Sagepointe Dental Membership Plan
Enrollment Form

Member Name _____

Address _____ City _____ State ___ Zip_____

Telephone _____ Email Address _____

Annual Membership Fee: $300.00 per member

Please read and sign below

I agree to pay Sagepointe Dental for a 12-month membership fee of $300 for my Sagepointe Dental Membership Plan. My 12-month membership begins on _____.

I will receive the following benefits:

1. Initial exam and x-rays

2. Up to two regular hygiene appointments (not deep cleanings)

3. Up to two dental exams

4. Discount of 20% for all other services provided by Sagepointe Dental Office.

I agree to the following terms:

1. If I have dental insurance, I will take advantage of those benefits before joining the Sagepointe Dental Membership Plan.

2. Only the services recommended by Dr. Warren Barr are included in my membership.

3. The services allowed by my membership will only be provided by Dr. Barr and his staff at Sagepointe Dental Office. The membership does not include services provided by specialists or other dental offices.

4. Drugs and medications are not included with this membership.

5. All fees are due at the time of services.

6. My membership fee is not refundable.

7. At the end of the year, I may be able to sign up for another year, but my membership fee and the benefits may be different than the previous year.

Signed: _____ Date _____
Member or Member's Guardian