

Dental Assistance Savings Plan

**It's Not Insurance...
It's Better!**

The Dream-Dentistry & Sleep Care Dental Discount Plan is designed to provide affordability and greater access to quality dental care.

Treatment Coverage

100% OFF

**2 x year
Dental Exam**

Child or Adult Prophylaxis†

(Simple Cleaning)

Fluoride - No Age Limit

50% OFF

All Xrays

20% OFF

Additional Cleanings‡

Sealants

Whitening

Multiple Methods Available

15% OFF

**Fillings & Core Buildups
Periodontics**

**Final Crowns
Save \$180**

**Final Dentures & Partials
Save \$300**

**Implants
Save Up To \$300**

**Limited Time Only
2 for \$600*
(Additional family
members \$300 each.)**

**For just \$342
(less than \$1 per day)**

**For treatment over \$500
we also offer a 5% pre-pay savings.**

PROGRAM EXCLUSIONS & LIMITATIONS

The program is a discount plan, not a dental insurance plan. It cannot be used:

- In conjunction with another dental plan, insurance plan, coupon or offers
- Your discount will be a smaller percentage if using Care CreditSM
- For services or injuries covered under workmans compensation
- For treatment by a specialist outside of Dream-Dentistry & Sleep Care
- For hospitalization or hospital charges for the costs of dental care
- In conjunction with any other discount offers

**This plan is only honored at
Dream-Dentistry & Sleep Care, Quakertown, PA.**

This dental discount plan is not an insurance plan. It cannot be used with any other dental office.

You will not receive a membership card - Your plan's effective date will be on file with our office.

***Additional DASP members at discounted rate must be seen within the same week and must also reside at the same address as the primary plan holder.
New DASP or Renewal Only - We cannot discount an already active plan.**

Yearly membership

CANNOT BE CANCELED, NO REFUNDS.

I agree to the terms of this plan as stated above.

Signature _____ Date _____

Employee Initials _____

†Does not include periodontal services.

Our Team is Your Dental Family

When you are here, you are family!



Serving our Community for over 25 years!



Experience the Difference!

Dr. Gordon Roeder
Dr. Zachary Kulp

Dream

Dentistry & Sleep Care™

EXPERIENCE THE EXCEPTIONAL

1326 West Broad Street
Quakertown, PA 18951

Call today 215.538.1109

www.dream-dentistry.com

Dental Savings Plan Application Form

Effective Date: _____
FOR OFFICE USE ONLY

Primary Plan Holder:

First Name: _____ Last Name: _____ Middle Initial: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Contact Phone # (cell): _____ E-mail: _____ Birthdate: _____

Annual Membership (pre-paid) Cost: \$342

Additional Family Members to be Covered:

Additional Cost per Member: _____

Name: _____ Relationship: _____ Birthdate: _____ Add: _____

Name: _____ Relationship: _____ Birthdate: _____ Add: _____

Name: _____ Relationship: _____ Birthdate: _____ Add: _____

Name: _____ Relationship: _____ Birthdate: _____ Add: _____

***Total Amount Due:** _____

*Annual Fee is required at enrollment and cannot be financed. Membership Fees for Dental Savings Plan are NON-REFUNDABLE. Failure to provide 48 hours notice when canceling or changing a dental hygiene appointment will VOID the benefit for that appointment. The missed appointment will count as one of your included professional cleanings. Dream-Dentistry & Sleep Care reserves the right to modify, change, or discontinue the Dental Savings Plan, terms, fees, and services at the company's discretion upon written notice from Dream-Dentistry & Sleep Care, prior to your anniversary renewal date.

Payment Method:

☐ Cash (in-office only**)

** If paying with cash, please return this application to our office in person. Do not mail cash payments.

☐ Check (make checks payable to Dream-Dentistry & Sleep Care and enclose check with application)

☐ Credit Card #: _____ Exp. Date: _____ CVC: _____

☐ Set my account listed above to Auto Draft**

Auto-Renewal Program: Sign up now and save 5% off next year's premium!

I, _____, authorize Dream-Dentistry & Sleep Care to charge my credit card each year upon my anniversary date to automatically renew my enrollment in the dental savings plan. Dream-Dentistry & Sleep Care will notify me when the plan is renewed, for my records. If I chose to discontinue participating in the dental savings plan, I will notify Dream-Dentistry & Sleep Care one month prior to my anniversary renewal date.

Please mail this complete application with appropriate payment (check or credit card to:)

Dream-Dentistry & Sleep Care - 1326 West Broad Street, Quakertown, PA 18951

By signing below, I acknowledge that I have read the Dental Savings Plan brochure and understand the plan details, benefits, and limitations.

Member Signature: _____ Date: _____