Collegeville Dental Center
555 North 2nd avenue D-500
Collegeville, PA 19426

Enrollment Application In-Office Discount Dental Plan

Name: _____
Last First MI

Address: _____
Street

_____
City State Zip

DOB: _____

SS: _____

Phone: _____
Home Cell

Email: _____

Dependents: _____
Name DOB Relation

_____
Name DOB Relation

_____
Name DOB Relation

_____
Name DOB Relation

Enrollment Fee
Effective Date: _____ Renewal Date: _____

Patient	Fee	Number	Total
Member	$299		
Spouse/Partner	$265		
Dependents	$175		

* * Checks should be made payable to Collegeville Dental Center

I, _____ do hereby understand the policies and limitations of Collegeville Dental Center In-Office Discount Dental Plan. Furthermore, I understand the office policies of Collegeville Dental Center and agree to them.