



**"FIRST CHOICE MAKES CENTS"**

*Introducing . . .*

**FIRST CHOICE DISCOUNT  
DENTAL  
MEMBERSHIP**

by

Diamond Dental Care  
4050 West I-20  
Arlington, Texas 76017  
(817) 563-1111

## First Choice Discount Dental Plan

Diamond Dental Care  
Fred Turner D.D.S. & Associates  
4050 West I-20  
Arlington, Texas 76017  
(817) 563-1111

### **Enrolling is Easy!**

Simply fill out the application on the next page.

Check the level you wish to have: "Individual Only", "Individual plus One", or "Individual and Entire Household".

Complete the information about yourself. (You MUST include your social security number, date of birth, home address and work address when you arrive at Diamond Dental Care).

If you checked "Individual Only", leave the "Household Members" section blank since you are not enrolling any household members. If you selected "Individual plus One" or "Entire Household", list all individuals legally residing in your household you want included on the dental plan. All members listed on your dental plan will be automatically enrolled for whatever products you have chosen. Please do not list yourself as a household member. Also list each household member's birth date.

Select your payment option.

Sign and date the Enrollment Application.

Bring PAYMENT and COMPLETED APPLICATION with you to your next appointment.

#### ANNUAL

Individual Only.....	\$120.00
Individual plus One.....	\$180.00
Entire Household.....	\$240.00
Company Plan (Every 5 employees).....	\$360.00

Payment by Check:

Please make your check payable to: Diamond Dental Care

We also Accept VISA, MASTERCARD, AMEX, CARE CREDIT or DISCOVER

### *Membership Card*

Name \_\_\_\_\_

Type of Discount Plan \_\_\_\_\_

Family Members \_\_\_\_\_

Effective Date \_\_\_\_\_

**Member's Discounted Dental Fees**  
*Payment must be made at time of treatment.*

**Diagnostic & Preventative**

0150	Initial Oral Exam	\$25
0120	Periodic Oral Exam	\$10
0140	Emergency Oral Exam	\$35
0220	Single Periapical X-ray	\$5
0230	Additional Periapical X-ray	\$5
0272	Bitewing X-ray (2 lms)	\$10
0330	Panoramic X-ray	\$40
0475	Infection Control*	\$5
1110	Prophylaxis – Adult (heavy deposits may require perio prophyl)	\$40
1120	Prophylaxis – Child (under 13 years)	\$30
1203	Topical Fluoride – Child	\$10
1351	Sealant (per tooth)	\$25

\* Infection control guidelines have been provided by OSHA and the American Dental Association

**Restorative and Cosmetic**

2330	Composite - 1 surface, anterior or posterior	\$55
2331	Composite - 2 surface, anterior or posterior	\$65
2332	Composite - 3 surface, anterior or posterior	\$85
2335	Composite - 4 surface, anterior or posterior	\$150

**Crowns and Bridges**

2752	Crown – Porc. fused/base metal	\$700
2790	Crown – Full cast high noble (gold)	\$850
2930	PreFab. SS Crown, primary	\$125
2920	Recement Crown	\$45
2950	Core buildup	\$85
2954	PreFab post	\$85
6240	Pontic - Porc. high noble (gold)	\$850
6242	Pontic - Porc. fused to metal	\$700
6253	Porc. Bridge Abutment	\$850
6930	Recement Bridge	\$85
2740	Full porc.crown	\$850

**Endodontics (Root Canal Therapy)**

3220	Therapeutic Pulpotomy	\$275
3310	Anterior RCT	\$375
3320	Bicuspid RCT	\$475
3330	Molar RCT	\$675
3340	Four canal RCT	\$775

**Periodontics**

4341	Perio Scale and Plane – per Quadrant	\$85
4345	Perio Prophyl (scaling)	\$75
4110	Perio Probing, Charting	\$25
4999	Perio Med	\$35
4360	Night Guard (hard)	\$350
4355	Full Mouth Debridement	\$95
9630	Irrigation – Per Quadrant	\$71
4380	Re-Eval, Prob.	\$25
4910	Perio Maintenance Prophyl	\$75
9910	Desensitizer per quad	\$40

**Additional Specialty Services**

Any treatment provided by a participating specialist (advance degree), if available in Endodontics, (root canal), Pedodontics (children's dentistry), Prosthodontics, (dentures), Orthodontics (braces), Periodontics (gum treatment), or Oral Surgery, will be charged at 20% reduction of participating specialists fees for that particular case. Some specialists may require a consultation visit before treatment is initiated.

