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.

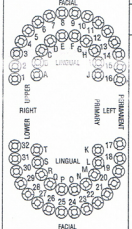
21. FIRST VISIT DATE CURRENT SERIES

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



31. EXAMINATION AND TREATMENT PLAN

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

32. REMARKS FOR UNUSUAL SERVICES

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

SIGNED (DENTIST) — DATE

TOTAL FEE

MAX. ALLOWABLE	
DEDUCTIBLE	
CARRIER %	
CARRIER PAYS	

TFD 1228 REV. 6/97