

Dental pre-application



Date: _____

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Name: _____ Last name: _____ DOB: _____

SSN: _____ Sex: ___ Male ___ Female Ph. # _____

Address: _____ City: _____ Zip code: _____

County: _____ Status: ___ Single ___ Married

Email address: _____ Tobacco user? Yes ___ No ___

Birth State, Province or Country: _____ (*where the person was born*)

Are you a permanent Florida resident? ___ Yes ___ No

Are you a US Citizen? ___ Yes ___ No

Documentation may be requested in order to validate your legal status.

Please provide your valid residency status:

___ Permanent resident card _____ Employment Authorization Card

___ Current Visa Exp. Date: _____ ___ None of them

___ Visa Extension Exp. Date: _____

Dependents:

Relationship	Last name	First name	DOB	SS #	Imm Status

Choose a plan:

___ BlueDental Copayment QF

___ BlueDental Choice QF

Adults \$25.35 /child up to 19 yrs - \$21.55

Adults \$34.47 /child up to 19 yrs - \$36.04

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Payment method:

Card # _____ Exp. _____ CVV _____

Bank acc. _____ Routing # _____