PLATINUM DENTAL

Savings Plan

Date:________

Name:____

Address:____

Phone (Cell):______________ Phone (Home):____________

Plan Type: **Adult:**________ **Child:** ________

Family Members:	Date of Birth:	SS#

Adult: $200.00 One Time fee

Each Child (Under13): $100.00 One Time fee

Enclosed Payment:

______ Check/Money Order

Please Make Check Payable to: Perkiomen Valley Dental

______ Credit Card (Visa/Mastercard

Card Number:______________

Expiration Date:______________

Signature: ______________________

Plan Disclaimer:

- All charges for dental services are to be paid by member.
- Insurance companies or claims are not involved.
- Usual fee charged for service. Fee schedules provided upon request.
- Fees apply to service performed at Perkiomen Valley Dental
- It is the member's responsibility to inform the staff of their membership in this plan when scheduling appointments
- Fee represents current rate charged to non-plan patient. There is a charge for broken appointments (maximum of $75.00 1 hour of scheduled time.)
- There may be a charge for providing copies of X-rays to members
- Perkiomen Valley Dental reserves the right to make changes and modifications, without notification, in material contained herein.