

NO INSURANCE?

NO PROBLEM!

WE HAVE A GREAT SOLUTION

Dental Health Care Plan

NO YEARLY MAXIMUMS

NO DEDUCTIBLES

NO CLAIM FORMS

**NO PRE-AUTHORIZATION
REQUIREMENTS**

**NO PRE-EXISTING CONDITION
LIMITATIONS**

NO ONE WILL BE DENIED COVERAGE

NO WAITING PERIODS

FREE CONSULTATIONS & 2ND OPINIONS

KELLER SMILES

 1540 Keller Parkway
Suite 140
Keller, TX 76248

 682.593.0993

 mykellersmiles.com

Office Hours

Monday 8a - 5p
Tuesday 8a - 5p
Wednesday 8a - 5p
Thursday 8a - 5p
Friday 8a - 12p

Dental Health Care Plan

AN INSURANCE ALTERNATIVE



KELLER SMILES

682.593.0993
mykellersmiles.com



\$365 PER INDIVIDUAL
\$299 PER CHILD (18 YRS & YOUNGER)

YEARLY ENROLLMENT FEE

PLUS

**12% OFF ANY NEEDED DENTAL
 TREATMENT IN THE YEAR
 (FILLINGS, GUM TREATMENTS,
 CROWNS, CLEAR BRACES, ETC)**

INCLUDES:

PREVENTIVE/DIAGNOSTIC CARE

2 CLEANINGS PER YEAR

2 EXAMS PER YEAR

ANY NEEDED X-RAYS

**2 FLUORIDE APPLICATIONS
 PER YEAR**

**NORMAL ANNUAL COST FOR THESE
 SERVICES AVERAGE \$604**

COVERED PATIENTS AGREE TO:

- Attend all scheduled appointments.
- Give minimum of 2 business days notice for appointment changes.
- Comply reasonably w/clinical recommendations
- Make payments at the time of service.
- Provide feedback to help us improve our services

HAVE QUESTIONS?

EMAIL US AT

INFO@MYKELLERSMILES.COM

ENROLLMENT FORM

Please fill out and send this form in today to begin coverage!

 Last Name First Name Initial

 Mailing Address City/State

 Email

 Employer Name/Phone Gender

 Spouse Date of Birth Gender

 Child Date of Birth Gender

 Child Date of Birth Gender

 Child Date of Birth Gender

Please Check:

- Full Amount \$365 Monthly Payment \$34
 Full Amount \$299 Monthly Payment \$25
 Visa MasterCard Discover Amex

 Name on Card Card Number

 Expiration Date Security Code

As a patient, I wish to apply for membership in the Dental Health Care Plan. I understand that all services under this program must be obtained at an affiliated dental office and further that my co-payment will be due in full at the time services are rendered. This is not an insurance program.

 Signature Date

NO INSURANCE?

NO PROBLEM!

WE HAVE A GREAT SOLUTION

*Dental Health Care
Periodontal Plan*

NO YEARLY MAXIMUMS

NO DEDUCTIBLES

NO CLAIM FORMS

**NO PRE-AUTHORIZATION
REQUIREMENTS**

**NO PRE-EXISTING CONDITION
LIMITATIONS**

NO ONE WILL BE DENIED COVERAGE

NO WAITING PERIODS

FREE CONSULTATIONS

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*Dental Health Care
Periodontal Plan*

AN INSURANCE ALTERNATIVE



KELLER SMILES

682.593.0993
mykellersmiles.com



\$749 PER INDIVIDUAL

YEARLY ENROLLMENT FEE

PLUS

**12% OFF ANY NEEDED DENTAL
TREATMENT IN THE YEAR
(FILLINGS, GUM TREATMENTS,
CROWNS, CLEAR BRACES, ETC**

INCLUDES:

PREVENTIVE/DIAGNOSTIC CARE

**4 PERIODONTAL MAINTENANCE VISITS
(GUM THERAPY CLEANINGS) PER YEAR**

2 EXAMS PER YEAR

ANY NEEDED X-RAYS

**4 CHLORHEXIDINE VARNISH
APPLICATIONS PER YEAR**

**NORMAL ANNUAL COST FOR THESE
SERVICES AVERAGE \$1,082**

COVERED PATIENTS AGREE TO:

- Attend all scheduled appointments.
- Give minimum of 2 business days notice for appointment changes.
- Comply reasonably w/clinical recommendations
- Make payments at the time of service.
- Provide feedback to help us improve our services

HAVE QUESTIONS?

EMAIL US AT

INFO@MYKELLERSMILES.COM

ENROLLMENT FORM

Please fill out and send this form in today to begin coverage!

Last Name First Name Initial

Mailing Address City/State

Email

Employer Name/Phone Gender

Spouse Date of Birth Gender

Please Check:

Full Amount \$749 Monthly Payment \$63

Visa MasterCard Discover Amex

Name on Card Card Number

Expiration Date Security Code

As a patient, I wish to apply for membership in the Dental Health Care Periodontal Plan. I understand that all services under this program must be obtained at an affiliated dental office and further that my co-payment will be due in full at the time services are rendered. This is not an insurance program.

Signature Date