

Please fax this form to: 843-357-9595 Murrells Inlet, SC
 or 843-546-7777 Georgetown, SC
 Email form to: InletAccts@Smile.Center
 or GtnAccts@Smile.Center



Enrollment Information

Personal Information

Last Name		First Name	Middle Initial
Date of Birth	Sex	SS#	
Address			
City		State	Zip Code
Phone:		Email:	

Spouse Information

Last Name		First Name	Middle Initial
Date of Birth	Sex	SS#	
Address			
City		State	Zip Code
Phone:		Email:	

Children Information

Last Name		First Name	Middle Initial
Date of Birth	Sex		
Address			
City		State	Zip Code
Phone:		Email:	

Children Information

Last Name		First Name	Middle Initial
Date of Birth	Sex		
Address			
City		State	Zip Code
Phone:		Email:	

Name on Credit Card: _____ Card#: _____ Exp. Date: ___/___/_____ V code on back: _____
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<input type="checkbox"/> Individual	\$25/month*
<input type="checkbox"/> Individual and Spouse.....	\$45/month*
<input type="checkbox"/> Family Plan..... <small>(2 adults, 2 kids under 18years old, no perio)</small>	\$75/month*
<input type="checkbox"/> Additional Child in Family.....	\$15/month*
<input type="checkbox"/> Periodontal Program.....	\$45/month*

I understand the benefits, limitations, and requirements of the plan and agree to the terms. Payments are due at time of service. All family members must reside in the same household. This is not an insurance product. I understand that once my application has been processed, my membership enrollment fee is non-refundable unless I request a refund in writing within the first 60 days and have not yet received discounted services. Program does not apply to treatment previously started.

Signature: _____ Date: _____ (renewal date)