FoxViewDental

Cosmetic | Restorative | Implant | Sedation

Green Bay's Smile Maker

Smile Maker Savings Plan

PRIMARY PLAN HOLDER:

Effective Date: _____
(IN OFFICE USE ONLY)

First Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Contact Phone #: _____ Email: _____ Birthdate: _____

Plan: Adult Preventative **Periodontal** **Child Preventative**

ADDITIONAL FAMILY MEMBERS TO BE COVERED:

Name: _____ Relationship: _____ Birthdate: _____

Plan: Adult Preventative **Periodontal** **Child Preventative**

Name: _____ Relationship: _____ Birthdate: _____

Plan: Adult Preventative **Periodontal** **Child Preventative**

Name: _____ Relationship: _____ Birthdate: _____

Plan: Adult Preventative **Periodontal** **Child Preventative**

*TOTAL AMOUNT DUE: _____

*Annual fee is required at enrollment and cannot be fi nanced. Smile Maker Savings Plan is NON-REFUNDABLE. Fox View Dental, reserves the right to modify, change, or discontinue the Smile Maker Savings Plan, terms, fees, and services at the company's discretion upon written notice from Fox View Dental prior.

PAYMENT METHOD:

☐ Cash (in-office only**)

☐ Check (make checks payable to Fox View Dental and enclose check with application)

☐ Credit Card #: _____ Exp. Date: _____ CVC: _____

Set my account listed above to Auto Draft***

Please mail this completed application with appropriate payment (check or credit card info) to our dental office location:

Fox View Dental - 2310 Oak Ridge Circle | De Pere, WI 54115

By signing below, I acknowledge that I have read the Fox View Dental Brochure and webpage understand the plan details, benefits, and limitations.

MEMBER SIGNATURE: _____ **DATE:** _____