SMILE CARD APPLICATION

Patient Information:

Patient Name: _____

DOB:_____

Address:_____

City: _____ State_____ Zip Code:_____

Phone: _____

Email: _____

Card Information:

Card Number: _____

Exp Date: _____ CVV:_____ Billing Zip Code:_____

Card Holder Name:_____

Card Holder Signature: _____ Date:_____

Effective Date:_____ Renewal Date: _____

This plan will renew automatically every year on the auto renewing date. After the minimum membership period of one year, you may cancel your membership without further obligation provided you must give at least one month prior notice of your intention to cancel your membership.

No refunds are offered on the annual membership program.

This plan is valid for the applicant only. Offers and discounts cannot be transferred to other patients.

Patient Signature: _____ Date:_____

Employee's Initials:_____