FAMILY & COSMETIC DENTISTRY

Members Fill Out This Portion Completely

PRIMARY MEMBER REGISTRATION

Last Name________________________ First Name________________________ MI_______ Home Address______________________________

Apt #__________ City______________________________ State_______ Zip Code__________________________Home Phone___________________________ Cell Phone__________________________

Date of Birth__________________ Name of Employer ______________________________

Driver's License Number____ State Issued_______________

ADDITIONAL MEMBERS

Full Name	Date of Birth	Relationship	Fee Amount

Preferred Office Location____________________________________ Enrollment Fee $79___________________________________

Select Plan Option: ☐ **Premier** ☐ **Advantage** ☐ **Value** Select Method of Payment: ☐ **Annual** ☐ **Monthly**

☐ CHARGE CARD(Visa, Discover, Mastercard, or American Express)

*Enclose 1st & last month's payment. Each monthly payment must be received in our office by the 5th of the month. **No statement will be sent.*

Card Number____Expiration Date______________________________

CVC# (3 digit on back of card):_____________________________

If paying monthly by charge card, 1st and last month's payment will be charged and monthly payments will be automatically charged to this account on the first of each month.

☐ 12 MONTH ANNUAL PAYMENT (*If using charge card, provide card information above.)*

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. Payment of less than 12 months' membership fees may result in my being charged usual and customary fees for all services (including those already provided) and my being charged remaining months' fees in lump sum. 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. Coverage must be continuous. Missing monthly payments must be made up for interrupted coverage. Last month fees are not refundable.

Signature (Required)____ Date___________________

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)** Dispensing of drugs not normally supplied in a dental office. **4)** Services for injuries or conditions which are covered under Worker's Compensation or Employer's Liability laws. **5)** General anesthesia/Conscious Sedation **6)** Services that cannot be performed because of the general health, physical or psychological limitations of the patient. **7)** Plan Participants cannot have other dental coverage.

Signature (Required)____ Date___________________

MAIL OR FAX TO: Apex Plus
Attn: Membership Department
12391 S 4000 W Ste: 206
Riverton, UT 84096
Fax: (801)542-8188