Winter Park Dental Care Plan

Last Name_____ **First Name**_____ **MI**____

Address_____ **City**_____ **State**____ **Zip**_____

Home Phone_____ **Mobile Phone**_____

Email Address_____ **Date of Birth**_____

Spouse
Last Name_____ **First Name**_____ **MI**____

Mobile Phone_____ **Date of Birth**_____

Email Address_____

1st Child
Last Name_____ **First Name**_____ **MI**____

Date of Birth_____ **Male/Female**_____

2nd Child
Last Name_____ **First Name**_____ **MI**____

Date of Birth_____ **Male/Female**_____

I understand that the annual fee for the Winter Park Dental Care Plan must be paid in full at time of service and is valid one year from date of purchase. The plan is non-refundable and non-transferrable. All additional services provided by Winter Park Dental must be paid in full at time of service in order to receive the 10% discount. Any services not paid in full at time of service will be billed at regular office fee. Plan is subject to change annually.

_____ _____
Print Name **Date**

_____
Signature

Winter Park Dental
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