ATTENDING DENTIST'S STATEMENT

CHECK ONE:

☐ DENTIST'S PRE-TREATMENT ESTIMATE

☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

INSURANCE CO. NAME AND ADDRESS
Camden County Council 10 Freedom of Choice
c/o Dr. Kernan's Office
Cuthbert Blvd. & MacArthur Blvd.
Westmont, NJ 08108

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.
8. EMPLOYEE/SUBSCRIBER MAILING ADDRESS
CITY, STATE, ZIP
9. NAME OF GROUP DENTAL PROGRAM
10. EMPLOYER (COMPANY) NAME AND ADDRESS

11. GROUP NUMBER
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? — DENTAL PLAN NAME — 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.

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.

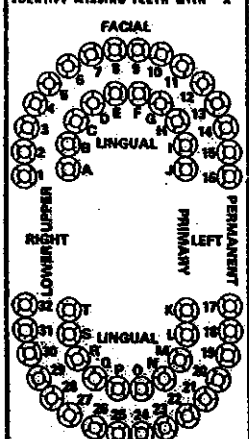
SIGNED (INSURED PERSON) — DATE

16. DENTIST NAME
17. MAILING ADDRESS
CITY, STATE, ZIP
18. DENTIST SOC. SEC. OR T.I.N.
19. DENTIST LICENSE NO.
20. DENTIST PHONE NO.

	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

21. FIRST VISIT DATE — CURRENT SERIES
22. PLACE OF TREATMENT — OFFICE | HOSP. | ECF | OTHER
23. RADIOGRAPHS OR MODELS ENCLOSED? — NO | YES | HOW MANY?

IDENTIFY MISSING TEETH WITH "X"



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 NO.	DAY	YEAR	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY
		1						
		2						
		3						
		4						
		5						
		6						
		7						
		8						
		9						
		10						
		11						
		12						
		13						
		14						
		15						

32. REMARKS FOR UNUSUAL SERVICES

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

SIGNED (DENTIST) — DATE

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

Medical Arts Press, Mpls., Mn. 55427