



Education - Health - Community

2025 Dentist or Dental Hygienist Participation Agreement

Provider's Name: _____

We are excited to partner with you! Please let us know if there's anything we can do to make your participation easier and more enjoyable.

Please tell us how you would like to participate in the program this year (mark all that apply below):

- Preventive appointments (Prophylaxis, Periodontal Maintenance, FL, Periodic Exams)**
- Periodontal Therapy (SRP)**
- Extractions**
- Fillings**
- Initial Exam, FMX or Panorex and Treatment Plan**
- Emergency treatment**
- Root Canal Therapy**
- Denture(s)***
- Flipper***
- Crown(s)****
- I will participate exactly as last year**

- Number of appointments available at my office per month _____
- Scheduler/contact person: _____
- Provider's Initials: _____

* VFD will only schedule a service with a lab fee if we have the funds to pay the lab fee.

All patients will be patients of record of Volunteer For Dental, not the dental office.

Please return this to our office by fax: 231.722.3137 or email: stanis@volunteerdental.org

Thank you in advance for your generosity,

Suzanne Tanis, RDH, BS
Executive Director