CORNERSTONE DENTAL

Dental Payment Plan Registration

Registration Form

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Birthdate: _____ Home Phone: _____ Cell Phone: _____

Email: _____

Additional Family Members

Name: _____	Birthdate: _____	Relationship: _____
Name: _____	Birthdate: _____	Relationship: _____
Name: _____	Birthdate: _____	Relationship: _____
Name: _____	Birthdate: _____	Relationship: _____
Name: _____	Birthdate: _____	Relationship: _____

Payment Method

Annual membership is $27/month for adults and $25/month for children (under age 13) with a $99 activation fee per patient which includes the first month's membership dues. You are eligible for a 5% discount if the year is paid in advance.

Payment Type: ☐ Cash ☐ Check ☐ Credit Card

Credit Card #: _____ Expiration Date: _____

Billing Zip Code: _____ CVC: _____

Total Per Month ($): _____

Signature: _____ Date: _____