

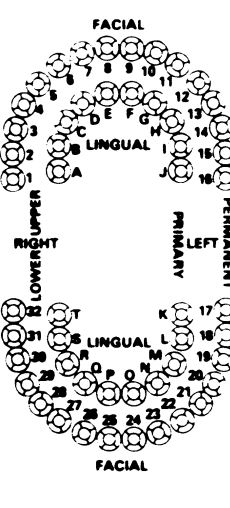
ATTENDING DENTIST'S STATEMENT

Check one: <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual services	Carrier name and address
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PATIENT COVERAGE INFORMATION	1. Patient name first _____ m.i. _____ last _____	2. Relationship to employee <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> other _____	3. Sex m f	4. Patient birthdate MM DD YYYY	5. If full time student school _____ city _____
	6. Employee/subscriber name and mailing address	7. Employee/subscriber soc. sec. or I.D. number	8. Employee/subscriber birthdate MM DD YYYY	9. Employer (company) name and address	10. Group number
	11. Is patient covered by another dental plan? yes no If yes, complete 12-a. Is patient covered by a medical plan? yes no	12-a. Name and address of carrier(s)	12-b. Group no.(s)	13. Name and address of other employer(s)	
	14-a. Employee/subscriber name (if different than patient's)	14-b. Employee/subscriber soc. sec. or I.D. number	14-c. Employee/subscriber birthdate MM DD YYYY	15. Relationship to patient <input type="checkbox"/> self <input type="checkbox"/> parent <input type="checkbox"/> spouse <input type="checkbox"/> other _____	

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment. Signed (Patient, or parent if minor) _____ Date _____	I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity. Signed (Insured person) _____ Date _____
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BILLING DENTIST	16. Name of Billing Dentist or Dental Entity			24. Is treatment result of occupational illness or injury? No Yes			If yes, enter brief description and dates
	17. Address where payment should be remitted City, State, Zip			25. Is treatment result of auto accident?			
	18. Dentist Soc. Sec. or T.I.N.			26. Other accident?			
	19. Dentist license no.		20. Dentist phone no.		27. If prosthesis, is this initial placement?		(If no, reason for replacement)
	21. First visit date current series	22. Place of treatment Office Hosp. ECF Other	23. Radiographs or models enclosed	No Yes	How many?	29. Is treatment for orthodontics?	28. Date of prior placement

Identify missing teeth with "x" 	30. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Use charting system shown.					For administrative use only			
	Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year			Procedure number	Fee	
31. Remarks for unusual services									

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures. Signed (Treating Dentist) _____ License Number _____ Date _____	Total Fee Charged
	Max. Allowable Deductible Carrier % Carrier pays Patient pays

See back of ID card for claim mailing address and customer service phone number.