INSURANCE FORM -

CHECK ONE:

☐ DENTIST'S PRE-TREATMENT ESTIMATE

☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

INSURANCE COMPANY NAME AND ADDRESS

PATIENT'S PORTION

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. NAME OF GROUP DENTAL PROGRAM

8. EMPLOYEE/SUBSCRIBER MAILING ADDRESS

CITY, STATE, ZIP

10. EMPLOYER (COMPANY) NAME AND ADDRESS

11. GROUP NO.

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? 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.

X

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.

X

SIGNED (INSURED PERSON) DATE

16. DENTIST NAME

17. MAILING ADDRESS

CITY, STATE, ZIP

18. DENTIST (SOC. SEC. OR T.I.N.)

19. DENTIST LIC. NO.

20. DENTIST PHONE NO.

21. FIRST VISIT DATE CURRENT SERIES

22. PLACE OF TREATMENT: OFFICE | HOSP. | ECF | OTHER

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

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

IDENTIFY MISSING TEETH WITH "X"

FACIAL — LINGUAL — UPPER — LOWER — RIGHT — LEFT — PRIMARY — PERMANENT — FACIAL

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 LET.	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) LINE NO.	DATE SERVICE PERFORMED MO. DA. YEAR	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY
		1				
		2				
		3				
		4				
		5				
		6				
		7				
		8				
		9				
		10				
		11				
		12				
		13				
		14				
		15				
		16				
		17				
		18				
		19				
		20				

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

SIGNED (DENTIST) DATE

TOTAL FEE CHARGED	
MAX. ALLOWABLE	
DEDUCTIBLE	
CARRIERS %	
CARRIER PAYS	
PATIENT PAYS	

Form Approved by the Council on Dental Care Programs of the A.D.A. 1975

FORM NO. 522-D HISTACOUNT CORPORATION, MELVILLE, L.I., N.Y.