Brookings Dental Arts
General & Implant Dentistry

Enrollment Form

Last Name_____ First_____ MI_____

Home Address_____

City_____State_____Zip_____

Home Phone_____ Work Phone_____

Birthdate____/____/____Employer_____

List Covered Dependents Name Birthdate Relationship

Payment Method: Annual Payment (see attached table)

_____ Check Enclosed: $_____ **(make checks payable to Brice Chang, DDS)**

Please read and sign below:

I understand the benefits, limitations, exclusions and requirements of the The Brookings Dental Gold Plan and I agree to the following:

1. I will remain in the plan and pay membership fees for a minimum of 12 months.

2. Payment of less than 12 months membership fees may cause me to be charged the usual and customary fees for all services (including those already provided) and my being charged for the remaining months fees in lump sum.

3. Fees for dental services are due when services are rendered.

4. Fees for prosthodontics and cast restorations are due at the preparation/impression visit. Failure to comply may result in my being charged usual and customary fees for such services.

5. I agree to pay any and all costs in collecting all charges, including but not limited to attorney fees and court costs.

Signature:_____ **Date**_____

Mail this form to:
Brookings Dental Arts P.O. Box 4370 Brookings, OR 97415