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. 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 _____

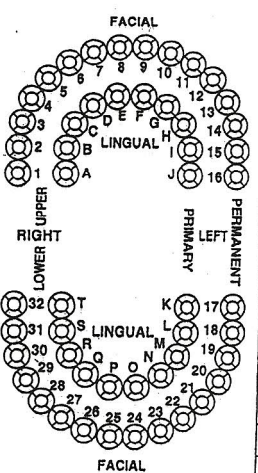
I hereby authorize payment of the dental benefits otherwise payable to me directly to the below-named dental entity.

▶ Signed (Insured person) _____ Date _____

BILLING DENTIST

16. Name of Billing Dentist or Dental Entity
17. Address 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 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?
26. Other accident?
27. If prosthesis, is this initial placement? (If no, reason for replacement)
28. Date of prior placement
29. Is treatment for orthodontics? 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. 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.

▶ Signed (Treating Dentist) _____ License Number _____ Date _____

Total Fee Charged	
Max Allowable	
Deductible	
Carrier %	
Carrier	