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(760) 622-3010

For Office Use Only
Renewal Month: _____
Staff Initials: _____

APPLICATION FOR ELEVATED SMILES IN-HOUSE DENTAL PLAN

Personal Information:

Name: _____ Email Address: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Additional Adult Family Member 1:

Name: _____ Email Address: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Additional Child Family Member 1:

Name: _____ Email Address: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Additional Child Family Member 2:

Name: _____ Email Address: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ Date of Birth: _____

Home Phone: _____ Cell Phone: _____

Applicant's Signature: _____

Date: _____

Payment Type:

Check: _____

Credit Card:

AMEX Discover Visa MasterCard

Card Number: _____

Expiration Date: _____ CVR Code: _____

Billing Address: _____

Cardholder Signature: _____