

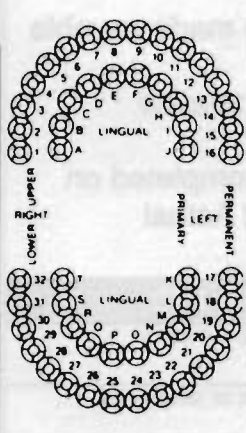


# PATIENT'S INFORMATION

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 NAME FIRST MIDDLE LAST				7 EMPLOYEE SOC. SEC. NO.			9 NAME OF GROUP DENTAL PROGRAM					
8 EMPLOYEE MAILING ADDRESS							10 EMPLOYER (COMPANY) NAME AND ADDRESS					
CITY, STATE, ZIP												
11a DATE OF BIRTH EMPLOYEE		11b DATE OF BIRTH SPOUSE		12 ARE ANY DEPENDENTS EMPLOYED <input type="checkbox"/> YES <input type="checkbox"/> NO		DEPENDENT SOC. SEC. NO.		13 NAME AND ADDRESS OF EMPLOYER IN ITEM 12				
14 IS PATIENT COVERED BY ANOTHER DENTAL PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO			DENTAL PLAN NAME		EFFECTIVE DATE		GROUP NO.		NAME AND ADDRESS OF EMPLOYER			
IS PATIENT COVERED BY A MEDICAL PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO			MEDICAL PLAN NAME		EFFECTIVE DATE		GROUP NO.		NAME AND ADDRESS OF CARRIER			
14a. I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT. I UNDERSTAND THAT BENEFITS WILL BE PAID DIRECTLY TO ME UNLESS THE BOX BELOW (14b) IS SIGNED. Any person who knowingly and with intent to defraud any insurance company or other person files and application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty five thousand dollars and the stated value of the claim for each such violation.												
SIGNED EMPLOYEE						DATE						
14b. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.							15 I HAVE RECEIVED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM					
SIGNED (PATIENT OR PARENT IF MINOR)							SIGNED					
							DATE					

DENTIST'S PRE-TREATMENT ESTIMATE
DENTIST'S INFORMATION
 STATEMENT OF ACTUAL SERVICES

16 DENTIST NAME				24 IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES	
17 MAILING ADDRESS				25 IS TREATMENT RESULT OF AUTO ACCIDENT?					
CITY, STATE, ZIP				26 OTHER ACCIDENT?					
18 DENTIST SOC. SEC. OR TIN		19 DENTIST LICENSE NO.		20 DENTIST PHONE NO.		28 IF PROSTHESIS, IS THIS INITIAL PLACEMENT?		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	

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 NO. OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC) LINE NO	DATE SERVICE PERFORMED MO DAY YEAR			PROCEDURE NUMBER	*USUAL FEE	MAXIMUM PREFERRED PROVIDER CHARGE
			1						
			2						
			3						
			4						
			5						
			6						
			7						
			8						
			9						
			10						
			11						
			12						
	32 REMARKS FOR UNUSUAL SERVICES  ORTHODONTICS (give diagnosis, class of malocclusion and describe appliance(s) in above treatment section) DATE FIRST APPLIANCE INSERTED _____ DATE LAST APPLIANCE REMOVED _____ TREATMENT PERIOD (NUMBER MONTHS) _____ TOTAL FEE \$ _____								

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED		TOTAL FEE CHARGED	
Signed (Dentist) _____		Date _____	
		CHARGES	
		CHARGES	
		LESS DEDUCTIBLE	
		TOTAL BENEFIT	
		OTHER INS. ADJ.	
		NET BENEFIT	

\* "If you are a J.J. Newman Dental Preferred Provider, please indicate your usual charge for each procedure."