

P.O. Box 7243
 Waco, TX 76714
 Tel: 254-399-8660
 Fax: 254-399-8680

TriDental, Inc.

For TriDental, Inc. Use Only

Date Input _____

Initials _____

Cards Sent _____



Enrollment Information

Full Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Day Phone: _____ Home Phone: _____

Social Security # _____ Date of Birth: _____

Type of Membership	Total
Membership Fee	
Enrollment Fee	
Cash _____ Check No. _____ CC (Type) _____ Total Pd w/Application	

Additional Dependent Information			
Last Name	First Name	MI	Date of Birth

Monthly Payment Information

Name on Credit Card _____ CC Type _____

Number _____ Exp. Date _____ Date Processed _____

OR

Name on Check _____

Bank Name _____

Routing/Transit Number _____ Account Number _____

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 two year 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. Fees are subject to change without written notice.

I further affirm that the name and personal information provided on this form are true & correct.

Applicant Signature _____ Date _____