



Ahmadi & Alvand DDS PA

4237 Louisburg Road Ste. 110, Raleigh NC 27604 P: 919-865-8300 F: 919-865-8301

New Patient Adult Annual Membership Enrollment \$289.00

(13 and over)

Patient Name: _____

Date of enrollment: _____

Date of expiration: _____

Our CDC membership entitles you to:

1 st Visit	Fees	Cost with Annual Membership	Savings
Comprehensive Exam	\$102.00		
Bitewing x-rays (required for new patient)	\$77.00		
Panoramic x-ray (required for new patient)	\$129.00		
Prophylaxis (Regular cleaning)	\$92.00		
2 nd Visit			
Periodic Exam	\$61.00		
Prophylaxis (Regular cleaning)	\$92.00		
Total annual cost without membership	\$553.00	\$289.00	\$264.00

Additional Savings:

Perio (30% discount)	Fees	Cost with Annual Membership	Savings
Full Mouth Debridement	\$172.00	\$120.40	\$51.60
Deep Cleaning (1-3 teeth)	\$147.00	\$102.90	\$44.10
Deep Cleaning (4+ teeth)	\$268.00	\$187.60	\$80.40
Periomaintenance	\$155.00	\$108.50	\$46.50
15% off other procedures	Fees	Cost with 15% discount	Savings
2 surface filling	\$265.00	\$225.25	\$39.75
Molar root canal	\$1102.00	\$936.70	\$165.30
Crown	\$1231.00	\$1046.35	\$184.65

10% discount on implant procedures.

Periodontal Patients: If you are diagnosed with periodontal disease, you understand that a deep cleaning will need to be done before your regular cleanings are done. **REGULAR CLEANINGS ARE NOT ALLOWED ON PERIODONTAL PATIENTS UNTIL PERIO THERAPY HAS BEEN COMPLETED.** You may be responsible to pay out of pocket for any additional cleaning if needed.

Appointment Policy: Please notify our office with 24 hours in advance if an appointment needs to be cancelled or rescheduled to avoid a cancellation fee. This membership is valid only at the location mentioned above and it is good for 1 year from the date of purchase; any unused portion of the membership will be forfeited upon expiration.

By signing below, you are stating that you understand what the membership entitles you to and are in agreement that the membership will expire 1 year from date of purchase.

Patient/Responsible Party: _____

Signature

Date

Witness: _____

Signature

Date



Ahmadi & Alvand DDS PA

4237 Louisburg Road Ste. 110, Raleigh NC 27604 P: 919-865-8300 F: 919-865-8301

New Patient Child Annual Membership Enrollment \$249.00

(12 and under)

Patient Name: _____

Date of enrollment: _____

Date of expiration: _____

Our CDC membership entitles you to:

1 st Visit	Fees	Cost with Annual Membership	Savings
Comprehensive Exam	\$99.00		
Bitewing x-rays (required for new patient)	\$52.00		
Panoramic x-ray (required for new patient)	\$125.00		
Prophylaxis (Regular cleaning)	\$68.00		
2 nd Visit			
Periodic Exam	\$59.00		
Prophylaxis (Regular cleaning)	\$68.00		
Total annual cost without membership	\$471	\$249.00	\$2222

Additional Savings:

Perio (30% discount)	Fees	Cost with Annual Membership	Savings
Full Mouth Debridement	\$195.00	\$136.50	\$58.50
Deep Cleaning (1-3 teeth)	\$200.00	\$140.00	\$60.00
Deep Cleaning (4+ teeth)	\$275.00	\$192.50	\$82.50
Periomaintenance	\$160.00	\$112.00	\$48.00
15% off other procedures	Fees	Cost with 15% discount	Savings
2 surface filling	\$207.00	\$175.95	\$31.05
Molar root canal	\$1070.00	\$909.50	\$160.50
Crown	\$1045.00	\$888.25	\$156.75

Periodontal Patients: If you are diagnosed with periodontal disease, you understand that a deep cleaning will need to be done before your regular cleanings are done. **REGULAR CLEANINGS ARE NOT ALLOWED ON PERIODONTAL PATIENTS UNTIL PERIO THERAPY HAS BEEN COMPLETED.** You may be responsible to pay out of pocket for any additional cleaning if needed.

Appointment Policy: Please notify our office with 24 hours in advance if an appointment needs to be cancelled or rescheduled to avoid a cancellation fee. This membership is valid only at the location mentioned above and it is good for 1 year from the date of purchase; any unused portion of the membership will be forfeited upon expiration.

By signing below, you are stating that you understand what the membership entitles you to and are in agreement that the membership will expire 1 year from date of purchase.

Patient/Responsible Party: _____

Signature

Date

Witness: _____

Signature

Date