NO INSURANCE?

NO PROBLEM!

WE HAVE A GREAT SOLUTION

Dental Health Care Plan

NO YEARLY MAXIMUMS

NO DEDUCTIBLES

NO CLAIM FORMS

NO PRE-AUTHORIZATION REQUIREMENTS

NO PRE-EXISTING CONDITION LIMITATIONS

NO ONE WILL BE DENIED COVERAGE

NO WAITING PERIODS

FREE CONSULTATIONS & 2ND OPINIONS

Smiles OF FORT WORTH

5601 Bridge Street
Suite 480
Fort Worth, TX 76112

817.457.4078
smilesftw.com

Office Hours

Monday 7a - 5p
Tuesday 7a - 5p
Wednesday 7a -5p
Thursday 7a - 5p
Friday 8a - 12p

Dental Health Care Plan

AN INSURANCE ALTERNATIVE

Smiles OF FORT WORTH

817.457.4078
smilesftw.com

$365 PER INDIVIDUAL

$299 PER CHILD (18 YRS & YOUNGER)

YEARLY ENROLLMENT FEE

INCLUDES:

PREVENTIVE/DIAGNOSTIC CARE

2 CLEANINGS PER YEAR

2 EXAMS PER YEAR

ANY NEEDED X-RAYS

2 FLUORIDE APPLICATIONS PER YEAR

NORMAL ANNUAL COST FOR THESE SERVICES AVERAGE $604

PLUS

12% OFF ANY NEEDED DENTAL TREATMENT IN THE YEAR (FILLINGS, GUM TREATMENTS, CROWNS, CLEAR BRACES, ETC)

COVERED PATIENTS AGREE TO:

- Attend all scheduled appointments.
- Give minimum of 2 business days notice for appointment changes.
- Comply reasonably w/clinical recommendations
- Make payments at the time of service.
- Provide feedback to help us improve our services

HAVE QUESTIONS?

EMAIL US AT

INFO@SMILESFTW.COM

ENROLLMENT FORM

Please fill out and send this form in today to begin coverage!

Last Name First Name Initial

Mailing Address City/State

Email

Employer Name/Phone Gender

Spouse Date of Birth Gender

Child Date of Birth Gender

Child Date of Birth Gender

Child Date of Birth Gender

Please Check:

☐ Full Amount $365 ☐ Monthly Payment $34

☐ Full Amount $299 ☐ Monthly Payment $25

☐ Visa ☐ MasterCard ☐ Discover ☐ Amex

Name on Card Card Number - - -

Expiration Date Security Code

As a patient, I wish to apply for membership in the Dental Health Care Plan. I understand that all services under this program must be obtained at an affiliated dental office and further that my co-payment will be due in full at the time services are rendered. This is not an insurance program.

Signature Date

NO INSURANCE?

NO PROBLEM!

WE HAVE A GREAT SOLUTION

Dental Health Care Periodontal Plan

NO YEARLY MAXIMUMS

NO DEDUCTIBLES

NO CLAIM FORMS

NO PRE-AUTHORIZATION REQUIREMENTS

NO PRE-EXISTING CONDITION LIMITATIONS

NO ONE WILL BE DENIED COVERAGE

NO WAITING PERIODS

FREE CONSULTATIONS

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Suite 480
Fort Worth, TX 76112

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Thursday 7a - 5p
Friday 8a - 12p

Dental Health Care Periodontal Plan

AN INSURANCE ALTERNATIVE

Smiles OF FORT WORTH

817.457.4078
smilesftw.com

$749 PER INDIVIDUAL

YEARLY ENROLLMENT FEE

INCLUDES:

PREVENTIVE/DIAGNOSTIC CARE

4 PERIODONTAL MAINTENANCE VISITS (GUM THERAPY CLEANINGS) PER YEAR

2 EXAMS PER YEAR

ANY NEEDED X-RAYS

4 CHLORHEXIDINE VARNISH APPLICATIONS PER YEAR

NORMAL ANNUAL COST FOR THESE SERVICES AVERAGE $1,082

PLUS

12% OFF ANY NEEDED DENTAL TREATMENT IN THE YEAR (FILLINGS, GUM TREATMENTS, CROWNS, CLEAR BRACES, ETC

COVERED PATIENTS AGREE TO:

- Attend all scheduled appointments.
- Give minimum of 2 business days notice for appointment changes.
- Comply reasonably w/clinical recommendations
- Make payments at the time of service.
- Provide feedback to help us improve our services

HAVE QUESTIONS?

EMAIL US AT

INFO@SMILESFTW.COM

ENROLLMENT FORM

Please fill out and send this form in today to begin coverage!

Last Name First Name Initial

Mailing Address City/State

Email

Employer Name/Phone Gender

Spouse Date of Birth Gender

Please Check:

☐ Full Amount $749 ☐ Monthly Payment $63

☐ Visa ☐ MasterCard ☐ Discover ☐ Amex

Name on Card Card Number - - -

Expiration Date Security Code

As a patient, I wish to apply for membership in the Dental Health Care Periodontal Plan. I understand that all services under this program must be obtained at an affiliated dental office and further that my co-payment will be due in full at the time services are rendered. This is not an insurance program.

Signature Date