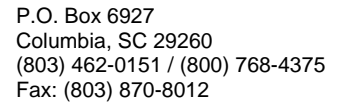


☐ Dentist's Pre-Treatment Estimate  
☐ Dentist's Statement of Actual Services



|   |  |   |     |  |   |  |  |                 |   |   |  |       |   |  |  |  |  |  |
|---|--|---|-----|--|---|--|--|-----------------|---|---|--|-------|---|--|--|--|--|--|
| 1. PATIENT NAME (First, Initial, Last)  |  |   |     | 2. Relationship to Employee<br>Self   Spouse   Child   Other |   |  |  | 3. Sex<br>M   F |   | 4. Patient Birthdate<br>Mo.   Day   Year  |  |       | 5. If full-time student:<br>School   City |  |  |  |  |  |
| 6. Employee/Subscriber Name (First, Middle, Last)   |  |   |     |  |   |  |  |                 | 7. Employee UMID # (on front of member's PAI ID card) |   |  |       |   |  |  |  |  |  |
| Spouse's Name   |  |   |     |  |   |  |  |                 | Spouse's Birthdate                                    |   |  | Month | Day                                       | Year   |  |  |  |  |
| 8. Employee Mailing Address<br><br>City   State   Zip   |  |   |     |  |   |  | 9. Employer (Company) Name and Address |                 |   |   |  |       |   |  |  |  |  |  |
| 10. Group No.   |  | 11. Are other family members employed? Yes No<br>If "yes," employee name: |     |  |   |  |  |                 |   |   |  |       |   | 12. Name and address of employer in item 11. |  |  |  |  |
| Birthdate:  |  | Mo.   | Day | Year   | Social Security Number:                   |  |  |                 |   |   |  |       |   |  |  |  |  |  |
| 13. Is patient covered by another Dental Plan?  |  | Dental Plan Name  |     |  | Group Number                              |  | Name and Address of Carrier            |                 |   |   |  |       |   |  |  |  |  |  |
| I have reviewed the following plan. I authorize release of any information relative to this claim to the insurer. |  |   |     |  | I hereby certify to the above statements. |  |  |                 |   | I hereby authorize payment directly to the below named dentist of the group benefits otherwise payable to me. This authorization is invalid unless the tax ID of the provider is given below. |  |       |   |  |  |  |  |  |
| Signed (Patient or Parent if Minor) _____ Date _____  |  |   |     |  | Employee Signature _____ Date _____       |  |  |                 |   | Employee Signature _____ Date _____   |  |       |   |  |  |  |  |  |

|                                     |                        |      |       |       |  |     |     |           |   | No  | Yes | If yes, enter brief description and dates   |  |  |                                 |
|-------------------------------------|------------------------|------|-------|-------|--|-----|-----|-----------|---|---|-----|---|--|--|---------------------------------|
| 14. Dentist Name                    |                        |      |       |       | 22. Is treatment result of occupational illness or injury? |     |     |           |   |   |     |   |  |  |                                 |
| 15. Mailing Address                 |                        |      |       |       | 23. Is treatment result of auto accident?                  |     |     |           |   |   |     |   |  |  |                                 |
| 24. Other accident?                 |                        |      |       |       |  |     |     |           |   |   |     |   |  |  |                                 |
| City                                |                        |      | State |       |  | Zip |     |           | 25. Are any services covered by another plan? |   |     |   |  |  |                                 |
| 16. Dentist Soc. Sec. or EIN        |                        |      |       |       | 17. Dentist License No.                                    |     |     |           |   | 26. If prosthesis, is this initial placement? |     |   |  |  | If no, reason for replacement:: |
| 18. Dentist Phone No.               |                        |      |       |       |  |     |     |           |   | 27. Date of prior placement:                  |     |   |  |  |                                 |
| 19. First visit date current series | 20. Place of Treatment |      |       |       | 21. Radio-graphs or models enclosed?                       | No  | Yes | How many? | 28. Treatment for Orthodontics?               |   |     | If services already commenced:<br>Date of case diagnosis:<br>Date appliances placed:<br>Mos. treatment remaining: |  |  |                                 |
|                                     | Office                 | Home | Hosp  | Other |  |     |     |           |   |   |     |   |  |  |                                 |

The diagram illustrates the human dental arch with teeth numbered 1 through 32. The upper arch (maxilla) is labeled 'UPPER' and the lower arch (mandible) is labeled 'LOWER'. The right side of the upper arch is labeled 'RIGHT' and the left side is labeled 'LEFT'. The right side of the lower arch is labeled 'RIGHT' and the left side is labeled 'LEFT'. The teeth are classified into 'FACIAL' (outer) and 'LINGUAL' (inner) sides. The teeth are also classified into 'PRIMARY' (deciduous) and 'PERMANENT' (permanent) teeth. The diagram shows the arrangement of teeth in the dental arch, with the central incisors at the front and the molars at the back.

| 29. Examination and Treatment Plan—List in Order From Tooth No. 1 through Tooth No. 32. Use Charting System Shown |         |   |                 |     |     |                      |     |                         |
|---|---------|---|-----------------|-----|-----|----------------------|-----|-------------------------|
| Tooth #<br>or letter  | Surface | DESCRIPTION OF SERVICE<br><small>(including X-Rays, Prophylaxis Materials Used, Etc.)</small> | Date of Service |     |     | ADA<br>Procedure No. | Fee | For Carrier<br>Use Only |
|   |         |   | Mo.             | Day | Yr. |                      |     |                         |
|   |         |   |                 |     |     |                      |     |                         |
|   |         |   |                 |     |     |                      |     |                         |
|   |         |   |                 |     |     |                      |     |                         |
|   |         |   |                 |     |     |                      |     |                         |
|   |         |   |                 |     |     |                      |     |                         |
|   |         |   |                 |     |     |                      |     |                         |
|   |         |   |                 |     |     |                      |     |                         |
|   |         |   |                 |     |     |                      |     |                         |
|   |         |   |                 |     |     |                      |     |                         |
|   |         |   |                 |     |     |                      |     |                         |
|   |         |   |                 |     |     |                      |     |                         |
|   |         |   |                 |     |     |                      |     |                         |
|   |         |   |                 |     |     |                      |     |                         |
|   |         |   |                 |     |     |                      |     |                         |
|   |         |   |                 |     |     |                      |     |                         |
| <b>Total fee actually charged</b>   |         |   |                 |     |     |                      |     |                         |

I hereby certify that the procedures as indicated by date have been completed.

\* Signed (Dentist) \_\_\_\_\_ Date\_\_\_\_\_