ATTENDING DENTIST'S STATEMENT

CARRIER NAME AND ADDRESS

CHECK ONE:

☐ DENTIST'S PRE-TREATMENT ESTIMATE
☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

PATIENT SECTION

1. PATIENT NAME — FIRST / M.I. / LAST
2. RELATIONSHIP TO EMPLOYEE — SELF / SPOUSE / CHILD / 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 SOCIAL SECURITY NUMBER
8. EMPLOYEE/SUBSCRIBER BIRTHDATE — MM / DD / YYYY
9. GROUP NUMBER
10. EMPLOYER (COMPANY) NAME AND ADDRESS
11. IS PATIENT COVERED BY ANOTHER PLAN OF BENEFITS? ☐ YES ☐ NO
12-A. NAME AND ADDRESS OF CARRIER(S)
12-B. GROUP NO.(S)
13. NAME AND ADDRESS OF EMPLOYER
14-A. EMPLOYEE/SUBSCRIBER NAME (IF DIFFERENT THAN PATIENTS)
14-B. EMPLOYEE/SUBSCRIBER SOCIAL SECURITY NUMBER
14-C. EMPLOYEE/SUBSCRIBER BIRTHDATE — MM / DD / YYYY
15. RELATIONSHIP TO PATIENT — SELF / SPOUSE / PARENT / OTHER

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

DENTIST SECTION

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

	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 THIS FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED ENTER — DATE APPLIANCES PLACED — MOS. TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH X

32. REMARKS FOR UNUSUAL SERVICES

31. EXAMINATION AND TREATMENT PLAN

DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY

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

▶ SIGNED (DENTIST) DATE

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

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