ATTENDING DENTIST STATEMENT

CHECK ONE: ☐ **DENTIST PRE-TREATMENT ESTIMATE** ☐ **DENTIST STATEMENT OF ACTUAL SERVICES**

PATIENT SECTION

1. Name of Patient: FIRST _____ MIDDLE _____ LAST _____
2. Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other 3. Sex: ☐ Male ☐ Female
4. Patient birth date:(DD/MM/YY) _____ 5. If full time student: School name:_____ City/Country _____
6. Insured name: _____ 7. Insured's birth date:(DD/MM/YY) _____ 8. Policy Number:_____
9. Mailing Address: _____
10. Is patient covered by another plan of benefits? ☐ Yes ☐ No ☐ Dental ☐ Medical
11. IF YES, name and address of carrier(s): _____ Policy number(s) _____
12. Name & address of employer: _____

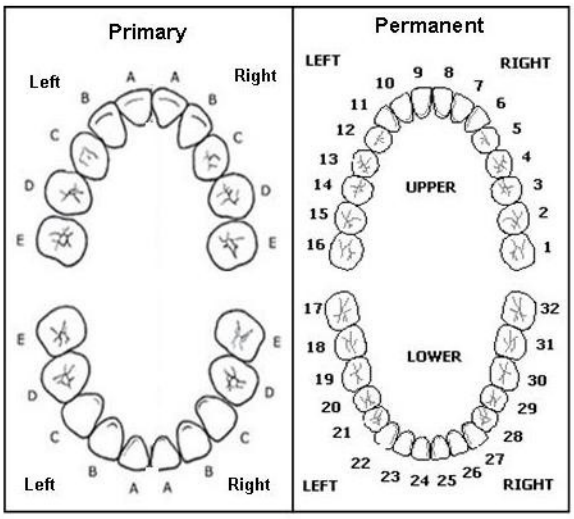
I have reviewed the following treatment plan and hereby authorize release of any information to this claim. I understand that I am responsible for all costs of dental treatment.
Signature of Insured/Patient: _____Date: _____

DENTIST SECTION

1. Dentist Name: _____ 2. Dentist License number: _____
3. Mailing address: _____4. Telephone number: _____5. First date of current series: _____
6. Place of treatment: _____ 7. Radiographs or models enclosed ☐ Yes ☐ No
8. Is treatment a result of occupational illness or injury ☐ Yes ☐ No If YES, state dates and give brief description (separately or on back of form)
9. Is treatment a result of auto accident? ☐ Yes ☐ No If YES, state dates and give brief description (separately or on back of form)
10. Other accident? ☐ Yes ☐ No If YES, state dates and give brief description (separately or on back of form)
11. Are any services covered by another plan? ☐ Yes ☐ No If YES, provide details (separately or on back of form)
12. If prosthesis, is this initial replacement? ☐ Yes ☐ No If NO state reason for replacement: _____
13. Date of prior replacement: _____ 14: Is treatment for Orthodontics? ☐ Yes ☐ No

If service already commenced, state date appliance was placed: _____ Date of prior placement:_____ Months of remaining treatment:_____

IDENTIFY MISSING TEETH WITH AN "X"



Remarks for unusual services: _____

EXAMINATION AND TREATMENT PLAN-LIST IN ORDER OF TOOTH NO. 1 THROUGH NO. 32

TOOTH NUMBER/ LETTER	SURFACE	DESCRIPTION OF SERVICE X-rays, prophylaxis, materials used etc. LINE NUMBER	DATE SERVICE PERFORMED (DD/MM/YY)	PROCEDURE NUMBER	FEE
		1.			
		2.			
		3.			
		4,			
		5,			
		6.			
		7.			
		8.			
		9.			
		10.			
		11.			
		12.			
		13.			
		14.			
		15.			

I hereby certify that the procedures as indicated by date have been completed.

Total Fee Charged

_____
Dentist signature