

AsmileSclicnic Registration Form

Please complete this form clearly, and ensure it is returned as soon as possible.

TITLE:	FORENAME (S):	SURNAME:	D.O.B.	DENTIST:
ADDRESS:		START DATE: 01/ /	REG FEE:	
		CATEGORY:	FEE AMOUNT: <small>(Please circle as appropriate)</small>	
POSTCODE :			£9.99	£13.99
PAYMENT DETAILS :				
BANK NAME:			ACCOUNT NAME:	
SORT CODE:			ACCOUNT NUMBER:	

Additional Patients:				
TITLE:	FORENAME (S):	SURNAME:	D.O.B.	DENTIST:
ADDRESS: <i>if different from above, please complete</i>		START DATE: 01/ /	REG FEE:	
		CATEGORY:	FEE AMOUNT: <small>(Please circle as appropriate)</small>	
POSTCODE :			£9.99	£13.99

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ADDRESS: <i>if different from above, please complete</i>		START DATE: 01/ /	REG FEE:	
		CATEGORY:	FEE AMOUNT: <small>(Please circle as appropriate)</small>	
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POSTCODE :			£9.99	£13.99

NOTES AND EXCLUSIONS <small>(FOR OFFICE USE ONLY)</small>

DEMANDS AND NEEDS STATEMENT: The Dental Injury & Emergency Insurance policy meets the demands and needs of those who want to ensure they have insurance cover for treatment costs arising from dental injury or emergency. This policy is a mandatory part of your dental plan, and no recommendation has been made in connection with this insurance policy.		
DECLARATION: I confirm that I have read the explanatory brochure and the Insurance Policy Summary and have understood all treatment that I am covered for. I am also aware of any registration fee and the date of commencement of cover.		
Signature:	Print Name:	Date: