ATTENDING DENTIST'S STATEMENT

CHECK ONE:

☐ DENTIST'S PRE-TREATMENT ESTIMATE

☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

CARRIER-NAME AND ADDRESS

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.

8. NAME OF GROUP DENTAL PROGRAM

9. EMPLOYEE/SUBSCRIBER MAILING ADDRESS

CITY, STATE, ZIP

10. EMPLOYER (COMPANY) NAME AND ADDRESS

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.

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 _____

16. DENTIST NAME

RICHARD A. RICHARDS II

17. MAILING ADDRESS

266 Mobil Avenue, Suite 209

CITY, STATE, ZIP

CAMARILLO, CA 93010

18. DENTIST SOC. SEC. OR T.I.N. 19. DENTIST LICENSE NO. 20. DENTIST PHONE NO.

TIN 770206057 SS#545-35-4507 32983 805-987-6167

21. FIRST VISIT DATE 22. PLACE OF TREATMENT | CURRENT SERIES | OFFICE | HOSP | ECF | OTHER |

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

24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? | NO | YES | IF YES, ENTER BRIEF DESCRIPTION AND DATES

25. IS TREATMENT RESULT OF AUTO ACCIDENT?

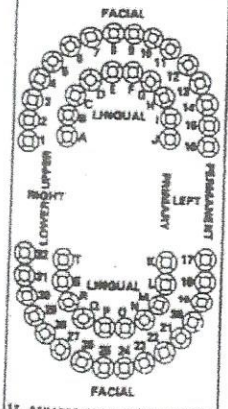
26. OTHER ACCIDENT?

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 SERVICES ALREADY COMMENCED, ENTER | DATE APPLIANCES PLACED | MOS TREATMT REMAINING

IDENTIFY MISSING TEETH WITH "X"



32. REMARKS FOR UNUSUAL SERVICES

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

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED.

SIGNED (DENTIST) _____ DATE _____

TOTAL FEE CHARGED	
MAX. ALLOWABLE	
DEDUCTIBLE	
CARRIER %	
CARRIER PAYS	