endo smile plan

MEMBERSHIP FORM

***Please complete the form and email it to nc@atlanticendo.com**

Atlantic ENDODONTICS

First Name _____ Last Name _____

Street Address _____

City _____ State _____ Zip _____

Email _____ Phone _____

Patient Type ☐ New ☐ Existing DOB ___/___/___

Additional Plan Members

First Name _____ Last Name _____ Age _____ ☐ New ☐ Existing

First Name _____ Last Name _____ Age _____ ☐ New ☐ Existing

First Name _____ Last Name _____ Age _____ ☐ New ☐ Existing

First Name _____ Last Name _____ Age _____ ☐ New ☐ Existing

Agreement Terms and Signatures

Membership is in effect for one calendar year from date fee is paid in full. Membership is valid on in-house services. Appointment times are limited, and it is the responsibility of the Member to schedule appropriate visits. Membership discount cannot be combined with dental insurance, dental products or any other discounted procedure. Membership Fee cannot be purchased with third-party financing. No transfers or refunds.

A team member has reviewed this plan with me. I have had the opportunity to ask questions and I fully understand my plan details. Prior to receiving any membership benefits, I also agree to payment in full of $5 for any adults (14 and older) and $5 for any children (13 and under) based on the information I have provided above.

Signature _____ **Date** ___/___/___