TriDental, Inc.

For TriDental, Inc. Use Only
Date Input:
____
Initials
____

P.O. Box 7243
Waco, TX 76714
Tel: 254-399-8660

Enrollment Information

Full Name: ____

Address: ____

City: ____
State: _________________________________ Zip Code: ___________________

Day Phone: ___________________________ Home Phone: _______________________

Type of Membership	Total
Membership Fee	
Enrollment Fee	
Cash ________ Check________ CCType________ Total Paid with Application	

Additional Dependent Information			
Last Name	First Name	MI	Date of Birth

I hereby make application to enroll in TriDental, Inc. for a minimum of one year. I agree to hold TriDental, Inc. harmless from any liability for negligence on the part of an affiliated provider and agree to discuss all fees with the provider before I receive services. I/"We agree to pay the enrollment fee plus annual or bi-annual membership fee at the time of application. If choosing the monthly membership option, I agree to pay the enrollment fee and first month membership fee at the time of application and I authorize TriDental, Inc. to continue to charge my credit card or draft my checking account for the monthly fee in the amount stated above until notice of cancellation in writing. I have received a copy of the Membership Agreement and agree to be bound by the terms and conditions thereof. I further affirm that the name and personal information provided on this form are true & correct.

Applicant Signature & Date: ____