ATTENDING DENTIST'S STATEMENT

Check one:

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

PATIENT COVERAGE

1. Patient name (first, m.i., last)
2. Relation to insured ☐ 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. 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? If yes, complete 12-a. ☐ Yes ☐ No
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 employer
14-A. Employee / subscriber name (if different than patient's)
14-B. Employee / subscriber soc. sec. number
14-C. Employee / subscriber birthdate MM DD YYYY
15. Relationship to insured ☐ self ☐ child ☐ 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)

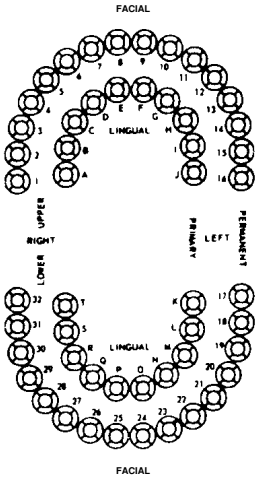
I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.

Signed (Insured person)

BILLING DENTIST

16. Name of Billing Dentist or Dental Entity
17. Address of where payment should be remitted
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 No Yes How Many?
24. Is treatment result of occupational illness or injury? No Yes If yes, enter brief description and dates
25. Auto accident?
26. Other accident?
27. If prosthesis, is this initial placement? (If no, reason for replacement) 28. Date of prior placement
30. Is treatment for orthodontics? If services already commenced, enter: Date appliances placed Mos. treatment remaining

Identify missing teeth with "X"



31. Examination and treatment plan - List in order from tooth No. 1 through tooth No. 32 – Use charting system shown.

Tooth No. or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.) Line No.	Date service performed MM DD YY	Procedure Number	Fee	For administrative use only

31. Remarks for unusual services

"WARNING: Any person who, knowingly and with intent to defraud or deceive an insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud."

I hereby certify that the procedures as indicated by date have been substantially completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

(Treating Dentist) License Number Date

Total Fee Charged	
Max allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

C-815