



MILLS & SHANNON DENTISTRY IN-HOUSE DENTAL PLAN

EFFECTIVE DATE: _____

Last Name: _____ First Name: _____ MI: _____

Date of birth: _____ Email: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Please select your plan:

☐ Routine Prophylaxis Plan \$299

☐ Periodic Maintenance Plan \$499

By signing this agreement, I acknowledge I have been informed of and understand the following:

*** The membership fee provides coverage for a period of twelve (12) months and must be renewed for benefits to continue.**

* The membership plan cannot be purchased unless the enrollee has had a up to date comprehensive exam with Mills & Shannon Dentistry and the enrollee is an established patient.

* The annual fee is required at time of enrollment (NO Carecredit or AMEX) and is non-refundable.

* Treatment that was started prior to enrollment of our in-house plan is not eligible for discounts under this plan

* Discounts offered by this plan take the place of any other discounts offered by Mills & Shannon Dentistry for payment on the date of service.

* Michele Mills, DMD & Travis Shannon, DMD reserve the right to modify, change or discontinue the benefit plan fees, terms and services at the practice's discretion upon written notice prior to your anniversary renewal date

* The in-house dental plan can be used as a secondary plan as long as the patient holds no Delta Dental policy.

I have read and understand the terms of the Mills & Shannon In-house dental plan Membership agreement.



SIGNATURE: _____

DATE: _____