Stacy L Davis, DDS, Inc.

*14062 US Highway 23 * Suite B * Waverly OH 45690 * 740-947-1990 * www.drstacydavis.com*

SMILE $AVINGS CLUB

Effective Date:_____ New Plan: _____ Renewal Plan: _____

Last Name: _____ First Name _____ MI _____

Home Address_____ Date of Birth _____

City _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ E-Mail:_____

Dental Health Savings Plan : _____ Membership Fee: $_____

Payment Method

Check

Cash

Debit/Credit Card # _____ Exp Date _____ CVC_____

By signing below, I acknowledge that I have read the brochure and understand the plan details and limitations.

Signature_____ Date_____

*Annual fee is required at enrollment and is non-refundable. Stacy L. Davis, DDS, LLC reserves the right to modify, change, or discontinue the Dental Health Savings Plan, fees, terms, and services at the company's option upon written notice from Stacy L. Davis, DDS, LLC prior to your anniversary renewal date.