INSURANCE MANAGEMENT SERVICES

P.O. Box 15688 • Amarillo, TX 79105

CHECK ONE:

☐ DENTIST'S PRETREATMENT ESTIMATE

☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

1 PATIENT NAME (FIRST MIDDLE INITIAL LAST)	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 NAME (FIRST MIDDLE INITIAL LAST)	7 EMPLOYEE SOCIAL SECURITY NUMBER	8 GROUP NAME (e.g. EMPLOYER NAME)

9 CITY STATE ZIP	

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

14 IS PATIENT COVERED BY ANOTHER DENTAL PLAN? YES ➔ NO IF YES	GROUP NAME	UNION LOCAL	GROUP NO.	NAME AND ADDRESS OF PROVIDER OF BENEFITS

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS THIS REQUEST.

▶ _____ _____

SIGNED (PATIENT OR PARENT IF MINOR) DATE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST FOR THE SERVICES DESCRIBED BELOW.

▶ _____ _____

SIGNED (EMPLOYEE OR AUTHORIZED PERSON) DATE

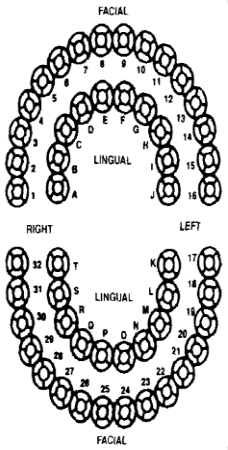
15 DENTIST NAME	16 MAILING ADDRESS	17 CITY STATE ZIP

18 DENTIST SOC SEC NO OR TIN	19 DENTIST LICENSE 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 OF OCCUPATIONAL ILLNESS OR INJURY?			
25 IS TREATEMENT 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



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

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

_____

SIGNED (DENTIST) DATE

TOTAL FEE CHARGED	
DEDUCTIBLE	
Balance	
At %	
At %	
AMOUNT PAYABLE	

Completed By: