Dental Savings Plan

We are excited to offer a dental savings plan designed for patients without dental insurance benefits.

Membership Fees:

- First Year Adult Members (age 18 and above): **$399 per year** **($33.25 per month)**
- Teenagers (age 13 to 17): **$299 per year** **($24.91 per month)**
- Children (age 4 to 12): **$249 per year** **($20.75 per month)**

Membership Benefits:

- Includes two preventive appointments. (two cleanings, two exams, necessary x-rays, and fluoride treatments)
- Free annual oral cancer screening.
- All x-rays are free of charge! This includes x-rays for emergency visits and consultation visits.
- All dental treatment completed within 12 months of enrollment will be discounted by **20%**. (Exclusions below)
- For edentulous patients with complete dentures, fees will drop to $199 per year. Plan will include free denture cleaning, instead of teeth cleaning, every 6 months and all other benefits.

Plan Disclaimers:

- The 20% discount will be dropped to 10% if Care Credit payment plan is used as the payment option. (Reduction in discount due to Care Credit fees charged to the office).
- 20% discount excludes invisalign, whitening procedures, merchandise sales, and nitrous oxide fees.
- This offer cannot be combined with any other offers.
- This is not a dental insurance plan.
- Coverage is in effect for one year with signup date serving as the plan anniversary.
- Membership fees are non-refundable.
- Appointment times are limited. It is the responsibility of the member to schedule appropriate visits during membership period.
- No refund of unused appointments (no rollover).
- Excludes care covered under workman's comp or auto coverage.
- Savings are valid at Bethlehem Town Family Dental only.
- Services requiring the care of a Specialist are not covered by this plan.

Plan Member Names:

1.____ DOB: _________________

2.____ DOB: _________________

3.____ DOB: _________________

4.____ DOB: _________________

5.____ DOB: _________________

6.____ DOB: _________________

7.____ DOB: _________________

8.____ DOB: _________________

Membership Fee: $___________

I have fully reviewed and understand the above terms.

Plan Holder: ____ Signature: ______________________________________

Enrollment Date: ________________________________ Expiration Date: ______________________________________