Please fax this form to 954-316-4433 or
Email form to: patientcare@dolphindentalcare.com

Enrollment Information

Personal Information

Last Name		First Name	Middle Initial
Date of Birth	Sex	SS#	
Address			
City		State	Zip Code
Phone:		Email:	

Spouse Information

Last Name		First Name	Middle Initial
Date of Birth	Sex	SS#	
Address			
City		State	Zip Code
Phone:		Email:	

Children Information

Last Name		First Name	Middle Initial
Date of Birth	Sex	Son / Daughter	
Address			
City		State	Zip Code
Phone:		Email:	

Children Information

Last Name		First Name	Middle Initial
Date of Birth	Sex	SS#	
Address			
City		State	Zip Code
Phone:		Email:	

I understand the benefits, limitations, and requirements of the plan and agree to the terms. Payments are due at time of service. All family members must reside in the same household. This is not an insurance product.

Signature: _____

Date: _____ (renewal date)

____	**Individual**	**$149/year***
____	**Individual and Spouse**.....	**$249/year***
____	**Family Plan**..... (2 adults, 2 kids under 18years old)	**$349/year***
____	**Additional Child in Family**.....	**$99/year***
____	**Periodontal Program**.....	**$499/year***