



Plantation Denta-Care Plan

Application

Please Print Clearly and answer all questions unless not applicable (N/A)

Personal Information:

Name _____ Email _____

DOB (MM/DD/YY) _____

Home Address _____

City _____ State _____ Zip _____

SS# (or drivers license #) _____

Home Phone# _____ Cell# _____

Spouse's Information:

Name _____ Email _____

DOB (MM/DD/YY) _____

Home Address _____

City _____ State _____ Zip _____

SS# (or drivers license #) _____

Home Phone# _____ Cell# _____

Children's information:

Name _____ M/F DOB _____

Name _____ M/F DOB _____

Name _____ M/F DOB _____

Individual - \$285

Each additional family member- \$195 x ___ = _____

Applicant's Signature _____ Date _____

Please make **checks** out to: **Plantation Dental Associates**

Credit Card: Visa MasterCard AMEX Discover

Card Number _____ Exp _____

Cardholder's Signature _____

Please mail or drop off completed applications with corresponding payment to:

Plantation Dental Associates

300 Main Street Suite 101

St. Simons Island, GA 31522

Questions? Call 912)638-9001