**STAPLE X-RAYS FOR ALL MAJOR SERVICES TO TOP LEFT CORNER OF FORMS. X-RAYS MUST BE LABELED WITH PATIENT NAME, DENTIST NAME AND ADDRESS.**

Delta Dental Insurance Company

P.O. Box 1809
Alpharetta, GA 30023-1809
www.deltadentalins.com

PLEASE MAKE SURE EMPLOYEE'S MAILING ADDRESS IS LEGIBLE, CURRENT & COMPLETE

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 SOCIAL SECURITY NUMBER**

7A. EMPLOYEE BIRTHDATE: MO. | DAY | YEAR

9. NAME OF GROUP DENTAL PROGRAM

**8. EMPLOYEE MAILING ADDRESS**

7B. SPOUSE BIRTHDATE: MO. | DAY | YEAR

10. EMPLOYER (COMPANY) NAME AND ADDRESS

**CITY, STATE, ZIP**

**11. EMPLOYEE GROUP NUMBER** | 12. LOCATION (LOCAL) | 13. ARE OTHER FAMILY MEMBERS EMPLOYED? EMPLOYEE NAME | SOC. SEC. NO. | 14. NAME AND ADDRESS OF EMPLOYER, ITEM 13

15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? | DENTAL PLAN NAME | UNION LOCAL | GROUP NO. | NAME AND ADDRESS OF CARRIER

**16. DENTIST NAME**

**17. MAILING ADDRESS**

**CITY, STATE, ZIP** — **IS THIS ADDRESS NEW?** YES ❑ 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?** | | | |

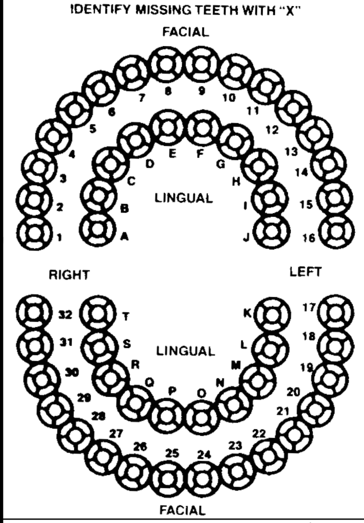
**18. DENTIST SOC. SEC. NO. OR T.I.N.** | **19. DENTIST LICENSE NO.** | **20. DENTIST PHONE NO.**

**28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? IF NO, ENTER 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 MODEL ENCLOSED?** NO ❑ YES ❑ | HOW MANY?

**30. IS TREATMENT FOR ORTHODONTICS?** NO | YES | **IF SERVICES ALREADY COMMENCED ENTER ⟶** | **DATE APPLIANCES PLACED** | **MOS. TREATMENT REMAINING**

**IDENTIFY MISSING TEETH WITH "X"**




32. REMARKS FOR UNUSUAL SERVICES

31. EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 USING CHARTING SYSTEM SHOWN.

| TOOTH # OR LETTER | SURFACES | **DESCRIPTION OF SERVICE** (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.) | **DATE SERVICE COMPLETED** MO. | DAY | YEAR | | **PROCEDURE NUMBER** | **FEE** |
|---|---|---|---|---|---|---|---|---|
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I ACCEPT THIS ATTENDING DENTIST'S STATEMENT AND AUTHORIZE RELEASE OF INFORMATION RELATING HERETO. I CERTIFY THE TRUTH OF ALL PERSONAL INFORMATION CONTAINED ABOVE. I AGREE TO BE RESPONSIBLE FOR PAYMENT FOR SERVICES PROVIDED DURING ANY INELIGIBLE PERIOD.

PATIENT (PARENT OR EMPLOYEE) SIGNATURE **X** ____________________

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED DENTIST OF THE BENEFITS OTHERWISE PAYABLE TO ME.

**X** ____________________
EMPLOYEE SIGNATURE DATE

| | |
|---|---|
| **TOTAL FEE CHARGED** | |
| **PATIENT PAYS** | |
| **PLAN PAYS** | |
| **AMOUNT APPLIED TO DEDUCTIBLE** | |

***NOTICE:*** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**PREDETERMINATION OF COST**

THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGMENT AND I REQUEST PREDETERMINATION OF BENEFITS.

DENTIST SIGNATURE DATE

**TREATMENT COMPLETED - PAYMENT REQUESTED**

THE TREATMENT LISTED WAS COMPLETED ON DATES INDICATED AND WAS NECESSARY IN MY PROFESSIONAL JUDGMENT.

DENTIST SIGNATURE DATE

**ATTENDING DENTIST'S STATEMENT**

FORM 3105 (REV. 5-02)