

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.		9. NAME OF GROUP DENTAL PROGRAM				
8. EMPLOYEE/SUBSCRIBER MAILING ADDRESS CITY, STATE, ZIP					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.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

_____ SIGNED (PATIENT, OR PARENT IF MINOR) _____ DATE _____

_____ SIGNED (INSURED PERSON) _____ DATE _____

16. DENTIST NAME		24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES			
17. MAILING ADDRESS CITY, STATE, ZIP		25. IS TREATMENT RESULT OF AUTO ACCIDENT?							
		26. OTHER ACCIDENT?							
		27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?							
18. DENTIST SOC. SEC. OR T.I.N.		19. DENTIST LICENSE NO.		20. DENTIST PHONE NO.		28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?		(IF NO. REASON FOR REPLACEMENT)	29. DATE OF PRIOR PLACEMENT
21. FIRST VISIT DATE CURRENT SERIES		22. PLACE OF TREATMENT OFFICE HOSP. ECF OTHER		23. RADIOGRAPHS OR MODELS ENCLOSED? NO YES HOW MANY?		30. IS TREATMENT FOR ORTHODONTICS?		IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED MOS. TREATMENT REMAINING	

<p>IDENTIFY MISSING TEETH WITH "X"</p> <p>32. REMARKS FOR UNUSUAL SERVICES</p>	31. EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 - USE CHARTING SYSTEM SHOWN.						FOR ADMINISTRATIVE USE ONLY	
	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		
	1							
	2							
	3							
	4							
	5							
	6							
	7							
	8							
	9							
	10							
	11							
	12							
	13							
	14							
15								

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