

# Attending Dentist's Statement



**DIRECT DENTAL ADMINISTRATORS, LLC**  
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<input type="checkbox"/> Dentist's pretreatment estimate
<input type="checkbox"/> Dentist's statement of actual services

## PATIENT SECTION

1. Patient name First M.I. Last		2. Relationship to employee <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse		3. Sex <input type="checkbox"/> m <input type="checkbox"/> f	4. Patient birth date MM DD YYYY	5. If full time student: School City
6. Employee/subscriber name and mailing address		7. Employee/subscriber SS number	8. Employee/subscriber birth date MM DD YYYY		9. Employer (company)	10. Group number name/address
11. Is patient covered by another plan or benefit? Dental _____ Medical _____		12-a. Name and address of carrier(s)		12-b. Group number (s)	13. Name and address of employer	
14-a. Employee/subscriber name (if different than patient's)		14-b. Employee/subscriber SS number	14-c. Employee/subscriber birth date MM DD YYYY		15. Relationship to patient <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> other	
I have received 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.				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 _____		

## DENTIST SECTION

16. Dentist name			24. Is treatment result of occupational illness or injury?		Yes	No	If yes, enter brief description and dates	
17. Mailing address: City State Zip			25. Is treatment result of auto accident?					
18. Dentist SS or T.I.N.			19. Dentist license no.		20. Dentist phone no.		26. Other or accident?	
21. First visit date current series			22. Place of treatment Off. Hosp. ECF Other		23. Radiographs or models enclosed? <input type="checkbox"/> Yes How many? <input type="checkbox"/> No _____		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 service already commenced enter: Date appliances placed: Months 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.						For administrative use only
	Tooth no. or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.) Line no.	Service performed MM. DD. YY.	Procedure number	Fee	

I hereby certify that the procedure as indicated by date have been completed and that the fees submitted are actual fees I have charged and intend to collect for those procedures.  Signed (dentist) _____ Date _____		Total Fee Charged	
		Max. allowable	
		Deductible	
		Carrier %	
		Carrier pays	
For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.		Patient pays	