ATTENDING DENTIST'S STATEMENT

Check one:

☐ **Dentist's pre-treatment estimate**

☐ **Dentist's statement of actual services**

Carrier name and address

PATIENT COVERAGE INFORMATION

1. Patient name (first, m.i., last)
2. Relationship to employee: ☐ self ☐ child ☐ spouse ☐ other_____
3. Gender: m f
4. Patient date of birth: MM DD YYYY
5. If full time student: school, city
6. Employee/subscriber name (Last, First, MI, Suffix) and mailing address, city, state, zip code
7. Employee/subscriber SSN or ID #
8. Employee/subscriber date of birth: MM DD YYYY
9. Employer (company) name and address
10. Plan/Group Number
11. Is patient covered by another dental, or medical plan? ☐ yes ☐ no. If yes, complete 12-a through 14-c. If no, skip 12-a through 14-c.
12-a. Name of Policy Holder/Subscriber in #11 (Last name, First Name, MI, Suffix)
12-b. Date of Birth: MM DD YYYY
13-a. Patient's relationship to person named in #11: ☐ self ☐ parent ☐ spouse ☐ other_____
13-b. Gender: ☐ male ☐ female
14-a. Other Insurance Company/Dental Benefit Plan Name and Address
14-b. Policy Holder/Subscriber SSN or ID #
14-c. Plan/Group Number(s)

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

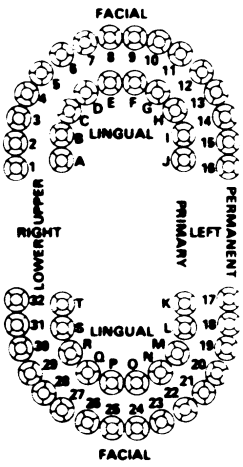
I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

➧ _____ _____
Signed (Insured person) Date

BILLING DENTIST

16. Name of Billing Dentist or Dental Entity
17-a. Address where payment should be remitted
17-b. City, State, Zip
17-c. Dentist phone no.
18. Dentist Soc. Sec. or T.I.N.
19. Dentist license no.
20. NPI
21. First visit date current series
22. Place of treatment: Office Hosp. ECF Other
23. Radiographs or models enclosed: No Yes How many?
24. Is treatment result of occupational illness or injury? No Yes — If yes, enter brief description and dates
25. Is treatment result of auto accident? No Yes
26. Other accident? No Yes
27. If prosthesis, is this initial placement? No Yes — (If no, reason for replacement)
28. Date of prior placement
29. Is treatment for orthodontics? No Yes — If services already commenced enter: Date appliances placed: Mos. treatment remaining

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 Mo.	Day	Year	Procedure number		Fee	

For administrative use only

31-a. Diagnosis Code List Qualifier ☐☐ ICD-9 = B; ICD-10 = AB

31-b. Diagnosis Code(s) (Primary diagnosis in "**A**")
A_____ C_____
B_____ D_____

32. Remarks for unusual services

33. Treating Dentist and Treatment Location Information (Treating Dentist Name and Address)
_____
Treating Dentist Name (Please Print)
Address City State Zip Code Phone Number

Total Fee Charged

Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

34. **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.**

_____ _____ _____ _____
Signature (Treating Dentist) License Number NPI Date