LAS POSITAS FAMILY DENTAL MEMBERSHIP APPLICATION

Please print clearly and answer all questions unless not applicable

Personal Information:

Name: _____ DOB: _____

SSN: _____ Email Address: _____

Home Address _____
Street

_____
City State Zip

Phone: Home _____ Cell_____Work_____

Spouse's Information (if applicable):

Name: _____ DOB: _____

SS#: _____ Email Address: _____

Phone: Home _____ Cell_____Work_____

Children's Information (if applicable):

Name:_____ M/F Birthday __/__/____

Name:_____ M/F Birthday __/__/____

Name:_____ M/F Birthday __/__/____

Name:_____ M/F Birthday __/__/____

- ❑ $399/year Single Adult
- ❑ $798/year Two Adults
- ❑ $1148/year Family of 3
- ❑ $1498/year Family of 4
- ❑ $350/year Additional Children under 18

TOTAL AMOUNT DUE: _____ Date: _____ Annual Renewal Date: _____

*Las Positas Family Dental reserves the right to limit the amount of new patients on this plan at any time.

Print Name: _____ Date: _____

Signature: _____ Date:_____