Attending Dentist's Statement

Check one:
- ☐ Dentist's pre-treatment estimate
- ☐ Dentist's statement of actual services

Carrier name and address

PATIENT SECTION

1. Patient name (first, m.i., last)
2. Relationship to employee: ☐ self ☐ child ☐ spouse ☐ other
3. Sex: m f
4. Patient birthdate: MM DD YYYY
5. If full time student: school, city
6. Employee/subscriber name and mailing address
7. Employee/subscriber Soc. Sec. number
8. Employee/subscriber birthdate: MM DD YYYY
9. Employer (company) name and address
10. Group number
11. Is patient covered by another plan of benefits? Dental ____ Medical ____
12-a. Name and address of carrier(s)
12-b. Group no.(s)
13. Name and address of employer
14-a. Employee/subscriber name (if different than patient's)
14-b. Employee/subscriber Soc. Sec. number
14-c. Employee/subscriber birthdate: MM DD YYYY
15. Relationship to patient: ☐ self ☐ parent ☐ spouse ☐ other

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

▶X ____ Signed (Patient, or Parent if Minor) ____ Date

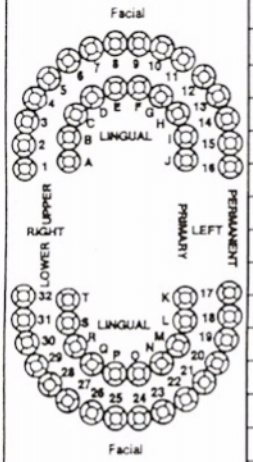
I hereby authorize payment directly to the below-named dentist of the group insurance benefits otherwise payable to me.

▶X ____ Signed (Insured Person) ____ Date

DENTIST SECTION

16. Dentist name: MARK W. BARTOSH, DDS
17. Mailing address: 1011 AUGUSTA DR. SUITE 208
City, State, Zip: HOUSTON, TX 77057
18. Dentist Soc. Sec. or T.I.N.
19. Dentist license no.
20. Dentist phone no.: (713)780-3427
21. First visit date current series
22. Place of treatment: Office X, Hosp, ECF, Other
23. Radiographs or models enclosed? no X, yes, How many?
24. Is treatment result of occupational illness or injury? no, yes — If yes, enter brief description and dates
25. Is treatment result of auto accident? no, yes
26. Other accident? no, yes
27. Are any services covered by another plan? no, yes
28. If prosthesis, is this initial placement? no, yes — (If no, reason for replacement)
29. Date of prior placement
30. Is treatment for orthodontics? no, yes — If services already commenced enter: Date appliances placed; Mos. treatment remaining

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 mo. 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 and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

▶ ____ Signed (Dentist) ____ Date

Total Fee Charged	
Max allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

Form Approved by the Council on Dental Care Programs

AMERICAN DENTAL ASSOCIATION

FORM 9392 COLWELL SYSTEMS INC CHAMPAIGN IL