BE COMBINED WITH ANY OTHER INSURANCE, DENTAL PLAN, COUPON, OR DISCOUNT. FAILURE TO COMPLY WITH THE TERMS OF THE PLAN MAY RESULT IN TERMINATION OF THE PLAN AND FORFEITURE OF ANY FEE PAID BY PATIENT OR OTHER THIRD-PARTY. HILLCREST DENTAL RESERVES THE RIGHT TO REFUSE TREATMENT AND/OR TERMINATE THE PATIENT'S PARTICIPATION IN THIS PLAN WITHOUT NOTICE OR REFUND IF THE PATIENT'S ACCOUNT BECOMES DELINQUENT OR PATIENT IS NON-COMPLIANT. THIS PLAN MAY BE MODIFIED, AMENDED OR CANCELLED AT ANYTIME WITHOUT PRIOR NOTICE AND MAY BE SUBJECT TO OTHER TERMS AND CONDITIONS.

PATIENT SIGNATURE	DATE