DENTAL EXCELLENCE
Brett Noorda, DMD, FAGD

Smile Protection Program

Especially designed to provide our patients easy access to affordable, quality dental care in our office.

- No yearly maximums
- No deductibles
- No pre-authorizations
- No claim forms
- No waiting periods

Annual Program Benefits

The following care is included at no charge in the annual program benefits:

- Annual Exam
- Annual Bitewing X-rays
- Periodic Panoramic X-ray (every 3-5 years)
- 2 semi-annual prophy cleanings[§]
- 10% Discount on all other dental treatments (*except* cosmetics and sedation)

[§] Periodontal Treatments (Deep Cleaning/Root Planing and Scaling), receive a 10% discount. Quarterly Periodontal Maintenance Treatments will receive the amount off of the otherwise included prophy cleanings (for the first two), and the other two will receive a 10% discount.

Limitations and Guidelines

* THIS IS AN IN-OFFICE DISCOUNT PROGRAM, *NOT* A DENTAL INSURANCE PLAN.
* THIS IS NON-TRANSFERABLE & NON-REFUNDABLE

THIS *CANNOT* BE USED:

- Anywhere other than Dr. Noorda's office, DENTAL EXCELLENCE.
- In combination with any insurance coverage, another discount dental program/plan, CareCredit, or any other offer.
- For treatment in another office or by another provider, even if recommended by Dr. Noorda and/or done in Dr. Noorda's office.
- For services covered under worker's compensation.
- Program and pricing subject to change.

Annual Membership Dues

ADULT (13+ years old) $549/year*
Adult Membership Renewal $359
CHILD (4-12 years old) $499/year*
Child Membership Renewal $339

*Your program will **expire one year** from the date of initial payment. Renewal must be paid *prior* to anniversary date to avoid cancellation. As long as renewals are paid on time, the anniversary date will not change.

Your program effective/anniversary date will be on file with our office and a reminder letter will be sent prior to that date.

(minimum value starts at $60)

TREATMENT SAVINGS

	Membership Year Discounts
Annual Exam	FREE
Annual Bitewing X-rays	FREE
Preventive Cleanings (2 per year included)	FREE
(additional cleanings will be done at a 10% discount)	
Fluoride	10%
Sealants	10%
Periodontal Treatment & Maintenance	10%
Extractions	10%
Fillings	10%
Root Canals	10%
Crowns & Bridges	10%
Implants and Abutments	10%
Dentures & Partials	10%
Nightguards & Sports Mouthguards	10%
Additional Limited Exams & X-rays	10%

NO DISCOUNT WILL BE GIVEN IF YOU UTILIZE CARECREDIT TO PAY FOR SERVICES.

THIS PROGRAM IS NON-REFUNDABLE!
No refunds, in whole or in part, will be issued at any time if participant(s) does not utilize dental program or discontinues care at this office.

Fill Out Today to Begin Membership!

PRIMARY PATIENT
Patient who will be legally and financially responsible for all patients listed on this form.

Name _____ (First / MI / Last)
Date of Birth ___/___/_____ S.S.#_____-_____-_____
Address _____
City _____ State _____ Zip _____
Phone (____)_____ Cell / Home / Work Gender: M F

DEPENDENT PATIENT(S)
Patients who are financial dependents of the Primary Patient signing this agreement

Name _____ (First / MI / Last)
Relationship to Primary Patient: *Spouse Child Other*_____
Date of Birth _____/_____/_____ Gender: M F

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Relationship to Primary Patient: *Spouse Child Other*_____
Date of Birth _____/_____/_____ Gender: M F

Name _____ (First / MI / Last)
Relationship to Primary Patient: *Spouse Child Other*_____
Date of Birth _____/_____/_____ Gender: M F

ADDITIONAL DEPENDENT PATIENT(S) LISTED ON BACK

I, _____, understand and accept all the given terms and conditions for myself and any dependents included in this agreement. I understand this is NOT an insurance plan but is a prepaid membership discount program, and that it is not transferable. I understand that this program is only valid in Dr. Brett Noorda's office for services provided by employees of Dr. Brett Noorda/DENTAL EXCELLENCE. I understand this progam/pricing is subject to change. I hereby authorize DENTAL EXCELLENCE to charge me for this amount $_____.

Primary Patient Signature _____

Date _____

PAYMENT: Check / Cash / MasterCard / Visa / Discover

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Smile Protection Program

WHAT is this?

This is a Discount Program we offer to encourage you to take care of yourself with regular visits and care, and to help you do so at reduced cost.

WHO is this program for?

Anyone without dental insurance.

WHY should I consider this?

This program can help you keep your overall costs down as you prioritize your health. Regular visits help us find and fix problems earlier, often *before* they become major issues requiring time-consuming and expensive treatments.
Oral problems can also be indicators of other health issues, so routine care is important.

WHEN can I sign up?

You may sign up any time, but there is no time like the present. Then just renew each year to keep your costs low and your wellness at its best!

WHERE does this program work?

Only at Dr. Noorda's office, DENTAL EXCELLENCE.

HOW do I sign up?

Simply fill out this form and pay the initial fee.

Our commitment is to provide you with *high-quality, pleasant care at every visit!*

We hope you will recommend us to your family and friends.

Thank you for your trust.

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Patients who are financial dependents of the Primary Patient signing this agreement

Name _____
First MI Last
Relationship to Primary Patient: *Spouse Child Other*_____
Date of Birth _____/_____/_____ Gender: M F

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Beautiful Smiles come from Happy Patients.

We Create Both.

DENTAL EXCELLENCE

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Smile Protection Program

Affordable Dental Care

by

DENTAL EXCELLENCE
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