

Complete This Form to Begin Coverage Today

Please List All Children
You Wish to Enroll

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 _____
Middle Initial _____ Son / Daughter
Date of Birth _____

Our Affordable Coverage Includes the Following Services at No Charge:

- Comprehensive Exam
(once every 6 months)
- X-Rays
(once every 12 months)
- Fluoride Treatment
for Children
(under the age of 18,
once every 6 months)
- Cleaning (Prophylaxis)
(once every 6 months)



Low-Cost Dental Coverage

Less Than \$1/day

We are located at the corner
of Century Boulevard
& Alexander Street.



Enroll Today!

Join South Hillsboro Family Dentistry's In-House Premier Dental Coverage

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



3075 Southeast Century Boulevard, Suite 107
Hillsboro, OR 97123

503-747-5607

SouthHillsboroDental.com



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Affordable Dental Coverage

Less Than \$1/day



SOUTH HILLSBORO FAMILY
DENTISTRY

We're Making Excellence in
Dentistry Affordable for You!

Affordable Dental Coverage for the Whole Family!

Now you can join our low-cost dental coverage for a nominal membership fee. Our coverage entitles you to preventive dental care at no cost! Corrective services are available for small co-payments 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 & return it with your check, money order or credit card information. Please make your check or money order payable to South Hillsboro Family Dentistry.

Low-Cost Dental Coverage

- Individual ~ \$22/mo.*
- Individual & Spouse ~ \$25/mo.*
- Family Plan ~ \$30/mo.* (two adults & two kids)
- Additional Child in Family ~ \$5/mo.*

*Monthly payment plan is available to patients providing direct deposit or credit card access.

Preventive Dentistry

| Service | Co-Payment "Basic Care" | Regular Fees as High as |
|--------------------------------|----------------------------|---------------------------------------|
| Examination..... | No Charge | \$104 |
| X-Rays (every 12 months) | No Charge | \$150 |
| Adult Cleaning | No Charge | \$118 (every 6 months) |
| Children's Cleaning..... | No Charge | \$86 (every 6 months) |
| Fluoride Treatment | No Charge | \$55 for Children (every 6 months) |

Implant Dentistry

| Service | Co-Payment "Basic Care" | Regular Fees as High as |
|------------------------|----------------------------|----------------------------|
| Implant Placement..... | \$1,493 | \$1,866 |
| Implant Abutment..... | \$477 | \$596 |

Restorative Dentistry

| Service | Co-Payment "Basic Care" | Regular Fees as High as |
|-----------------|----------------------------|--------------------------------------|
| Fillings | \$164-\$324 | \$204-\$404 |
| Crown..... | \$1,032 | \$1,289 |
| Root Canal..... | \$685-\$940 | \$856-\$1,174 (Anterior or Molar) |
| Denture | \$1,480 | \$1,850 (Top or Bottom) |

Other Treatments

| Service | Co-Payment "Basic Care" | Regular Fees as High as |
|-----------------------------|----------------------------|----------------------------|
| Emergency Exam | \$69 | \$86 |
| Sealants (per tooth)..... | \$54 | \$67 |
| Nightguard..... | \$543 | \$678 |
| Cosmetic Whitening..... | \$270 | \$337 (per arch) |
| Cosmetic Consultation | No Charge | \$95 |

Please Inquire About Services
Not Listed Here!



Complete This Form to Begin Coverage Today!

First Name _____

Last Name _____

Middle Initial _____ Female / Male

Home Address _____

City _____ State _____ Zip _____

Phone _____

Email _____

Date of Birth ____/____/____

Spouse First Name _____

Last Name _____

Middle Initial _____ Female / Male

Date of Birth ____/____/____

Enrollment Period _____ to _____

Signature (member & spouse) _____

_____ Date _____

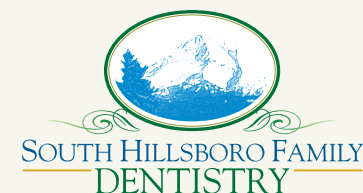
_____ Date _____

American Express / Discover / MasterCard / Visa

Card Number _____

Expiration Date _____

☐ Make your check or money order payable to
South Hillsboro Family Dentistry.



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Patients agree that South Hillsboro Family Dentistry 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. Coverage 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.