Sutton Dental

160 Worcester Providence Tpke, Suite 16
Sutton MA, 01590
(508)865-2334

In-Office Dental Savings Plan

REGISTRATION FORM

First Name:______________________________ **Last Name**:______________________________

Current Address:____

Home Phone Number: _____________________ **Cell Phone**:______________________________

Date of Birth:____________________________________

List of dependents you wish covered under the plan by name, date of birth, and relationship (under the age of 19).

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Payment Method

Yearly Discount plan $325/year, $600 per couple, + $200 per additional plan member under the age of 19.

Total amount to be charged: _____________________ **per year.**

Cash:________________ **Check**:_____________ **Charge**:_______________

Signature: ____ **Date**:_______________