Dental Savings Plan

Patient
Name:_____

I am enrolling in Barrett Family Dental's Adult Dental Savings Plan (Ages 13 and older). The cost of the plan is $299.00 per year and coverage will end 1 calendar year from the date signed. During the year the plan is in effect, I am eligible for the following treatments at no additional cost:

- 2 Routine or Maintenance Cleanings
- 1 Comprehensive New Patient Evaluation
- 2 Annual Recall Evaluations
- 1 Emergency Evaluation
- 1 Full Mouth Set of Radiographs (every 5 years)
- 4 Bite-Wing Radiographs
- Any Other Radiographs Required at Included Evaluations

In addition to the included care listed above, the plan provides a 10% discount for all other dental care. Examples include (but are not limited to):

- Fillings
- Crowns
- Root Canals
- Extractions
- Treatment of Active Periodontal Disease
- Dentures

By signing below, I state that I have read the above benefit plan and I agree to its terms. I understand that $299.00 is due at the time of activation of the plan and that fees must be paid at the time of service to receive the 10% discount.

Signature of
Patient/Guardian:_____

Date Signed:_____ Date
Expires:_____