**Prosthetics**

5211	Upper Partial – Resin Base	\$650
5212	Lower Partial – Resin Base	\$650
5225	Upper Flex Part	\$875
5226	Lower Flex Part	\$875
5510	Repair Denture Base	\$125
5640	Replace Broken Tooth	\$125
5650	Add Tooth	\$125
5660	Add or repair Clasp	\$125
5730/5731	Reline Denture (chair) u/l	\$125
5750/5751	Reline Denture (lab) u/l	\$275
5213/5214	Cast metal partial <3 teeth	\$800
5213/5214	Cast metal partial >3 teeth	\$1200
5899	Upgrade teeth (per arch)	\$200

**Implant Restoration**

6057	Implant Abut	\$600
6010	Implant Crown	\$950

**Oral Surgery**

7111	Extraction – simple	\$70
7120	Extraction – each additional	\$60
7210	Extraction – surgical/erupted	\$120
7310	Alveoplasty w/extractions (per quad)	\$50
7510	Incision/drain abscess	\$50

**General**

9310	Professional 2 <sup>nd</sup> Option	\$50
9998	Broken Appointments	\$50
3967	Boost Whitening	\$450

**Plan Exclusions and Limitations**

9920	Behavior Mgt. 6 yrs and under	\$60
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1. The following exclusions apply:
  - A. Service for injuries or conditions that are covered under Workman's Compensation or Employer's Liability Laws;
  - B. Services which are provided without cost to the member by any municipality, country or other political subdivision;
  - C. Cost of dental care which is covered under automobile, Medical no fault, or similar no type insurance;
  - D. General anesthesia (put to sleep), I.V. sedation, and hospitalization or hospital or medical charges of any kind; and
  - E. Osseo integrated implants.
2. Member's dental fees apply only when treatment is performed at Diamond Dental Care. If the services of a nonparticipating specialist are required, these dental fees do not apply and the patient will be responsible to the nonparticipating dentist for his usual, customary and reasonable fee.
3. Reduced fees will not be honored if membership is no longer valid.
4. A patients existing dental or medical condition may necessitate extra precautionary procedures and require additional charges. Please discuss all fees with the dentist prior to treatment.

**Specialists will be referred by  
 Diamond Dental Care**  
 Discuss case with specialists prior to beginning any treatment.

*I Hereby enroll in Diamond Dental Care 1<sup>st</sup> Choice Discount Program for a period of one year, from effective date I hold DDC blameless for any negligence on the part of the participating provider and agree to discuss all fees with the provider before I receive services. DDC Administration may terminate this Agreement without cause by returning the membership fees to the above address.*

### ENROLLMENT APPLICATION

*Please Print In Ink*

LAST NAME	FIRST	INITIAL	DOB	<input type="checkbox"/> MALE	<input type="checkbox"/> MARRIED
				<input type="checkbox"/> FEMALE	<input type="checkbox"/> SINGLE
RESIDENCE ADDRESS	CITY	STATE	ZIP	HM. PHONE #	CELL PHONE #
PLACE OF WORK & ADDRESS	CITY	STATE	ZIP	WORK PHONE #	
FAMILY MEMBER NAME	DOB	<input type="checkbox"/> M <input type="checkbox"/> F	NAME	DOB	<input type="checkbox"/> M <input type="checkbox"/> F
FAMILY MEMBER NAME	DOB	<input type="checkbox"/> M <input type="checkbox"/> F	NAME	DOB	<input type="checkbox"/> M <input type="checkbox"/> F

**Applicants**

**Signature:** **X** \_\_\_\_\_ **Date:** \_\_\_\_\_