Enrollment Form

PLEASE FILL OUT & SUBMIT THIS FORM TODAY TO BEGIN COVERAGE

First Name _____

Middle Name _____

Last Name _____

◯ Male | ◯ Female

Home Address _____

_____

City/State/ZIP _____

Phone _____

Secondary Phone _____

Email _____

Date of Birth ____ /____ /____

S.S.# _____ - ____ - _____

Spouse First Name _____

Spouse Middle Name _____

Spouse Last Name _____

◯ Male | ◯ Female

Date of Birth ____ /____ /____

S.S.# _____ - ____ - _____

Please include any children's information on back.

Enrollment Period To Begin: ____ /____ /____

Through: ____ /____ /____

Signature:

_____ Date: _____

◯ Check (made payable to Shirley Dentistry)

◯ MasterCard ◯ Visa ◯ Discover

Card Number _____

Name on Card _____

Expiration Date ____ /____

We would be happy to answer your questions or set up your dental savings plan today!

(417) 678-4141

smile@shirleydentistry.com

ShirleyDentistry.com

Find us on Facebook!

SHIRLEY DENTISTRY

1402 S. Elliott Ave. Aurora, MO 65605

SHIRLEY DENTISTRY

Dental Savings Plan

Shirley Dentistry
Dental Savings Plan

Our goal is to provide you and your loved ones with exceptional, comprehensive dental care. When you are in our office, our entire focus is on you and your oral health. We want to see you smiling at the end of each visit!

Our dental savings plan is designed to give you full access to quality dental care at affordable prices, without the hassles of working with third-party administrators or insurance companies.

PROGRAM GUIDELINES

- This program is a discount dental plan valid only at Shirley Dentistry; it is not a dental insurance plan.
- All payments are due at time of service to receive the discount. Any services received that are not paid for at the time of service will be billed at the usual fee.
- The savings plan premiums are nonrefundable and nontransferable.
- Enrollment is activated at the time premiums are paid.
- This program may not be used in conjunction with any other insurance, financing program or discount.
- This program is not valid for care provided outside our office.

DENTAL SAVINGS PLAN ANNUAL PREMIUMS

- Individual—$289
- Dual—$548
- Family of 3—$777
- Family of 4—$976
- Each additional family member—$189

* Must have family relationship to enter family plan.

OUR COMPREHENSIVE DENTAL SAVINGS PLAN INCLUDES:

- 1 comprehensive annual exam
- 1 healthy patient recall exam
- 1 problem-focused emergency exam
- 2 professional dental cleanings (non-periodontal based)
- 2 oral cancer screenings
- 2 TMJ evaluations
- 2 fluoride tooth applications to strengthen and desensitize teeth
- 4 bitewing radiographs (if indicated)
- 1 panoramic radiographic image (as needed)
- any individual x-rays prescribed during the year
- 50% discount on custom bleaching trays, fluoride trays, biteguards, mouthguards, and retainers
- 15% discount on implants, crowns, root canals, oral surgery, sedation dentistry, fillings, periodontal therapy, bone grafts, complete and partial dentures, veneers, and all other dental services currently offered
- Free consultations to answer questions or discuss treatment options

ADDITIONAL BENEFITS (VS. INSURANCE)

- No yearly maximums
- No deductible
- No copays
- No claim forms
- No third-party administrators
- No preauthorizations required
- No preexisting condition limitations
- No waiting periods
- No cards to carry or lose

OUT-OF-POCKET COST COMPARISON

	Dental Savings Plan	Our Regular Fees	Average Dental Fees
Annual cost for preventative care	$289	$499	$684
Annual cost—family of 4	$976	$1,996	$2,736
Crowns/veneers	$826	$972	$1,075
Root canal	$867	$1,020	$1,055
Implants (single tooth)	$1,139	$1,340	$2,151
Implants (dentures)	$2,278	$2,680	$4,302
Bleaching trays	$125	$250	$450
Dental cleaning	$0	$77	$95
Panoramic x-ray	$0	$87	$115
Comprehensive evaluation	$0	$55	$93
Periodontal therapy	$184	$216	$281

Source: Average dental fees in Springfield, MO 65805 from fairhealthconsumer.org as of 12/1/2016

ENROLLMENT FORM, CONTINUED

1. Child's Full Name _____

Date of Birth ____ /____ /____ ◯ M | ◯ F

2. Child's Full Name _____

Date of Birth ____ /____ /____ ◯ M | ◯ F

3. Child's Full Name _____

Date of Birth ____ /____ /____ ◯ M | ◯ F

4. Child's Full Name _____

Date of Birth ____ /____ /____ ◯ M | ◯ F

5. Child's Full Name _____

Date of Birth ____ /____ /____ ◯ M | ◯ F

Mail completed form, with payment, to: Shirley Dentistry, 1402 S. Elliott Ave. Aurora, MO 65605