ATTENDING DENTIST'S STATEMENT

Check one:							Carrier name and address						
	Dentist's pre-trea	atment	estimate										
\ln	Dentist's stateme			vices									
P	1. Patient name				2. Relationship to e	employee	3. Sex	4. Patie	ent birthda	te	5. If full time st	udent	
P A T	first	m.i.		last	self	child	m,	f MM	, DD	, Y1	YYY school		
Įį					☐ spouse ☐	other					city		
E N T	6. Employee/subscriber	nama a	nd mailing add	troce					0 Employ	or (co	ompany) name and a	ddress 10. Group	numbor
	o. Employee/subscriber	name a	nu mailing auc	11633	Employee/subso soc. sec. or I.D.	number 8. i	Employee/sub pirthdate	scriber	a. Lilipioy	61 (66	mpany) name and a	udiess 10. Gloup	riumbei
١ŏ						N.	IM , DD	YYYY					
ĮĚ													
COVERAGE													
E	11. Is patient covered be dental plan?	y anothe	er 12-a. Na	ame and addi	ress of carrier(s)		12-b. Group	no.(s)			13. Name and a	ddress of other empl	oyer(s)
Ţ	yes no												
Ę	If yes, complete 12-a. Is patient covered by a medical												
K	plan? yes	no no	icai										
NFORMAT	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				15. Relationship to patient		
lт	(ii dillerent than pa	atient s)			soc. sec. or	I.D. number	MM	l DD	, `	YYYY	self	parent	
N											spouse	other	_
I ha	ave reviewed the followi					relating to	I hereby at	thorize pay	yment of	the d	ental benefits other	wise payable to me	directly to the
	s claim. I understand the	at I am r	esponsible fo	or all costs of	dental treatment.		I .	ed dental e	entity.				
•	Named (Detion)	if male					Cimpad (l	annad					
\vdash	Signed (Patient, or parent in 16. Name of Billing Den		ental Entity		Date			A. Is treatment		Yes	If yes, enter brief de	Da scription and dates	ile .
В			,					of occupatio	nal				
L	17. Address where pay	ment sho	ould be remitte	ed .				5. Is treatment		+			
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N	City, State, Zip							6. Other accide	ent?				
G	Oity, Otato, Zip							o. Other accide	ont:				
DE	19 Dantist Son Son or	. T I NI	10 Don	tiat license no	20 Dontiet phone	atiat about as		7 If avanthania	in Abia		(If no, reason for replacement) 28. Date of prior		29 Date of prior
N	N					TIO.	'	7. If prosthesis initial placen			(if no, reason for replacement) 28. Date of price placement		
1	T los sistematical designation of the sistematical designation					. InclyI			0 2011 11		Mary design		
S	21. First visit date current series	Office	ce of treatmen Hosp. EC	t F Other	Radiographs or models enclosed	No Yes How	many?	9. Is treatment orthodontics			If services already commenced	Date appliances placed:	Mos. treatment remaining
_											enter:		
lo	dentify missing teeth with				nt plan - List in order from	tooth no. 1 th	rough tooth no	o. 32 - Use o			_		For administrative
	FACIAL		ooth Surface	Description (including x	Date service performed			Procedure Fee number		use only			
	FACIAL	1 #	or i			. ,				Yea	ar		
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