

PATIENT SECTION		ATTENDING DENTIST'S STATEMENT <input type="checkbox"/> PRE-DETERMINATION / PRIOR AUTHORIZATION <input type="checkbox"/> STATEMENT OF ACTUAL SERVICES	PATIENT ACCOUNT NUMBER
1. PATIENT NAME (LAST) (FIRST) (INITIAL)		2. RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT	
3. SEX <input type="checkbox"/> M <input type="checkbox"/> F	4. PATIENT BIRTH DATE MONTH DAY YEAR	5. IF FULL TIME STUDENT CITY STATE	7. SUBSCRIBER IDENTIFICATION NUMBER
6. SUBSCRIBER NAME (LAST) (FIRST) (INITIAL)		SUBSCRIBER HOME PHONE NUMBER ()	SUBSCRIBER WORK PHONE NUMBER ()
8. SUBSCRIBER ADDRESS (STREET OR RFD NUMBER, CITY, STATE, ZIP CODE)		9. EMPLOYER NAME AND ADDRESS (STREET, CITY, STATE, ZIP)	
10. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		DENTAL PLAN NAME	UNION LOCAL GROUP NUMBER
NAME AND ADDRESS OF OTHER INSURANCE COMPANY			
I hereby accept the treatment below and authorize release of any information relating to this claim.			
PATIENT/PARENT OR EMPLOYEE-MEMBER SIGNATURE X		DATE	

DENTIST SECTION		PLEASE PROVIDE TOOTH NUMBERS WHEN REQUIRED	
11. DENTIST NAME AND ADDRESS (STREET, CITY, STATE, ZIP)		16. IS TREATMENT A RESULT OF OCCUPATIONAL INJURY? YES NO	IF YES, ENTER BRIEF DESCRIPTION AND DATES
12. NPI		17. IS TREATMENT A RESULT OF AUTO ACCIDENT? OTHER ACCIDENT?	
13. DENTIST LICENSE NUMBER	14. TAX ID NUMBER	18. IS TREATMENT FOR ORTHODONTICS?	IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED MONTHS TREATMENT REMAINING
15. PHONE NUMBER		19. IF PROTHESIS, IS THIS INITIAL PLACEMENT?	IF NO, REASON FOR REPLACEMENT 20. DATE OF PRIOR PLACEMENT

DIAGNOSTIC AND TREATMENT RECORD LIST IN TOOTH ORDER (1 - 32 OR A - T) ARE X-RAYS OR OTHER REVIEW DOCUMENTS ATTACHED? YES NO 21. PLACE OF TREATMENT OFFICE HOSPITAL OTHER

TOOTH # OR LETTER	QUAD	SURFACES	DESCRIPTION OF SERVICE	COMPLETION DATE MONTH / DATE / YEAR	DIAGNOSES CODE	PROCEDURE CODE	CHARGE
			1.)				
			2.)				
			3.)				
			4.)				
			5.)				
			6.)				
			7.)				
			8.)				
			9.)				

22. IDENTIFY ALL MISSING TEETH WITH AN X:		TOTAL																																																																													
<table border="1" style="display: inline-table; margin-right: 20px;"> <tr><td colspan="16" style="text-align: center;">PERMANENT</td></tr> <tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td></tr> <tr><td>32</td><td>31</td><td>30</td><td>29</td><td>28</td><td>27</td><td>26</td><td>25</td><td>24</td><td>23</td><td>22</td><td>21</td><td>20</td><td>19</td><td>18</td><td>17</td></tr> </table> <table border="1" style="display: inline-table;"> <tr><td colspan="10" style="text-align: center;">PRIMARY</td></tr> <tr><td>A</td><td>B</td><td>C</td><td>D</td><td>E</td><td>F</td><td>G</td><td>H</td><td>I</td><td>J</td></tr> <tr><td>T</td><td>S</td><td>R</td><td>Q</td><td>P</td><td>O</td><td>N</td><td>M</td><td>L</td><td>K</td></tr> </table>	PERMANENT																1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	PRIMARY										A	B	C	D	E	F	G	H	I	J	T	S	R	Q	P	O	N	M	L	K	LESS THIRD PARTY PAYMENTS
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I hereby certify that the services listed above have been completed and to the best of my knowledge are within the provisions of the plan, payment is therefore due.		NET CHARGE																																																																													
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