



ADVANCED PLAN

Application

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

Personal Information:

Name _____ Phone # _____

Address _____ City _____ State ___ Zip _____

Email _____

Spouse's Information:

Name _____ Phone# _____

Children's Information:

Name _____

Name _____

Individual **\$295**

Each additional family member **\$249 X** __ = _____

Total (Annual Cost): _____

Applicant's Signature _____ Date _____

Please make **checks** out to: Advanced Dental Arts

Credit Card: Visa MC AmEx Discover

Card # _____ Exp. Date _____

Cardholder's Signature _____

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

Advanced Dental Arts • 8770 Wadsworth Blvd Ste H • Arvada, CO 80003