ATTENDING DENT	rist	r's st	ATEM	NENT										
CHECK ONE:  DENTIST'S PRE-TREATMENT ESTIMATE								INSURANCE CO. E AND ADDRESS						
L					200	*								
DENTIST'S STATE	EME	ENT OF	ACT	UAL SER	VICES									
1. PATIENT NAME		œ.		2. R SE	RELATIONSHIP TO	EMPLOYEE D   OTHER	3. S	EX 4. PATIENT F MO.   DA	BIRTHDA Y   YEA	ATE R	5. IF	F FULL TIME STUC SCHOOL	DENT	CITY
6. EMPLOYEE/SUBSCRIBER NAM FIRST MIDI	E DLE		L	AST	7. EMPLOYEE SOCIAL SE	E/SUBSCRIBI	ER .	9. NAME OF GI	ROUP DE	NTAL	PRO	GRAM	**	- N
8. EMPLOYEE/SUBSCRIBER MAIL	LING	ADDRESS						10. EMPLOYER	(COM PA	NY) I	MAME	AND ADDRESS	v v	
CITY, STATE, ZIP												•		
11. GROUP NUMBER 12. L	OCAT	ION (LOCA	L) 13.	ARE OTHER FAN	MILY MEMBERS E	MPLOYED? SOC. SEC. N	٥.	14.	NAME	ND /	ADDR	ESS OF EMPLOYER	R IN ITEM 13	
15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN?	DEN	TAL PLAN	NAME	UNION	LOCAL GRO	UP NO.	NAM	E AND ADDRESS	OF CAR	RIER				
I HAVE REVIEWED THE FO				NT PLAN. I A	UTHORIZE RE	LEASE OF	ANY	I HEREBY AU GROUP INSU	THORIZ RANCE	BEN	AYME	ENT DIRECTLY 1	TO THE BELOW PAYABLE TO	- NAMED DENTIST OF THE ME.
SIGNED (PATIENT, OR PARENT IF MINOR) DATE								SIGNED (INSURED PERSON)  24. IS TREATMENT RESULT NO YES IF YES, ENTER BRIEF DESCRIPTION AND DATES						
16. DENTIST NAME								OF OCCUPATIONAL ILLNESS OR INJURY:			163	IF TES, ENTER	BRIEF DESCRIFIN	The same of the sa
17. MAILING ADDRESS								25. IS TREATMENT RESULT OF AUTO ACCIDENT? 26. OTHER ACCIDENT?			-	-	·	
CITY, STATE, ZIP								27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			Ta:	1	7.	<del>, , , , , , , , , , , , , , , , , , , </del>
18. DENTIST SOC. SEC. OR-T.I.I	N.	19. DENT	ST LICEN	NSE NO. 2	O. DENTIST PHO	NE NO.		28. IF PROSTHE THIS INITIAL PLACEMENT	L			(IF NO. REASON	FOR REPLACEME	ENT) 29. DATE OF PRIOR PLACEMENT
21. FIRST VISIT DATE 22. PLAC CURRENT SERIES OFFICE			OTHER	23. RADIOGRA MODELS	APHS OR ENCLOSED?	NO YES	HOW MANY?	30. IS TREATME ORTHODONT	NT FOR			IF SERVICES ALREADY COMMENCED. ENTER	DATE APPLIANCE	S PLACED MOS. TREATMENT REMAINING
IDENTIFY MISSING TEETH WITH "X"	31.	EXAMINA	TION AND	TREATMENT PL	AN - LIST IN ORD	DER FROM TO	оотн	NO. 1 THROUGH	тоотн	NO. 3	32 - U	JSE CHARTING SYS	STEM SHOWN.	FOR
		TOOTH # OR SURFACE		DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS U LINE NO.			SED. ETC.) PERF			ICE			USE ONLY	
FACIAL FA	# 0	R SURFAC	E		RAYS, PROPHYLAX	KIS, MATERIA		ED. ETC.)	PERF	ORME	D	PROCEDURE	FEE	USE ONE!
