

Last Name _____ First _____ MI _____

Home Address _____

City _____ State ____ Zip _____

Home Phone _____ Work Phone _____

Birth Date _____ Employer _____

List Covered Dependents:

Name	Birth Date	Relationship

Quality Dental Plan - Total Amount Due _____

Payment Method:

Check

Cash

Card # _____ Exp Date _____

Card Type: MC Visa Discover (Circle One)

Signature _____

Please read and sign below:

Quality Dental Plan offers significant discounts on the dental services. I understand the benefits and requirements of this plan and I agree to the following:

Fees for dental services are due when services are rendered. Fees for prosthodontic (dentures) and cast restorations (crowns, onlays, inlays, veneers) are due at the preparation/impression visit. If you chose not to pay at the time of service, you will be billed our usual and customary fees for such services.

Signature _____ Date _____