ESPARZA FAMILY DENTISTRY BENEFIT PLAN APPLICATION

Please complete this form and bring it with you to our practice location at:

Esparza Family Dentistry, 762 Independence Blvd., Virginia Beach, VA 23455; (757) 499-4707; Fax: (757) 499-2158.

APPLICANT INFORMATION

First Name: _____

M.I.: _____ Last Name: _____

Date of Birth: (mm/dd/yyyy) _____ SSN: Email: _____

Current Address: _____

City: _____State:_____ ZIP Code: _____

Mailing Address (if different than above): _____

City: _____State:_____ ZIP Code: _____

Home Phone: _____Cell Phone: _____

Preferred Contact #: H / C / W

EMPLOYMENT INFORMATION

Current Employer: _____

Employer Address:

_____

Email: _____City:_____ State: _____

ZIP Code: _____ Position: _____Phone: _____

FAMILY MEMBER #1

First Name: _____

M.I.: _____ Last Name: _____

Date of Birth: _____ (mm/dd/yyyy)

SSN# _____ Email _____

Current Address: (circle one) Employed Self-Employed Retired Student Gender: M F

Relation to Applicant: _____

FAMILY MEMBER #2

First Name: _____

M.I.: _____ Last Name: _____

Date of Birth: _____ (mm/dd/yyyyy)

SSN# _____ Email _____

Current Address: (circle one) Employed Self-Employed Retired Student Gender: M F

Relation to Applicant:

First Name: _____

M.I.: _____ Last Name: _____

Date of Birth: _____ (mm/dd/yyyyy)

SSN# _____ Email _____

Current Address: (circle one) Employed Self-Employed Retired Student Gender: M F

Relation to Applicant: _____

FAMILY MEMBER #3

First Name: _____

M.I.: _____ Last Name: _____

Date of Birth: _____ (mm/dd/yyyy)

SSN# _____ Email _____

Current Address: (circle one) Employed Self-Employed Retired Student Gender: M F

Relation to Applicant: _____

FAMILY MEMBER #4

First Name: _____

M.I.: _____ Last Name: _____

Date of Birth: _____ (mm/dd/yyyy)

SSN# _____ Email _____

Current Address: (circle one) Employed Self-Employed Retired Student Gender: M F

Relation to Applicant: _____

FAMILY MEMBER #5

First Name: _____

M.I.: _____ Last Name: _____

Date of Birth: _____ (mm/dd/yyyy)

SSN# _____ Email _____

Current Address: (circle one) Employed Self-Employed Retired Student Gender: M F

Relation to Applicant: _____

FAMILY MEMBER #6

First Name: _____

M.I.: _____ Last Name: _____

Date of Birth: _____ (mm/dd/yyyy)

SSN# _____ Email _____

Current Address: (circle one) Employed Self-Employed Retired Student Gender: M F

Relation to Applicant: _____

I authorize the verification of the information provided on this form as to my credit and employment. I have received a copy of this application.

Esparza Family Dental Benefit Plan Membership Application

Membership Plan Policies

- Members must pay the membership fee prior to receiving treatment.
- Membership effective date and anniversary date is based on date of payment.
- Membership is non-transferable and non-refundable at any time.
- Plan benefits do not roll over from year to year. All benefits have to be used within the anniversary date.
- Membership fee cannot be used for purchase of dental retail products.
- Total payment amount is due at time of service. If full payment is not received at time of service, fee reduction will be void.
- Cannot be combined with any other dental insurance or discount including Care Credit.
- Courtesy fee reduction or included dental services are non-transferable.
- Crowns are payable at ½ the services upon preparation and the balance due upon completion at time of delivery.
- Members will receive a designated courtesy from dental specialists who accept the benefit plan as Affiliate Partners with Esparza Family Dentistry.
- If treatment is the result of an injury which involves litigation, disability, and or Workers Compensation then membership is void and the discount will not apply.
- Dr. Esparza reserves the right to refuse, limit, make changes to the plan, or terminate enrollment in the membership plan at any time.
- It is the patient's responsibility to schedule and to keep all appointments; The member will forfeit the prepaid fee for any appointment canceled without a 48 hour notice. Our normal broken appointment fee which is $25 per appointment hour will be assessed without discount. This fee will be required to be paid before any further services are rendered.

ACKNOWLEDGMENT: By submitting this form, I acknowledge that I am 18 years of age or older, or have permission from my parent/guardian to apply to this program.

By submitting this application, I acknowledge that I have read over the fees and payment requirements. I know and understand that should I enroll with Esparza Family Dental Benefit Plan, I will be responsible for paying my fees in full via an agreed upon payment method.

Signature of Applicant: _____Date: _____