ATTENDING DENTIST'S STATEMENT

CHECK ONE:

☐ DENTIST'S PRE-TREATMENT ESTIMATE

☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

INSURANCE CO. NAME AND ADDRESS

1. PATIENT NAME | 2. RELATIONSHIP TO EMPLOYEE (SELF | SPOUSE | CHILD | OTHER) | 3. SEX (M | F) | 4. PATIENT BIRTHDATE (MO. | DAY | YEAR) | 5. IF FULL TIME STUDENT (SCHOOL | CITY)

6. EMPLOYEE/SUBSCRIBER NAME (FIRST | MIDDLE | LAST) | 7. EMPLOYEE/SUBSCRIBER SOCIAL SECURITY NO. | 9. NAME OF GROUP DENTAL PROGRAM

8. EMPLOYEE/SUBSCRIBER MAILING ADDRESS | 10. EMPLOYER (COMPANY) NAME AND ADDRESS

CITY, STATE, ZIP

11. GROUP NUMBER | 12. LOCATION (LOCAL) | 13. ARE OTHER FAMILY MEMBERS EMPLOYED? (EMPLOYEE NAME | SOC. SEC. NO.) | 14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13

15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? | DENTAL PLAN NAME | UNION LOCAL | GROUP NO. | NAME AND ADDRESS OF CARRIER

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

SIGNED (PATIENT, OR PARENT IF MINOR) _____ DATE _____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

SIGNED (INSURED PERSON) _____ DATE _____

16. DENTIST NAME

17. MAILING ADDRESS

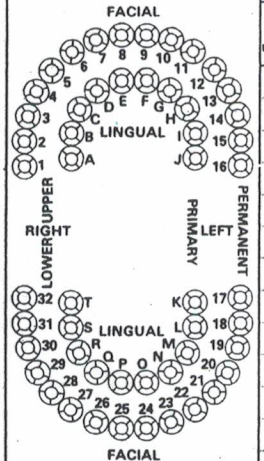
CITY, STATE, ZIP

18. DENTIST SOC. SEC. OR T.I.N. | 19. DENTIST LICENSE NO. | 20. DENTIST PHONE NO.

	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
24. Is Treatment Result Of Occupational Illness Or Injury?			
25. Is Treatment Result Of Auto Accident?			
26. OTHER ACCIDENT?			
27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			(IF NO, REASON FOR REPLACEMENT) 29. DATE OF PRIOR PLACEMENT
30. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED, ENTER: DATE APPLIANCES PLACED; MOS. TREATMENT REMAINING

21. FIRST VISIT DATE CURRENT SERIES | 22. PLACE OF TREATMENT (OFFICE | HOSP. | ECF | OTHER) | 23. RADIOGRAPHS OR MODELS ENCLOSED? (NO | YES | HOW MANY?)

IDENTIFY MISSING TEETH WITH "X"



31. EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 - USE CHARTING SYSTEM SHOWN.

LINE NO.	TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED (MO. DAY YEAR)	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							

32. REMARKS FOR UNUSUAL SERVICES

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED.

SIGNED (DENTIST) _____ DATE _____

TOTAL FEE CHARGED	
MAX. ALLOWABLE	
DEDUCTIBLE	
CARRIER %	
CARRIER PAYS	
PATIENT PAYS	

#1A9380

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