White House Dental

Creating Beautiful Smiles

Advanced Care Membership Agreement

Our Advanced Care Membership has been designed and developed to satisfy the requests of patients who have asked for something better. Individuals, who value access, prompt service and quality dental care in a relaxed, at-home atmosphere.

Enrollment Date: _____/_____/_____

Amount Paid $ _____

Adults: $ 265.00 each

Of Adults (15 & Older): _____

Name(s) of Member(s) Please Print

_____
_____
_____
_____
_____

Children: $ 255.00 each

Of Children (14 & Under): _____

Name(s) of Member(s) Please Print

_____
_____
_____
_____
_____

Method Of Payment

Credit card

Visa ☐ / Master Card ☐ / CareCredit ☐

Card #: _____

Expiration Date: _____/_____/____

Personal Check ☐

Check #: _____

Cash ☐

Date of Birth

_____/_____/_____
_____/_____/_____
_____/_____/_____
_____/_____/_____
_____/_____/_____

I, the undersigned, understand and accept all the given terms and conditions explained to me in the Advanced Care Membership brochure, for myself and any members included in this agreement, and I hereby authorize White House Dental to charge me for the stated amount.

*Payments are non refundable.

*This is a trial program and may be discontinued at any time; however your contractual year will be honored.

Signature: _____

Date: _____/_____/_____

Phone
(541)889-8837

Web
www.whitehousedental.net

Fax
(541)889-8991

Address
347 West Idaho Avenue
Ontario, OR 97914