All Stahr Dental Membership Plan

Enrollment Form

Member Name_____

Address _____ City _____ State___ Zip _____

Telephone_____ E-mail Address _____

Annual Membership Fee: $250.00 per child member
$300.00 per adult member
$500.00 per perio member

Please read and sign below:

I agree to pay All Stahr Dental for a 12-month membership fee of $_____ for my All Stahr Dental Membership Plan. My 12-month membership begins on _____ and expires on _____.

I will receive the following benefits as part or the membership plan:

1. Initial exam and x-rays
2. Up to two regular hygiene appointments (or three perio-maintenance)
3. Up to two dental exams
4. Discount of 20% off all other dental and cosmetic treatment provided by All Stahr Dental.

I agree to the following terms:

1. The membership is not an insurance plan and cannot be combined with any other discount plan or insurance.
2. The services allowed by my membership will only be provided by All Stahr Dental Providers and staff. The membership does not include services provided by specialist or other dental offices.
3. Drugs and medications are not included with the membership.
4. Membership fees are due at the time of joining the program.
5. Payment is due on the date of service to qualify for the discount.
6. Membership is non-transferable.
7. No refunds will be issued at any time if patient decides not to utilize dental plan.
8. No discounts on consumable items such as Oral B, Prevident, PerioGuard, take home whitening, etc.
9. **All previous account balances must be paid in full prior to participating in membership plan.**
10. At the end of the 12-months, I may be able to sign up for another year, but my membership fee and the benefits may be different than the previous year.

Signature _____ Date _____

Member or Member's Guardian