PM DentalCare
FAMILY & URGENT CARE DENTISTRY WHEN YOU NEED US

121 Jericho Turnpike, Mineola, NY 11501
Email: Admin@PMDentalCare.com
www.PMDentalCare.com

PM Dental Savings Plan Enrollment Form

Enrollment Date: Termination Date:

Name: Date of Birth: / /
Last Name First Name

Home Address:
Street Address City State Zip

Phone Number: Email Address:
Home Cell

Are you covered under any other dental plans? ☐YES ☐ NO *If yes,* please provide other insurance company name:

Services Included in PM Savings Plan:

Routine Dental Exams (Limit twice per year)	Dental Cleanings (Limit twice per year)	X-rays (Limit Once per year)

Additional Services in PM Savings Plan:

- 20% Discount off General & Restorative Treatment (i:e: Fillings, Fluoride, Crowns, Bridges)
- 15% Discount off Orthodontic & Cosmetic Treatment (i:e: Clear Aligner Therapy, Veneers, Implants)

Annual Membership Fee:

Individual: $349.00 Couple: $499.00 Each additional child (under 18): $249

Enrollment Status: ☐ Individual ☐ Couple ☐ Family

List all eligible dependents you wish to enroll: Enrollment Fee:

☐ Spouse $
Last Name First Name Date of Birth

☐ Child $
Last Name First Name Date of Birth

☐ Child $
Last Name First Name Date of Birth

Note: Enrollment is available to patients without insurance and may not be combined with any other dental coverage.

I hereby apply for enrollment in PM Dental Care Savings Plan. I authorize payment of my yearly enrollment fee and understand that it is non-refundable. I understand this plan is in effect for 12 months from my purchase date. I certify that I am eligible to participate, and that the above information is correct. A photocopy of this authorization shall be valid as the original. This authorization, and plan enrollment shall remain valid for one year from the initial enrollment date.

Signature: _____ Date: _____