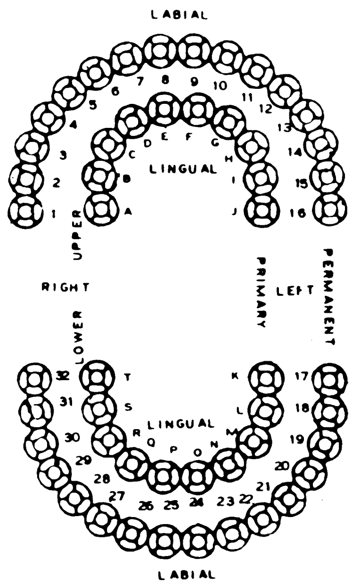
PART II TO BE COMPLETED BY PROVIDER (ENTER CHARGE FOR EACH ITEM AS APPROPRIATE)

PATIENT'S NAME	PATIENT'S RELATIONSHIP TO EMPLOYEE	PATIENT'S BIRTHDATE MONTH | DAY | YEAR	DATE OF PATIENT'S FIRST VISIT (CURRENT SERIES)

			Yes	No
DENTIST'S NAME LICENSE NO.	INDIV. PRACTITIONERS – SS#	IS PATIENT COVERED BY OTHER PLAN? (NAME OTHER PLAN)		
DENTIST'S MAILING ADDRESS PHONE NO.	ALL OTHERS – EMPLOYER I.D. #	IS ANY OF TREATMENT FOR ORTHODONTIC PURPOSES?		
CITY STATE ZIP.	Must be furnished under authority of law	TREATMENT RESULT OF ACCIDENT?		
		RESULT OF OCCUPATIONAL INJURY?		

IF PROSTHESIS, IS THIS INITIAL PLACEMENT?	YES	NO	(IF NO, REASON FOR REPLACEMENT)	DATE OF PRIOR PLACEMENT



INDICATE MISSING TEETH WITH AN "X"

IS THIS STATEMENT
- ☐ STATEMENT OF ACTUAL CHARGES
- ☐ A PREDETERMINATION OF BENEFITS?

REMARKS FOR UNUSUAL SERVICES

EXAMINATION AND TREATMENT RECORD – LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32

TOOTH *# or Letter	Sur-faces	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS MATERIALS USED, ETC.)	Date Service Performed MO / DAY / YR.			Procedure Number	Fee	ESTIMATE OF BENEFITS
						Total Fee Actually Charged		

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 $ ____________________

Dentist Signature ________________________________

Date ________________________________