Morgan Dental QDP Dental Membership Plan

PRIMARY MEMBER REGISTRATION

LAST NAME: ___________________ FIRST NAME: _______________________ MI: _________

ADDRESS: ______________________ CITY: ______________________ STATE: ___ ZIP: ________

PHONE: (____) _______-_________ SECONDARY PHONE: (____) _______-_________

DOB: ________/________/________ EMPLOYER: __________________

BILLING

PERSON RESPONSIBLE FOR BILL (*ONLY COMPLETE IF DIFFERENT FROM PATIENT*)

RELATIONSHIP TO PATIENT: (CHECK ONE): ( ) SELF ( ) SPOUSE ( ) PARENT

NAME: ____ DOB: ________/________/_______

SOCIAL SECURITY #: _____ - _____ - _____ ADDRESS (if different from above): _________________________

PHONE (if different from above) (____) _______-__________

LIST ANY DEPENDENTS YOU WISH TO INCLUDE IN YOUR MEMBERSHIP PLAN FOR THIS 12 MONTH PERIOD:

NAME	DOB	RELATIONSHIP

TOTAL DUE $_________________

METHOD OF PAYMENT (CHECK ONE): ( ) CASH ( ) CHECK ( ) CREDIT/DEBIT CARD

( ) MASTERCARD ( ) VISA ( ) AMERICAN EXPRESS ( ) DISCOVER

CREDIT/DEBIT CARD #: ________________________ EXP: __________ SIGNATURE_______________________

PLEASE READ DISCLAIMER AND SIGN BELOW:

Using Quality Dental Plan (QDP), our office offers significant savings to patients for dental services. Furthermore, I understand the benefits, limitations, exclusions, and requirements of this plan and agree to the following:

- Fees for dental services are due when rendered
- Fees for prosthodontic (dentures) and cast restorations (crowns, in-lays, on-lays, veneers) are due at the preparation/impression visit.

If I, ______________________ choose not to pay at the time of service or not have a financial arrangement in place, I shall be billed the customary fees for such services. I acknowledge that I am financially responsible for payment.

SIGNATURE: ______________________________________ DATE: ____________