Blaskovich Dental
120 S Crescent Dr. Suite B
Pueblo West, CO 81007

Name:_____ Date:_____

DOB:_____

GOLD PLAN

ALL PLAN OPTIONS ARE FOR ONE YEAR FROM DATE OF PURCHASE, DISCOUNT PLANS ARE **NON-REFUNDABLE**

- **INDIVIDUAL PLAN- $344**
  - ALL EXAMS, 2 CLEANINGS, 2 FLUORIDE TREATMENTS, AND ALL X-RAYS

  -ADDITIONAL FAMILY MEMBERS: $289

- **PERIODONTAL PLAN- $399**

  -ALL EXAMS, 3 PERIODONTAL CLEANINGS, 3 FLUORIDE TREATMENTS, AND ALL X-RAYS

  (THIS DOES **NOT** INCLUDE SCALING AND ROOT PLANING)

  -ADDITIONAL PERIODONTAL FAMILY MEMBER: $349

ALL PLANS INCLUDE A 20% DISCOUNT ON DENTAL TREATMENT

SOME SERVICES ARE EXCLUDED FROM THIS DISCOUNT

I UNDERSTAND THAT MY YEARLY MEMBERSHIP PAYMENT WILL BE DUE ON THE ANNIVERSARY OF SIGNING UP FOR THE PLAN. I ALSO UNDERSTAND THAT ALL PAYMENTS FOR TREATMENT RECEIVED ARE DUE AND PAYABLE AT THE TIME OF SERVICE. I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK ANY QUESTIONS I MAY HAVE CONCERNING THE DISCOUNT PLAN AND I FEEL THAT MY QUESTIONS HAVE BEEN ANSWERED SATISFACTORY.

_____

PATIENT SIGNATURE **DATE**