SAMPLE

Attending Dentist's Statement

Check one:
- ☐ Dentist's pre-treatment estimate
- ☐ Dentist's statement of actual services

Carrier name and address

PATIENT SECTION

1. Patient name (first, m.i., last)	2. Relationship to employee	3. Sex (m f)	4. Patient birthdate (MM DD YYYY)	5. If full time student (school, city)
	☐ self ☐ child ☐ spouse ☐ other			

6. Employee/subscriber name and mailing address	7. Employee/subscriber Soc. Sec. number	8. Employee/subscriber birthdate (MM DD YYYY)	9. Employer (company) name and address	10. Group number

11. Is patient covered by another plan of benefits?	12-a. Name and address of carrier(s)	12-b. Group no.(s)	13. Name and address of employer
Dental _____ Medical _____			

14-a. Employee/subscriber name (if different than patient's)	14-b. Employee/subscriber Soc. Sec. 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

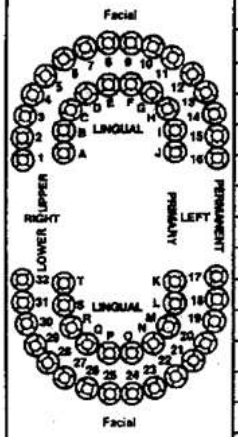
I hereby authorize payment directly to the below-named dentist of the group insurance benefits otherwise payable to me.

▶ _____ Signed (Insured Person) _____ Date

DENTIST SECTION

16. Dentist name	24. Is treatment result of occupational illness or injury?	no	yes	If yes, enter brief description and dates
17. Mailing address	25. Is treatment result of auto accident?			
	26. Other accident?			
City, State, Zip	27. Are any services covered by another plan?			
18. Dentist Soc. Sec. or T.I.N. 19. Dentist license no. 20. Dentist phone no.	28. If prosthesis, is this initial placement?			(If no, reason for replacement) 29. Date of prior placement
21. First visit date current series 22. Place of treatment (Office, Hosp, ECF, Other)	23. Radiographs or models enclosed?	no	yes	How many?
	30. Is treatment for orthodontics?			If services already commenced enter: Date appliances placed; Mos. 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 # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.) line no.	Date service performed (mo. day year)	Procedure number	Fee	For administrative use only
		1				
		2				
		3				
		4				
		5				
		6				
		7				
		8				
		9				
		10				
		11				
		12				
		13				
		14				
		15				

32. 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 (Dentist) _____ Date

Total Fee Charged	
Max allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

Form Approved by the Council on Dental Care Programs

AMERICAN DENTAL ASSOCIATION

FORM 9392 COLWELL SYSTEMS INC CHAMPAIGN IL