ParkDental CLINIC

For office use only

Start Date:_____

End Date: _____

APPLICATION FOR Park Dental Care Plan

Print clearly in black or blue ink, and answer all questions or indicate "not applicable" (i.e. N/A).

Your Profile

Name _____ DOB _____
Last First MM/DD/YYYY

Mailing Address _____

City _____ State _____ ZIP _____

Mobile Phone _____ Home Phone _____ Work Phone _____

Email _____
(if applicant is under age of 18, application needs to be filled by guardian)

Guardian's Name _____ DOB _____
Last First MM/DD/YYYY

Choose Your Care Plan

Park Dental Care Plan Tier1	$249 ☐		senior $219 ☐	
Park Dental Care Plan Tier2	$399 ☐		senior $319 ☐	
Park Dental Care Plan Kid's:	0 - under 3 years old	$129 ☐	3 – 13 years old	$199 ☐

* Senior discount applies to the age of 66 and over
* In-office Promotion (implant, ortho-clear aligner treatment, whitening, etc.) is not applicable to Tier discount

I carefully read and understand contents of Park Dental Care Plan coverage. All my questions have been answered.

Initial _____

Member Signature **Date**

<<Your membership starts the day your full payment is processed>>