

Please Fill Out & Send This
Form in Today to Start Saving!

First Name _____

Last Name _____

Middle Initial _____ Male/Female

Home Address _____

City _____ State _____ Zip _____

Phone _____

Date of Birth ____/____/____

Social Security Number _____ - _____ - _____

Spouse's Name _____

Date of Birth ____/____/____

Social Security Number _____ - _____ - _____

Enrollment Period _____ to _____

Signature (member and spouse)

_____ date

_____ date

Mastercard/Visa/Discover

Card Number _____

Exp Date _____

Or Make Check Payable to: Smith Dental

Smith Dental Low-Cost Dental Plans

- Individual ~ \$139/year
- Individual and Spouse ~ \$219/year
- Family Plan ~ \$299/year
(Individual and up to three other family members)
- Additional Family Members ~ \$79/year

W **elcome to Our Office!**

Join Smith Dental's In-House Premier Dental

It's not insurance, it's smarter: a discounted fee schedule for most services, only good at Smith Dental. You save on everything from cleanings and fillings to cosmetic procedures and crowns!

Start Saving Today! Co-Payment Includes the Following Services at No Charge:

- **Comprehensive Exam**
(Once every 6 months)
- **X-Rays**
(Once every 12 months)
- **Cleaning**
(Twice per calendar year)
- **Fluoride Treatment for Children**

Smith Dental

259 Athens Street, Hartwell, GA 30643

(706)376-2345

CSmithDental.com

Affordable Supplemental Dental Plan

For You and Your Entire Family

Now you can join our low-cost dental plan for a nominal membership fee. Our co-payment entitles you to preventive dental care at no cost! Corrective services are available for small co-payments that are far less than the usual, customary fees. And our professional staff is qualified to care for all of your dental needs!

To enroll, simply fill out the enclosed enrollment form and return it with your check, money order, or credit card information. Please make checks payable to Smith Dental.

Smith Dental

(706)376-2345

Our Low-Cost, Co-Payment Schedule

Preventive Dental Care

<i>Service</i>	<i>Co-Payment</i>	<i>Regular Fees</i>
Examination <i>(every 6 months)</i>	No Charge	\$25
X-rays <i>(every 12 months)</i>	No Charge	\$43
C l e a n i n g <i>(every 6 months)</i>	No Charge	\$67
Fluoride Treatment	No Charge	\$20

Fillings

1 Surface <i>(tooth-colored)</i>	\$75	\$105
2 or more Surfaces <i>(tooth-colored)</i>	\$125	\$210

Periodontics

Scaling and Root Planing..... <i>(per quadrant)</i>	\$175	\$271
Periodontal Maintenance <i>(2 per year)</i>	\$65	\$105

Orthodontics

Invisalign®	\$3,500	\$4,150
Traditional Braces	\$3,500	\$4,500
Self-Ligating Braces	\$4,500	\$5,500

(Financing Available)

Join Smith Dental's

It's not insurance, it's smarter: a discounted fee schedule for most services, only good at Smith Dental. You save on everything from cleanings and fillings to cosmetic procedures and crowns!

Crowns and Bridges

<i>Service</i>	<i>Co-Payment</i>	<i>Regular Fees</i>
All Porcelain <i>(per unit)</i>	\$950	\$1170
Porcelain Fused to Metal..... <i>(per unit)</i>	\$750	\$893

Cosmetic Dentistry

In Office Whitening.....	\$250	\$350
Veneers.....	\$950	\$1170

Other Treatments

Sealants <i>(per tooth, age limit 14)</i>	\$30	\$45
Full Mouth X-Ray	\$69	\$84
Implants.....	\$1,999	\$2415
Partials.....	\$999	\$1,363
Root Canals.....	\$750	\$950

Members will also be eligible for a 10% discount on any products purchased. *(mouthrinse, extra bleach, etc.)*

- Co-payments must be paid at time of service.
- Any service not paid at the time of service will be billed at the usual, customary rate.
- Membership is valid for one year from date of sign up
- This is *not* an insurance product

Call Today For More Details!

(706)376-2345

Or send us an email at:

Info@CSmithDental.com

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Please List All Unmarried Children Up to Age 20

Fill Out this form and send it in today to start saving!

- 1 Child's First Name _____
Middle Initial _____ Son/Daughter
Date of Birth ____/____/____
- 2 Child's First Name _____
Middle Initial _____ Son/Daughter
Date of Birth ____/____/____
- 3 Child's First Name _____
Middle Initial _____ Son/Daughter
Date of Birth ____/____/____
- 4 Child's First Name _____
Middle Initial _____ Son/Daughter
Date of Birth ____/____/____
- 5 Child's First Name _____
Middle Initial _____ Son/Daughter
Date of Birth ____/____/____

Patients agree that Smith Dental fees stated must be paid at the time services are rendered. Any service not paid at the time of service will be billed at the usual, customary rate. Plan rates are only valid during the time of enrollment. All family members must reside in the same household. This is not an insurance product.

CSmithDental.com