STAPLE X-RAYS FOR ALL MAJOR SERVICES TO TOP LEFT CORNER OF FORMS. X-RAYS MUST BE LABELED WITH PATIENT NAME, DENTIST NAME AND ADDRESS.

DELTA DENTAL®

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809
www.deltadentalins.com

PLEASE MAKE SURE EMPLOYEE'S MAILING ADDRESS IS LEGIBLE, CURRENT & COMPLETE

1. PATIENT NAME

2. RELATIONSHIP TO PATIENT: SELF | SPOUSE | CHILD | OTHER

3. SEX: M | F

4. PATIENT BIRTHDATE: MO. | DAY | YEAR

5. IF FULL TIME STUDENT: SCHOOL | CITY

6. PRIMARY ENROLLEE EMPLOYEE/ NAME: FIRST | MIDDLE | LAST

7. PRIMARY ENROLLEE ID NUMBER

7A. PRIMARY ENR. BIRTHDATE: MO. | DAY | YEAR

9. NAME OF GROUP DENTAL PROGRAM

8. ENROLLEE MAILING ADDRESS

7B. SPOUSE BIRTHDATE: MO. | DAY | YEAR

10. EMPLOYER (COMPANY) NAME AND ADDRESS

CITY, STATE, ZIP

11. EMPLOYEE GROUP NUMBER

12. LOCATION (LOCAL)

13. ARE OTHER FAMILY MEMBERS EMPLOYED? ENROLLEE NAME | ENROLLEE ID NUMBER

14. NAME AND ADDRESS OF EMPLOYER, ITEM 13

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

16. DENTIST NAME

17. MAILING ADDRESS

CITY, STATE, ZIP

IS THIS ADDRESS NEW? YES ☐ NO ☐

18. DENTIST SOC. SEC. NO. OR T.I.N.

19. DENTIST LICENSE NO.

20. DENTIST PHONE NO.

	NO	YES
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, ENTER REASON FOR REPLACEMENT.		

IF YES, ENTER BRIEF DESCRIPTION AND DATES

29. DATE OF PRIOR PLACEMENT

21. FIRST VISIT DATE CURRENT SERIES

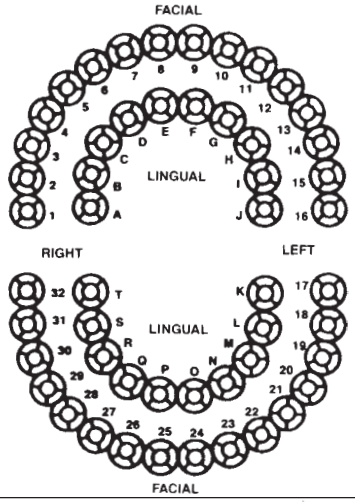
22. PLACE OF TREATMENT: OFFICE | HOSP | ECF | OTHER

23. RADIOGRAPHS OR MODEL ENCLOSED? NO ☐ YES ☐ | HOW MANY?

30. IS TREATMENT FOR ORTHODONTICS? NO | YES

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 RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 USING CHARTING SYSTEM SHOWN.

TOOTH # OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE COMPLETED MO.	DAY	YEAR		PROCEDURE NUMBER	FEE		

I ACCEPT THIS ATTENDING DENTIST'S STATEMENT AND AUTHORIZE RELEASE OF INFORMATION RELATING HERETO. I CERTIFY THE TRUTH OF ALL PERSONAL INFORMATION CONTAINED ABOVE. I AGREE TO BE RESPONSIBLE FOR PAYMENT FOR SERVICES PROVIDED DURING ANY INELIGIBLE PERIOD.

PATIENT (PARENT OR ENROLLEE) SIGNATURE X _____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED DENTIST OF THE BENEFITS OTHERWISE PAYABLE TO ME.

X _____
ENROLLEE SIGNATURE | DATE

TOTAL FEE CHARGED	
PATIENT PAYS	
PLAN PAYS	
AMOUNT APPLIED TO DEDUCTIBLE	

NOTICE: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

PREDETERMINATION OF COST

THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGMENT AND I REQUEST PREDETERMINATION OF BENEFITS.

DENTIST SIGNATURE | DATE

TREATMENT COMPLETED - PAYMENT REQUESTED

THE TREATMENT LISTED WAS COMPLETED ON DATES INDICATED AND WAS NECESSARY IN MY PROFESSIONAL JUDGMENT.

DENTIST SIGNATURE | DATE

ATTENDING DENTIST'S STATEMENT