

Check one:

- Dentist's pre-treatment estimate
- Dentist's statement of actual services

PATIENT COVERAGE INFORMATION

1. Patient's name first m.i. last	2. Relationship to employee self child spouse 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 self parent spouse 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 directly to the below named dentist of the group insurance benefits otherwise payable to me.

Signed (insured person) _____ Date _____

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		25. Is treatment result of auto accident?			
City, State, Zip		26. Other accident?			
18. Dentist Soc. Sec. or T.I.N.	19. Dentist license no.	20. Dentist phone no.	27. If prosthesis, is this initial placement?	(if no, reason for replacement)	28. Date of prior placement
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?	If services already commenced enter: Date appliances placed Mos. treat. remain.	

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.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed			Procedure number	Fee	For administrative use only
			Mo.	Day	Year			

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.

Total Fee Charged	
Max. Allowable	
Deductible	
Carrier %	

Signed (Treating Dentist) _____ License Number _____ Date _____