FACIAL  (C) (S) (S) (S) (S) (S) (S) (S) (S) (S) (S	# 0	R SURFAC	E		RAYS, PROPHYLAX	KIS, MATERIA		ED. ETC.)	PERF	ORME	D		FEE	USE ONE!
FACIAL  (6 7 8 9 10 11  (7 5 0 12  (7 6 7 6 7 13  (7 7 6 7 13  (7 7 7 7 13  (7 7 7 7 7 13  (7 7 7 7 13  (7 7 7 7 13  (7 7 7 7 7 13  (7 7 7 7 7 13  (7 7 7 7 13  (7 7 7 7 13  (7 7 7 7 7 13  (7 7 7 7 7 13  (7 7 7 7 7	# 0	R SURFAC	:E		RAYS, PROPHYLAX LINE 1 2	NO.		SED, ETC.)	PERF	ORME	D		FEE	ose one!
67 8 9 10 11 10 12 10 12 10 13 10 15	# O LETT	R SURFAC	SE '		RAYS, PROPHYLAX LINE 1 2	NO.		ED. ETC.)	PERF	ORME	D		FEE	OSE ONL!
6 8 9 10 11 0 12 0 12 0 12 0 13 0 15 0 15 0 15 0 15 0 15 0 15 0 15	# O LETT	R SURFAC	SE .		RAYS, PROPHYLAX LINE 1 2	NO.		ED. ETC.)	PERF	ORME	D		FEE	OSE ONE!
6 8 9 10 11 0 12 0 12 0 12 0 13 0 15 0 15 0 15 0 15 0 15 0 15 0 15	# O LETT	R SURFAC	E		RAYS, PROPHYLAX LINE I  1 2 6 4	NO.		ED. ETC.)	PERF	ORME	D		FEE	ose one!
6 7 8 9 10 11  C 4 5 DE F G 113  3 C DE F G 113  3 B LINGUAL I 15  16 PERMANENT  PRIMARY  PRIMARY	# O LETT	R SURFAC			1 2 6 4 5 6 2 7	NO.		ED. ETC.)	PERF	ORME	D		FEE	OSE ONE!
67 8 9 10 11 10 12 10 12 10 13 10 15	# O LETT	R SURFAC	E		RAYS, PROPHYLAX LINE I  1 2 6 4	NO.		ED. ETC.)	PERF	ORME	D		FEE	OSE ONE!
6 7 8 9 10 11  5 0 1 12  3 0 0 1 15  3 0 0 1 15  3 0 0 1 15  3 0 0 0 15  3 0 0 0 15  4 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	# O LETT	R SURFAC	E		1 2 6 4 5 6 2 7	NO.		ED. ETC.)	PERF	ORME	D		FEE	
6 7 8 9 10 11  5 0 1 12  3 0 0 1 15  3 0 0 1 15  3 0 0 1 15  3 0 0 0 15  3 0 0 0 15  4 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	# O LETT	R SURFAC	E		1 2 6 4 5 6 2 7	NO.		ED. ETC.)	PERF	ORME	D		FEE	
6 7 8 9 10 11  5 0 1 12  3 0 0 1 15  3 0 0 1 15  3 0 0 1 15  3 0 0 0 15  3 0 0 0 15  4 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	# O LETT	R SURFAC	E		EAYS. PROPHYLAX LINE 1  2 6 4 5 6 7 8	NO.		ED. ETC.)	PERF	ORME	D		FEE	
6 7 8 9 10 11  5 0 1 12  3 0 0 1 15  3 0 0 1 15  3 0 0 1 15  3 0 0 0 15  3 0 0 0 15  4 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	# O LETT	R SURFAC	E		EXPANS. PROPHYLAX LINE I  I  2  6  4  5  7  8  1  1  1  1  1  1  1  1  1  1  1  1	NO.		ED. ETC.)	PERF	ORME	D		FEE	
6 7 8 9 10 11  5 0 1 12  3 0 0 1 15  3 0 0 1 15  3 0 0 1 15  3 0 0 0 15  3 0 0 0 15  4 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	# O LETT	R SURFAC	E		RAYS. PROPHYLAX LINE 1  2 6 4 5 6 7 8 8 9 10 11 12 13 14	NO.		ED. ETC.)	PERF	ORME	D		FEE	
