

**TENDING DENTIST'S STATEMENT**  
**HECK ONE:**  
**PRE-TREATMENT ESTIMATE**  
**STATEMENT OF ACTUAL SERVICES**

CARRIER NAME AND ADDRESS

1. PATIENT NAME: \_\_\_\_\_ CITY: \_\_\_\_\_  
 2. RELATIONSHIP TO EMPLOYEE: SELF  SPOUSE  CHILD  OTHER   
 3. SEX: M  F   
 4. PATIENT BIRTHDATE: MO \_\_\_\_ DAY \_\_\_\_ YEAR \_\_\_\_  
 5. IF FULL TIME STUDENT SCHOOL: \_\_\_\_\_  
 6. EMPLOYEE/SUBSCRIBER NAME: FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ LAST \_\_\_\_\_  
 7. EMPLOYEE/SUBSCRIBER SOCIAL SECURITY NO.: \_\_\_\_\_  
 8. EMPLOYEE/SUBSCRIBER MAILING ADDRESS: \_\_\_\_\_  
 9. NAME OF GROUP DENTAL PROGRAM: \_\_\_\_\_  
 10. EMPLOYER (COMPANY) NAME AND ADDRESS: \_\_\_\_\_

11. GROUP NO.: \_\_\_\_\_  
 12. LOCATION (LOCAL): \_\_\_\_\_  
 13. ARE OTHER FAMILY MEMBERS EMPLOYED? YES  NO  SOC. SEC. NO.: \_\_\_\_\_  
 14. NAME AND ADDRESS OF EMPLOYER IN ITEM (13): \_\_\_\_\_  
 15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? YES  NO   
 16. DENTIST NAME: \_\_\_\_\_  
 17. MAILING ADDRESS: \_\_\_\_\_  
 18. DENTIST SOC. SEC. OR T.I.N.: \_\_\_\_\_  
 19. DENTIST LIC. NO.: \_\_\_\_\_  
 20. DENTIST PHONE NO.: \_\_\_\_\_  
 21. DENTIST PHONE EXT.: \_\_\_\_\_

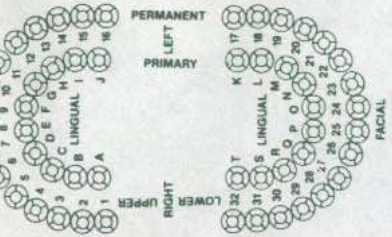
I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

16. DENTIST NAME	17. MAILING ADDRESS	SIGNED (PATIENT, OR PARENT, IF MINOR)		DATE	SIGNED (INSURED PERSON)		DATE
		NO	YES		NO	YES	
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?							IF YES, ENTER BRIEF DESCRIPTION AND DATES
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?							29. DATE OF PRIOR PLACEMENT
30. IS TREATMENT FOR ORTHODONTICS?							MOS. TREATMENT REMAINING

31. 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 MO. DAY YEAR	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY



32. REMARKS FOR UNUSUAL SERVICES: \_\_\_\_\_

SIGNED (DENTIST) \_\_\_\_\_ DATE \_\_\_\_\_

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

FOR PRACTICE USE ONLY