MFD Affordable Dental Plan

Call today for more details

(973) 524-7702

Visit us on the web at

www.MorristownFamilyDental.com

Dental insurance can be complicated…but the **MFD Affordable Dental Plan** isn't. There are no waiting periods, no yearly maximums, exlusions, or headaches with this offer, and patients of all ages are eligible to join for discounted dental care. Membership includes x-rays's, exams, cleanings, and other preventative services you all need to enjoy a full year of healthy theeth and excellent dental hygiene!

Our Low-cost, Co-payment Schedule

PROCEDURE	UCR FEE	MFD Plan Fee	Discount
Deep Cleaning Per Quad	$339	$212	15%
One Surface Filling	$248	$143	15%
Crown	$1585	$996	15%
Root Canal Molar	$1439	$995	15%
Complete Denture	$2233	$1077	15%
Implant Placement	$2675	$1800	15%
Night Guard	$750	$334	15%

Address: 84 Maple Ave, Suite A, Morristown, NJ 07960

Some of the things you can benefit from when you sign up for the **MFD Affordable Dental Plan** are listed below. Which of these advantages would YOU enjoy the most?

Single Member:

$360 annually (actual value $615) includes 2 cleanings, two exams, two sets of necessary x-rays. ignore bonus goodie bag with toothbrush, floss, toothpaste. **MFD Affordable Dental Plan** offers reduced fee schedule for members.

Single member with 4 cleanings per year (periodontal maintainance):

$600 annually (actual value $1012) includes 4 cleanings, two exams, two sets of necessary xrays. Bonus goodie bag with toothbrush, floss, toothpaste. **MFD Affordable Dental Plan** offers reduced fee schedule for members.

Summary of benefits for MFD plan are as follows

PROCEDURE	DISCOUNTS
Check-up Exam	100%
X-rays	100%
Cleaning	100%
Basic	15%
Major	15%

- Basic services are white composite fillings deep cleanings and root canals.
- Major services are extractions crowns bridges implants orthodontics.
- Cosmetic procedures such as whitening do not qualify for discount.

I have read the above terms, and I have had an opportunity to ask questions. I understand and agree to the terms specified above and wish to participate.

_____	_____	_____
Name of Patient, Guardian or Responsible Party	**Signature** of Patient, Guardian or Responsible Party	Date