6 7 8 9 10 11  5 0 1 12  3 0 0 1 15  3 0 0 1 15  3 0 0 1 15  3 0 0 0 15  3 0 0 0 15  4 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	# O LETT	R SURFAC	E		EXPANS. PROPHYLAX LINE I  I  2  6  4  5  7  8  1  1  1  1  1  1  1  1  1  1  1  1	NO.		ED. ETC.)	PERF	ORME	D		FEE	
6 7 8 9 10 11  5 0 1 12  3 0 0 1 15  3 0 0 1 15  3 0 0 1 15  3 0 0 0 15  3 0 0 0 15  4 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	# O LETT	R SURFAC	E		RAYS. PROPHYLAX LINE 1  2 6 4 5 6 7 8 8 9 10 11 12 13 14	NO.		ED. ETC.)	PERF	ORME	D		FEE	
6 7 8 9 10 11  5 0 1 12  3 0 0 1 15  3 0 0 1 15  3 0 0 1 15  3 0 0 0 15  3 0 0 0 15  4 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	# O LETT	R SURFAC	E		RAYS. PROPHYLAX LINE 1  2 6 4 5 6 7 8 8 9 10 11 12 13 14	NO.		ED. ETC.)	PERF	ORME	D		FEE	
6 7 8 9 10 11  5 0 1 12  3 0 0 1 15  3 0 0 1 15  3 0 0 1 15  3 0 0 0 15  3 0 0 0 15  4 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	# O LETT	R SURFAC	E		RAYS. PROPHYLAX LINE 1  2 6 4 5 6 7 8 8 9 10 11 12 13 14	NO.		ED. ETC.)	PERF	ORME	D		FEE	
6 7 8 9 10 11  6 7 8 9 10 11  3	# O LETY	R SURFACER		(INCLUDING X-R	RAYS. PROPHYLAX LINE I  1 2 6 4 5 7 8 11 12 13 14 15	NO.	ALS US		PERF	ORME	D	NUMBER		
FRIMANENT  32 B LINGUAL  11 B LINGUAL  13 B LINGUAL  14 F G H 134  15 B LINGUAL  15 B LINGUAL  16 PERMANENT  17 B B 10 11  18 B B 10 11  19 B B 10 11  10 B B B B B B B B B B B B B B B B B B B	# O LETY	R SURFACER		(INCLUDING X-R	RAYS. PROPHYLAX LINE I  1 2 6 4 5 7 8 11 12 13 14 15	NO.	LETEC		PERF	ORME	D	NUMBER  TOTAL FEE CHARGED		
FRIMANENT  32 B LINGUAL  11 B LINGUAL  13 B LINGUAL  14 F G H 134  15 B LINGUAL  15 B LINGUAL  16 PERMANENT  17 B B 10 11  18 B B 10 11  19 B B 10 11  10 B B B B B B B B B B B B B B B B B B B	# O LETY	ROCEDUR		NDICATED BY	RAYS. PROPHYLAX LINE I  1 2 6 4 5 7 8 11 12 13 14 15	NO.	ALS US		PERF	ORME	D	TOTAL FEE CHARGED MAX.ALL	OWABLE	
FACIAL  32. REMARKS FOR UNUSUAL SERVICES  1 HEREBY CERTIFY THAT TH	# O LETY	ROCEDUR	ES AS II	NDICATED BY	RAYS. PROPHYLAX LINE I  1 2 6 4 5 7 8 11 12 13 14 15	EEN COMP	LETEC		PERF MO.	DAY I	PEAR	TOTAL FEE CHARGED MAX.ALL DEDUCTI	OWABLE	
FACIAL  32. REMARKS FOR UNUSUAL SERVICES	E PR	ROCEDUR	ES AS II	NDICATED BY	RAYS. PROPHYLAX LINE I  1 2 6 4 5 7 8 11 12 13 14 15	EEN COMP	LETEC		PERF MO.	DAY I	PEAR	TOTAL FEE CHARGED MAX.ALL	OWABLE BLE %	