



## ENROLLMENT FORM

Last Name		First	MI
Home Address			Apt#
City	State		Zip Code
Home Phone	Work Phone	Cell Phone	
Date of Birth		Social Security No:	
List of Covered Dependants	Date of Birth	Male/Female	Relationship to Member

**Method of Payment:**

Check Enclosed

Credit Card (Visa, MasterCard , Discover and Amex)

I understand the benefits, limitations, exclusions and requirements of the Plan and I agree to the following: I will remain in the plan and pay membership fees for a minimum of 12-months. Fees for dental services are due as services are rendered. Fees for prosthodontic and cast restoration services are due at the preparation/impression visit. Failure to comply may result in my being charged usual and customary fees for such services. I agree to pay any and all costs in collecting all charges, including but not limited to attorney fees and court costs.

**Signature** \_\_\_\_\_

**Mail this form to:**  
**DentaCare Associates**  
**100 NW 82<sup>nd</sup> Avenue**  
**Suite 203**  
**Plantation, FL 33324**  
**Fax: (954) 475-9931**

## **DENTAL LIMITATIONS AND EXCLUSIONS**

1. Demonstrated non compliance with recommended course of treatment.
2. Services, which in the opinion of the attending dentist are neither necessary nor recommended for the patient's dental health.
3. Oral surgery requiring the setting of fractures or dislocations.
4. Treatment of malignancies, cysts, or neoplasms, or congenital malformations, except congenital anomaly of a tooth or teeth covered from birth.
5. Electronic toothbrushes, whitening strips, medications or any other products sold by the dental practice.
6. Applied medications, including but not limited to Arestin and CH.
7. Occlusal Guards and teeth whitening procedures.
8. Hospital benefits for any dental procedure.
9. Loss or theft of dentures or bridgework.
10. Any procedures of implantation or experimental procedures.
11. Services for injuries or conditions that re covered under Worker's Compensation or Employer's Liability laws. Services that are provided without cost to the member by any municipality, county or other political subdivision.
12. General anesthesia
13. Services that cannot be performed because of the general health, physical, or psychological limitations of the patient
14. Those procedures requiring appliances or restorations that are necessary for full mouth rehabilitations, or to alter, restore or maintain occlusion, including without limitation, treatment of disturbances of the temporomandibular joint.
15. Fluoride application is limited to one per year to age 16.
16. Diagnosis and treatment of myofacial pain dysfunction syndrome.
17. Procedures performed in the hospital.
18. Any and all procedures performed outside of the DentaCare Associates office or by non participating DentaCare Dental Associates provider.
19. If the member relocates to an area and is unable to receive treatment from a DentaCare dentist or no longer receives care from a DentaCare office, coverage under this plan ceases and it becomes the obligation of the patient/member to pay the usual and customary fee of the non participating dentist at whose facility treatment is completed.



CREDIT CARD BILLING FORM

Patient Name: \_\_\_\_\_

Description of Charges: \_\_\_\_\_

**Please charge the total above to my credit card.**

Authorized Signature: \_\_\_\_\_

**Credit Card Information:**

Mastercard     Visa     American Express     Discover

Name on the Account: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_

Account #: \_\_\_\_\_ Exp Date: \_\_\_\_\_ / \_\_\_\_\_  
MO YR

IMPORTANT: CSC (Credit Security Code) #: \_\_\_\_\_

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Fax Credit Card Billing Form to (954) 475-9931 for payment processing.