# REGISTRATION FORM

## APPLICANT

| Name (Please Print) | Date of Birth / / |
|---|---|
| | |

## JOINT APPLICANT

| Name (Please Print) | Date of Birth / / |
|---|---|
| | |

Please enroll me in the Lowman Family Dental LoyalCare Plan. I understand the preventive services will be provided in exchange for my payment as well as 15% discounted services. I understand that it is my responsibility to schedule appointment and complete necessary treatment within my 12 month membership year. Any treatment not completed in the 12 month period will be forfeited unless membership is renewed. I agree to pay now for the next 12 months of membership. I understand that any balance past due 90 days voids this agreement.

| Signature of Applicant | Signature of Applicant |
|---|---|
| X _____ Date _____ (Please Do Not Print) | X _____ Date _____ (Please Do Not Print) |

## ADDITIONAL DEPENDENT(S) OVER 14 YEARS OLD

| Name (Please Print) | Date of Birth / / |
|---|---|
| | |
| Name (Please Print) | Date of Birth / / |
| | |
| Name (Please Print) | Date of Birth / / |
| | |

## CHILDREN UNDER 14 YEARS OLD

| Name (Please Print) | Date of Birth / / |
|---|---|
| | |
| Name (Please Print) | Date of Birth / / |
| | |
| Name (Please Print) | Date of Birth / / |
| | |
| Name (Please Print) | Date of Birth / / |
| | |

## ENROLLMENT TYPE

❑ **Adult LoyalCare** (ages 14 and older) ....$300/Yr X____=$____/Yr

❑ **Child LoyalCare** (ages 0-13) .....$150/Yr X____=$____/Yr

❑ **His & Hers LoyalCare**.....$500/Yr X____=$____/Yr

❑ **Perio LoyalCare**.....$600/Yr X____=$____/Yr

| **FEE $** | Office Member (Initial) | Date / / | Payment Type ❑ Cash ❑ Check ❑ Credit Card |
|---|---|---|---|
| | | | |

LOWMAN
FAMILY DENTAL