# Attending Dentist's Statement

☐ Dentist's pretreatment estimate
☐ Dentist's statement of actual services

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## PATIENT SECTION

| 1. Patient name<br>first m.i. last | 2. Relationship to employee<br>__self __child __spouse __other _____ | 3. Sex<br>__m. __f. | 4. Patient birth date<br>MM DD YYYY | 5. If full time student:<br>school<br>city |
|---|---|---|---|---|
| 6. Employee/subscriber name and mailing address | 7. Employee/subscriber soc. sec. number | 8. Employee/subscriber birth date<br>MM DD YYYY | 9. Employer (company) | 10. Group number name/address |
| 11. Is patient covered by another plan or benefit?<br>Dental _____ Medical _____ | 12-a. Name and address of carrier(s) | 12-b. Group number (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 birth date<br>MM DD YYYY | 15. Relationship to patient<br>__self __child __spouse __other _____ | |

I have received 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 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.

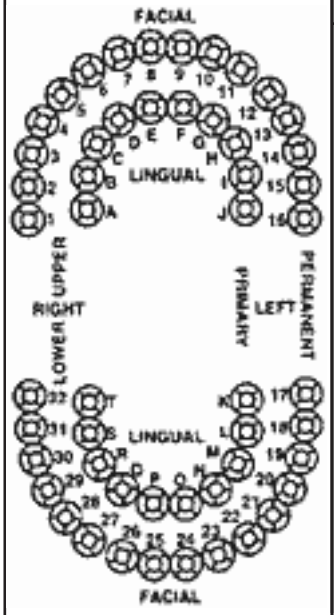
21. First visit date current series

22. Place of treatment: Off. Hosp. ECF Other

23. Radiographs or models enclosed?
☐ Yes How many? _____
☐ No

| | Yes | No | 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 or 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 treatment for orthodontics? | | | If service already commenced enter: Date appliances placed: / Months 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. | Service performed MM. DD. YY. | Procedure number | Fee | For administrative use only |
|---|---|---|---|---|---|---|
| | | | | | | |

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

_____ _____
Signed (dentist) Date

| | |
|---|---|
| **Total Fee Charged** | |
| Max. allowable | |
| Deductible | |
| Carrier % | |
| Carrier pays | |
| Patient pays | |

For your protection California law requires the following to appear on this form:
Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.