

OAKRIDGE DENTAL SOLUTIONS



Oakridge Dental Center

441 S. Livernois Suite 210

Rochester Hills, Mi 48307

(248)652-1100

www.oakridgedentalcenter.com

Oakridge Dental Solutions gives patients the quality dental care that they have grown accustomed to receiving, at a reduced rate.

Oakridge Dental Solutions can only be used by patients that do not have dental insurance. It cannot be used along with any other dental plan, or in any other dental professional office.

Effective January 1, 2011, Oakridge Dental Solutions is a free yearly program that renews one year to the date of membership.

The percentages listed indicate the amount a member will receive off of the original price of each procedure.

Preventative

Prophylaxis (cleaning)	20%
Topical Fluoride	20%
X-rays	20%
Limited Oral Examination (problem related)	20%
Comprehensive Oral Exam (first visit)	20%
Periodic Examination	20%
Oral Hygiene Instructions	N/C

Periodontal (Gum)

Scaling & Root Planing	20%
Full mouth debridement	20%
Periodontal maintenance	20%

Restorative

Tooth colored fillings	20%
Crowns and Bridges	20%

Cosmetic

Whitening	10%
-----------	-----

Orthodontics Related	
Retainers	20%
Space Maintainers	20%

Prosthetics	
Dentures & Partials	20%
Flippers	20%

Repairs	
Dentures & Partials	10%
Flippers & Mouth Guards	10%
Re-cementation of existing crown or bridge	10%

Root Canal Therapy 20%

Surgical Procedures 20%

Oral appliances 20%

There is no charge for adjusting the fit of a crown, bridge, filling, denture, partial or any other appliance. Your comfort and happiness is important to us.

*Discounts do not apply to products or medications sold or recommended by Oakridge Dental Center.

Patients must pay at the time of service. We accept all major credit cards and a Care Credit plan that offers no interest for up to one year. Restrictions may apply to approved Care Credit users and applicants.

This plan does not cover services for injuries covered under workman's compensation, cost of dental care which is covered under automobile medical no-fault or similar insurance.

ENROLLMENT FORM

LAST NAME/FIRST NAME

SPOUSES LAST NAME/FIRST NAME

DEPENDANTS

HOME ADDRESS

CITY/STATE/ZIP CODE

AS A SUBSCRIBER, I WISH TO APPLY FOR MEMBERSHIP IN THE OAKRIDGE DENTAL SOLUTIONS PROGRAM. I UNDERSTAND THAT ALL SERVICES UNDER THIS PROGRAM MUST BE OBTAINED AT OAKRIDGE DENTAL CENTER, AND FURTHER THAT MY CO-PAYMENT WILL BE DUE IN FULL AT THE TIME SERVICE IS RENDERED. THIS IS NOT AN INSURANCE PROGRAM, AND IS SUBJECT TO CHANGE AT THE TIME OF RENEWAL.

SIGNATURE/DATE