# ATTENDING DENTIST'S STATEMENT

CHECK ONE:

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

**CARRIER NAME AND ADDRESS**

## 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 RELEASEOF 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.

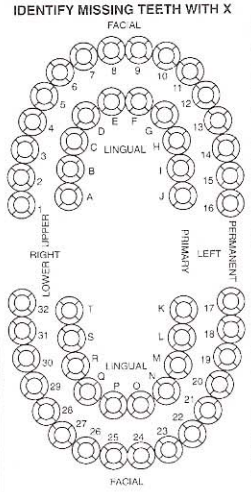
▶ _____ SIGNED (INSURED PERSON) DATE

## 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 PRSTHESIS, 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 | |