Please List All Unmarried Children Up to Age 25

1.	Child's First Name	
	Middle Initial	Son / Daughter
	Date of Birth	
2.	Child's First Name	
	Middle Initial	Son / Daughter
	Date of Birth	
3.	Child's First Name	
	Middle Initial	Son / Daughter
	Date of Birth	
4	Child's First Name	
7.		
	Middle Initial	Son / Daughter
	Date of Birth	

Patients agree that Farinacci Dental Care fees stated must be paid at the time services are rendered. Any service not paid for at the time of service will be billed at usual & customary fees. Membership fees are valid only when paid at the time of enrollment. All family members must reside in the same household. This is not an insurance product. Membership renews annually on the day & month of initial enrollment. Membership renews automatically unless member formally requests otherwise in advance. Member may cancel enrollment at any time. Requests to terminate or cancel enrollment must be issued in writing to Farinacci Dental Care. If Farinacci Dental Care chooses to cancel a member's enrollment. member will be given a refund pro-rated for the remainder of the current enrollment period. If Farinacci Dental Care cancels a member's enrollment due to non-payment of fees, no pro-rated refund will be given. Any complaints may be addressed directly to Farinacci Dental Care in writing or submitted to the Ohio Department of Insurance via insurance.ohio. gov or by calling 1-800-686-1526.

Low-Cost Individual Membership
As Low as \$18.75/mo.

No Deductibles, Ever

Enroll Today!

Join Farinacci Dental Care's In-House Premier Dental Care Membership

- All Health Conditions Accepted!
- You Cannot Be Denied Coverage!
- No Waiting Period!
- No Health Questions!
- You Cannot Be Singled Out for Rate Increases or Cancellations!

Membership Includes the Following Services at No Charge:

- Comprehensive Exam (once every six months)
- Fluoride Treatment for Children (under the age of 18, once every six months)
- X-Rays (once every 12 months)
- $\bullet \ \ Cleaning \left(Prophylaxis \right) (once \ every \ six \ months)$

Call Today for Your Appointment & More Details!

Welcome to Our Office!





1225 South Main Street, North Canton, OH 44720 Our office is located half a mile north of the intersection of Everhard Road & Main Street.

330-497-7302 • OhioSmileCenter.com

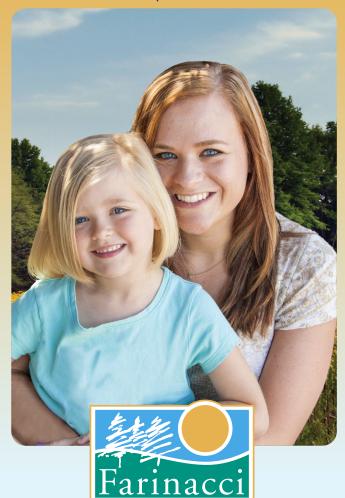
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Affordable Dental Care Membership

For You & Your Entire Family

As Low as \$18.75/mo.



We're Making Excellence in Dentistry Affordable for You!

Dental Care

Low-Cost Individual Dental Coverage

Now you can join our low-cost dental savings membership for a nominal fee. Our membership entitles you to preventive dental care at no cost! Corrective services are available for small fees that are far less than the usual, customary fees. Our professional staff is qualified to care for all of your dental needs!

To enroll, simply fill out the enclosed enrollment form \mathscr{E} return it with your check, money order or credit card information. Please make check or money order payable to Farinacci Dental Care.

Low-Cost Individual Membership As Low as \$18.75/mo.

- Individual ~ \$225/year
- Individual & Spouse ~ \$400 / year
- Family ~ \$545/year (two adults & two kids)
- Additional Child in Family ~ \$109/year

Preventive Dentistry

Service	Co-Pay
Examination	No Charge
X-Rays (every 12 months)	No Charge
Adult Cleaning	No Charge
Children's Cleaning (every six months)	No Charge
Fluoride Treatment for Children (every six months)	No Charge

Periodontics

Service	Co-Pay
Root Planing	\$273
Periodontal Maintenance	\$122

Orthodontics

Service	Co-Pay
Invisalign [®] (financing available as low as \$89/mo.)	\$5,100
Nightguard	\$540

Fillings

Service	Co-Pay
1 Surface	\$201
2 Surfaces (composite/tooth-colored)	\$246
3 Surfaces (composite/tooth-colored)	\$302
4 Surfaces (composite/tooth-colored)	\$370

Crowns & Bridges

Service	Co-Pay
All-Porcelain Crown	\$1,181
Porcelain Onlay	\$1,098

Other Treatments

Service	Co-Pay
Emergency Exam	\$102
Cosmetic Whitening	\$422
Sealants (per tooth)	\$48



Complete This Form to Begin Enrollment!

First Name		
Last Name		
Middle Initial		Female / Male
Home Address		
	_ State	Zip
Phone		
Email		
Date of Birth/	_/S.S.#	#
Spouse First Name		
Last Name		
Middle Initial		Female / Male
Date of Birth/	_/S.S.#	#
Enrollment Period	to)
Signature (member & spouse)		
		Date
		Date
American Express / Disco	ver / Maste	rcard / Visa
Card Number		
Expiration Date		
Make check or money of	order payable	to



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