# SANDHILLS FAMILY DENTAL

## Membership Program Application

| Name: _____ | DOB: _____ |
|---|---|
| | |
| Type of Plan: ☐ Adult ($290) ☐ Child ($250) ☐ Perio ($700) | |

I, _____, understand that the membership fee for enrollment in the Sandhills Family Dental Membership Program is an annual fee & includes two (2) routine cleanings for the regular Adult & Child Membership, or four (4) routine cleanings & periodontal maintenance for the Perio Membership, for exactly one (1) year after signature date of this contract. The 2 routine cleanings each year will include 1 comprehensive exam, 1 periodic exam, bitewing X-rays, & 2 prophy & fluoride treatments. The Perio Membership will include an additional 2 exams, 2 fluoride treatments, plus periodontal maintenance at each appointment. By paying the agreed upon membership fee, I will also receive 15% off of the posted treatment rates at time of service for exactly one (1) year. The 15% discount applies to all treatment that Dr. Kelly or Dr. Adam see fit for my dental health. This includes, but is not limited to: additional diagnostic X-rays & exams, endodontics, restorations, extractions, crowns, dentures, partials, bridges, implants, & periodontics. The discount for orthodontics will be 5% off if paid in full at time of ortho contract signing. The membership fee is non-refundable & unused cleanings cannot be transferred to a future year, even if I choose to re-enroll in the program. ***Care credit will not be accepted for membership program fees & discounted treatment fees under the membership program.***

Signature of Patient: _____ Date: _____
(or Responsible Party)