

The Healthy Smiles Club

Based on the dental insurance concept, the Healthy Smiles Club is offered solely to our patients who need an alternative to traditional insurance and would like to focus on comprehensive and preventative oral health care.

Benefits to our members include:

Immediate enrollment and treatment

No lengthy paperwork or commitment

No waiting periods, limits or maximums

No Third Party predeterminations or claims

Eric E. Mohr, D.M.D.

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Pompano Beach, FL 33062

(954)785-1102

The Healthy Smiles Club

Annual Membership Fees:

Single Individual	\$175
Second Family Member	\$125
Additional Family Members	\$100

*This membership is not dental insurance and covers services provided only at the office of Eric E. Mohr, D.M.D. for a period of one (1) year after the enrollment date.

Additional family members from the same household may be added after the initial enrollment date but are limited to the same initial one (1) year period.

Healthy Smiles Club

Benefits:

Office Visit	\$10
Diagnostic/Examinations	
Comprehensive, Periodic, Emergency	Included
Oral Cancer Screening	Included
X-Rays	Included
Preventative/Cleanings/Periodontal Therapy	
Adult Cleaning/Prophylaxis (2 per enrollment year)	Included
Child Cleaning/Prophylaxis, 14 and Under (2 per enrollment year)	Included
Additional Cleaning/Prophylaxis	\$50
Full Mouth Debridement	\$60
Periodontal Scaling and Root Planing, per Quadrant	\$100
Periodontal Maintenance	\$60
Restorative/Cosmetic	
Composite Resin Fillings	25% Off
Porcelain Inlays, Onlays, Crowns and Veneers	25% Off
Bleaching/Tooth Whitening	25% Off
Prosthodontics	
Fixed Bridges, Removable Partial and Complete Dentures	25% Off
Removable Repairs and Relines	25% Off
Specialty Dental Treatment	
Endodontics	25% Off

Healthy Smiles Club

Membership Enrollment:

Last Name: _____

First Name: _____ M.I. _____

Date of Birth: _____ Sex _____

Address: _____

Home Phone: _____ Cell: _____

Additional Enrolling Family Members:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Total Cost of Enrollment for # _____ Family Members: \$ _____

Signature _____ Date _____