ATTENDING DENTIST'S STATEMENT

CHECK ONE:

☐ **DENTIST'S PRE-TREATMENT ESTIMATE**

☐ **DENTIST'S STATEMENT OF ACTUAL SERVICES**

1. PATIENT NAME	2. RELATIONSHIP TO EMPLOYEE SELF | SPOUSE | CHILD | OTHER	3. SEX M | F	4. PATIENT BIRTHDATE MO. | DAY | YEAR	5. IF FULL TIME STUDENT SCHOOL CITY

6. EMPLOYEE/SUBSCRIBER NAME FIRST MIDDLE LAST	7. EMPLOYEE/SUBSCRIBER SOCIAL SECURITY NO.	9. DATE OF EMPLOYMENT	PHONE NO. AT WORK

8. EMPLOYEE/SUBSCRIBER MAILING ADDRESS	10. EMPLOYER (COMPANY NAME AND ADDRESS
CITY, STATE, ZIP	

11. GROUP NUMBER	12. LOCATION (LOCAL)	13. ARE OTHER FAMILY MEMBERS EMPLOYED? EMPLOYEE NAME SOC. SEC. NO	14. NAME AND ADDRESS OF EMPLOYER IN ITEM 13.

15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN?	DENTAL PLAN NAME	UNION LOCAL	GROUP NO.	NAME AND ADDRESS OF CARRIER

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I CERTIFY TO THE ABOVE STATEMENTS, AND TO MY ELIGIBILITY FOR BENEFITS UNDER THIS PLAN, AND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES IF NOT COVERED BY THE PLAN.

SIGNED (PATIENT, OR PARENT IF MINOR) _____ DATE _____

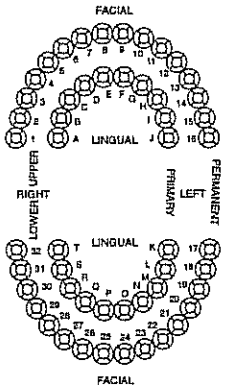
I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME.

SIGNED (INSURED PERSON) _____ DATE _____

16. DENTIST NAME	24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
17. MAILING ADDRESS	24. 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 TIN. 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	30. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED. ENTER DATE APPLIANCES PLACED MOS. TREATMENT REMAINING

23. RADIOGRAPHS OR MODELS ENCLOSED?	NO	YES	HOW MANY?

IDENTIFY MISSING TEETH WITH AX≡



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 BENEFIT CALCULATIONS
		1				
		2				
		3				
		4				
		5				
		6				
		7				
		8				
		9				
		10				
		11				
		12				
		13				
		14				
		15				

32. REMARKS FOR UNUSUAL SERVICES

33. TO BE COMPLETED BY DENTIST AI 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.≡

DENTIST'S SIGNATURE _____ DATE _____

TOTAL FEE CHARGED	
MAX ALLOWABLE	
DEDUCTIBLE	
COB	
COMPANY %	
COMPANY PAYS	
PATIENT PAYS	
INDIV DED TO DATE	
FAMILY DED TO DATE	

TOTAL PAID TO DATE	

SEND TO: **LIFETIME BENEFIT SOLUTIONS**
Address noted on the back of the ID card.

Jmsqr-dent