dentalAccess Plan Enrollment

Bradley J Shuder DDS
FAMILY AND COSMETIC DENTISTRY

Responsible Party:

First Name: _____ Last Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Birthdate: _____

Email Address: _____

Enrollee: (Children are ages 13 and under/ adults are ages 14 and over)

Name: _____ Birthdate: _____
☐ Adult ☐ Child

Name: _____ Birthdate: _____
☐ Adult ☐ Child

Name: _____ Birthdate: _____
☐ Adult ☐ Child

Enrollment Fees:

Children (ages 13 and under) - $300/person TOTAL # CHILDREN: _____

Adults (ages 14 and over) - $320/person TOTAL # ADULTS: _____

Each Additional Adult - $300/person TOTAL # ADDT'L ADULTS: _____

TOTAL AMOUNT DUE: $ _____

Payment: ☐ Cash ☐ Check ☐ Credit Card

Credit Card: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name: _____ Expiration Date: _____

Card Number: _____ CVV #: _____

By signing below, I acknowledge that I understand, have agreed to and reviewed the terms and conditions of the dentalAccess Plan. I authorize this dental office to process my payment as listed in this Agreement.

Printed Name: _____

Signature: _____ Date: _____