In-House Dental Plan

Date ______
EXP ______

Application

Please print clearly and answer all questions unless not applicable (N/A)

Personal Information

Name ______________________ Email Address ______________________

Home Address ____

City ______________________ State ____________ Zip ____________

SS# (or driver's license #) ______________________________________

Home Phone# ______________ Cell# ______________ Work# ______________

Spouse Name ______________________ Email Address ______________________

Home Address ____

City ______________________ State ____________ Zip ____________

SS# (or driver's license #) ______________________________________

Home Phone# ______________ Cell# ______________ Work# ______________

Children Information

Name ______________________ M/F Birth date ____________ SS# ____________

Name ______________________ M/F Birth date ____________ SS# ____________

Name ______________________ M/F Birth date ____________ SS# ____________

Name ______________________ M/F Birth date ____________ SS# ____________

Applicant's Signature ______________________________ Date ____________

Please mail or drop off completed application with corresponding payment to:

Highland Creek Family Dental
4921 State Rd. 26 E. Suite 100
Lafayette, IN 47905

Please circle one

Single	$247
Double	$467
Family	$747

Please make checks out to: Highland Creek Family Dental

Card Number ______________________________ Exp. Date ____________

Card holder's Signature ______________________ Visa MC Discover Am Ex