DENTAL EXCELLENCE
Brett Noorda, DMD

Smile Protection Program

This program is designed to provide our patients easy access to affordable, quality dental care in our office.

- No yearly maximums
- No deductibles
- No pre-authorizations
- No claim forms
- No waiting periods

Annual Program Benefits

The following care is included at no charge in the annual program benefits:

- Annual Comprehensive Examination
- Annual Bitewing X-rays
- Periodic Panoramic X-ray (every 3-5 years)
- 2 semi-annual preventive teeth cleanings[§]
- Discounted prices on all other dental treatments (see next column)
  (minimum value $307-414)

[§] Periodontal Deep Cleaning/Root Planing and Scaling Treatments, as well as quarterly Periodontal Maintenance Treatments will be provided at significantly discounted fees.

Limitations and Guidelines

THIS PROGRAM IS AN IN-OFFICE DISCOUNT PROGRAM.
IT IS *NOT* A DENTAL INSURANCE PLAN.
IT IS NON-TRANSFERABLE.

IT *CANNOT* BE USED:

- Anywhere other than Dr. Noorda's office, DENTAL EXCELLENCE.
- For treatment in another office or by another provider, even if recommended by Dr. Noorda and/or done in Dr. Noorda's office.
- In conjunction or combination with any insurance coverage, another discount dental program/plan, or any other offer.
- For services covered under worker's compensation.

Annual Membership Dues-
Initial Adult Membership (13+ years) - $325.00
Adult Membership Renewal - $249.00
Initial Child Membership (4-12 years) - $295.00
Child Membership Renewal - $219.00

*Your program will expire one year from the date of initial payment. Renewal must be paid *prior* to anniversary date to receive the multi-year benefits. As long as renewals are paid on time, the anniversary date will not change.

Your program effective/anniversary date will be on file with our office and a reminder letter will be sent prior to that date.

TREATMENT SAVINGS

	Year 1	*Year 2*	*Year 3+*
Exams (2 per year)	FREE	FREE	FREE
X-rays	FREE	FREE	FREE
Preventive Cleanings (2 per year)	FREE	FREE	FREE
(additional cleanings will be done at a 20% discount)			
Fluoride	50%	50%	50%
Sealants	50%	50%	50%
Periodontal Maintenance	30%	40%	50%
Gum Disease Therapy	20%	25%	30%
Extractions	20%	20%	20%
Fillings	15%	17%	20%
Root Canals	15%	17%	20%
Crowns & Bridges	15%	17%	20%
Implants and Abutments	15%	17%	20%
Dentures & Partials	15%	17%	20%
Cosmetics/Whitening	15%	17%	20%

IF YOU UTILIZE CARE CREDIT TO PAY FOR SERVICES, ANY DISCOUNT WILL BE REDUCED BY 10% DUE TO PROCESSING FEES.

THIS PROGRAM IS NON-REFUNDABLE!
No refunds, in whole or in part, will be issued at any time if participant(s) does not utilize dental program or discontinues care at this office.

Fill Out Today to Begin Membership!

PRIMARY PATIENT
The patient who will be legally and financially responsible for all patients listed on this form

Name _____
First MI Last
Date of Birth ____/____/_____ S.S.#_____-_____-_____
Address _____
City _____ State _____ Zip _____
Phone (____)_____Cell / Home / Work Gender: M F

DEPENDENT PATIENT(S)
Patients who are financial dependents of the Primary Patient signing this agreement

Name _____
First MI Last
Relationship to Primary Patient: *Spouse Child Other*_____
Date of Birth ____/____/_____ Gender: M F

Name _____
First MI Last
Relationship to Primary Patient: *Spouse Child Other*_____
Date of Birth ____/____/_____ Gender: M F

Name _____
First MI Last
Relationship to Primary Patient: *Spouse Child Other*_____
Date of Birth ____/____/_____ Gender: M F

ADDITIONAL DEPENDENT PATIENT(S) LISTED ON BACK

I, _____, understand and accept all the given terms and conditions for myself and any dependents included in this agreement. I understand this is NOT an insurance plan but is a prepaid membership discount program, and that it is not transferable. I understand that this program is only valid in Dr. Brett Noorda's office for services provided by employees of Dr. Brett Noorda/DENTAL EXCELLENCE. I hereby authorize DENTAL EXCELLENCE to charge me for this amount: $_____.

Primary Patient Signature_____
Date _____

PAYMENT: Check / Cash / MasterCard / Visa / Discover