NAME OF INSURANCE COMPANY

INSURANCE COMPANY ADDRESS
PHONE NUMBER

PATIENT NAME	RELATIONSHIP TO EMPLOYEE *Self Spouse Child Other*	SEX M F	PATIENT BIRTH DATE	IF FULL TIME STUDENT *School City*

EMPLOYEEE / MEMBER/SUSCRIBER NAME (First, Middle, Last)	EMPLOYEE SOCIAL SECURITY NO	EMPLOYEE BIRTH DATE

EMPLOYEE MAILING ADDRESS	COMPANY (EMPLOYER NAME AND ADDRESS AND OR/DIVISION)

ACCOUNT/POLICY #	IS SPOUSE OR OTHER FAMILY MEMBER EMPLOYED ? Yes No If yes, Member's Name SOCIAL SECURITY NUMBER	NAME AND ADDRESS OF SPOUSE'S OR OTHER FAMILY MEMBER'S EMPLOYER	SPOUSE BIRTHDATE

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

AUTHORIZATION TO RELEASE INFORMATION-I hereby authorize any Provider, Insurer or other Organization to release any information regarding the dental history,treatment, or benefits payable for this claim to the Plan Administrator or its authorized agent for the purpose of determining benefits payable. This authorization or a copy shall be valid for one year from the date of signature	X SIGNED (Patient or Parent if Minor)	DATE
AUTHORIZATION TO PAY BENEFITS TO DENTIST – I hereby authorize payment directly to the below named Dentist of the Dental Benefits otherwise payable to me.	X SIGNED (EMPLOYEE)	DATE
CERTIFICATION – I certify that the foregoing information is true and correct	X SIGNED (EMPLOYEE)	DATE

DENTIST NAME
MAILING ADDRESS
CITY,STATE,ZIP

TAX I.D. # TO BE USED FOR TAX REPORTING	TAX ID #	SOC. SEC#
DENTIST LICENSE NO.	DENTIST PHONE NO.	

FIRST VISIT DATE CURRENT SERIES	PLACE OF TREATMENT OFFICE	RADIOGRAPHS OR MODELS ENCLOSED? ?	HOW MANY?

	NO	YES
IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY ?		
IS TREATMENT RESULT OF AUTO ACCIDENT? OTHER ACCIDENT?		
IF PROSTHESIS, IS THIS INITIAL PLACEMENT?		
IS TREATMENT FOR ORTHODONTICS?		

CHECK ONE:

- PREDETERMINATION OF BENEFITS
- STATEMENT OF ACTUAL SERVICES

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THE FEES INDICATED ARE THOSE ACTUALLY CHARGED THE PATIENT REGARDLESS OF THE EXISTENCE OF INSURANCE COVERAGE.

SIGNED (DENTIST) DATE