

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: _____