Whittle Family Dentistry

Dental Savings Program Application

Effective Date: _____

Last Name: _____ First Name _____ MI _____

Home Address_____ Date of Birth _____

City _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-Mail:_____

Covered plan members:
Include Full Name and Birthdate

(1) _____Date of Birth _____

(2) _____Date of Birth _____

(3) _____Date of Birth _____

(4) _____Date of Birth _____

Dental Savings Plan Total Amount: _____

Payment Method

- Check
- Cash
- Debit/Credit Card # _____ Exp Date _____ CVC_____

By signing below, I acknowledge that I have read and understand the plan details and limitations.

Signature_____ Date_____
(Signature of plan holder)

*Annual fee is required at enrollment and is non-refundable. Exclusions and limitations apply. Membership is good for one year from date of enrollment. An additional fee may be charged for any missed, cancelled or broken appointments without 24 hour notice. This is not insurance coverage. It is a discount dental plan. Discount does not apply to work performed outside this office. This discount plan cannot be combined with any other offers, discounts, or insurance. This plan is non-transferrable, which means that no other friend or family member may be substituted for the plan's purchaser. It is also non-refundable. No refunds will be issued even if you choose not to use the benefits during the year. Annual fees are due at the time of enrollment. The day the enrollment fee is paid, the plan goes into effect and the expiration/renewal date is exactly one calendar year from that date. Your enrollment status will be kept in our electronic records eliminating the need for identification cards. Enrollment fees are subject to change annually. Benefits must be used during the year and cannot be rolled over to the next year if not used. This discount plan does not apply toward Invisalign or Teeth Whitening.