



Dental Wellness Plan Application

Application: Premier _____ Referred By: _____

Name: _____ Birthdate: _____
First M.I. Last

Social Security #: _____ OR Driver's License #: _____

Mailing Address: _____
Street City State Zip

Cell: (_____) _____ Home: (_____) _____ Work: (_____) _____

Email: _____

Program Exclusions and limitations:

This program is a discount plan, not a dental insurance plan. It is only offered to patients with no dental insurance. It **cannot*** be used:

- *In conjunction with another dental plan
- *For referrals to specialists
- *For hospitalization or hospital charges of any kind
- *For cost of dental care that would be covered under automobile medical claims
- *For services for injuries covered under worker compensation
- *For treatment which, in the sole opinion of the treating dentist, lies outside the realm of their capability
- *For treatment covered by any insurance plan; dental, medical, worker's compensation etc.

Program Guidelines:

- *You will not receive a membership card (membership is recorded in office)
- *Benefit coverage table and terms are subject to revision annually
- *Membership valid only at Kountze Dental Center
- *Patient portion of bill is due at time of service
- *NON-REFUNDABLE. No refunds or premiums will be issued at any time if participant decides not to utilize the dental plan.
- *Fee of \$79 + 1st Month due at time of enrollment

Make check in the amount of \$79 + 1st Month payable to: All Needz Dental
112 Pine Plaza
Silsbee, TX 77656

Name on Credit Card: _____

Credit Card Number: _____ CVV: _____ Expires: _____

Authorized Signature: _____ Date: _____

Drs. Craig & Zach Worsley
All NeedZ Dental - Kountze
530 South Pine Street
Kountze, TX 77625
P: (409) 246-4777
www.allneedzdental.com