

# KiddieKlub Dental Plan Enrollment

Please complete the application to enroll your children in the plan.

Name: \_\_\_\_\_ Date : \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Circle One: Male or Female  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ How did you find us? \_\_\_\_\_  
Email: \_\_\_\_\_

Additional children in your family you wish to enroll today?

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Male or Female  
Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Male or Female  
Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Male or Female  
Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Male or Female

Payment Option #1: Credit card payment

I authorize Kiddie Dental to charge my credit card a one time annual membership fee in the amount of \$\_\_\_\_\_ for one year of my KiddieKlub dental plan.

Circle type of card: MasterCard Visa Discover Amex

Card Number: \_\_\_\_\_ Expiration: \_\_\_\_\_ Signature: \_\_\_\_\_

Payment Option #2: Check payable to: KiddieDental

Mail or fax your application to:

KiddieDental  
15833 Pines Blvd  
Pembroke Pines, Florida 33027  
Telephone: 954-443-3030 FAX: 954-443-9431