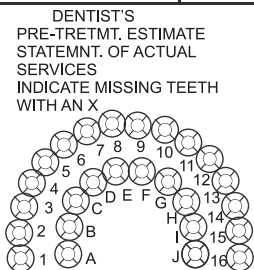


## PATIENT'S INFORMATION

1. PATIENT NAME		2. RELATIONSHIP	3. SEX	4. PATIENT BIRTHDAY	5. MARITAL STATUS SINGLE MARRIED DIVORCED WIDOWED	
6. (IF FULL TIME STUDENT) SCHOOL NAME			ADDRESS		CITY	ZIP
7. EMPLOYEE/SUCRIBER NAME FIRST MIDDLE LAST			8. SOCIAL SECURITY #	9. EMPLOYEE'S HOME PHONE		
10. EMPLOYEE/SUBSCRIBER MAILING ADDRESS					CITY	STATE, ZIP
11. EMPLOYER (COMPANY) NAME			ADDRESS		CITY	STATE, ZIP
12. GROUP NUMBER	13. LOCATION (LOCAL)	14. ARE OTHER FAMILY MEMBERS EMPLOYED		YES <input type="checkbox"/> NO <input type="checkbox"/>	SOCIAL SECURITY NO.	
15. EMPLOYER (COMPANY) NAME			ADDRESS		CITY	STATE, ZIP
16. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/>		DENTAL PLAN NAME	UNION LOCAL	GROUP NO.	NAME AND ADDRESS OF CARRIER	
16. A I AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.				16. B I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM		
SIGNED (PATIENT OR PARENT OF MINOR)			DATE		SIGNED (PATIENT OR PARENT OF MINOR)	
					DATE	

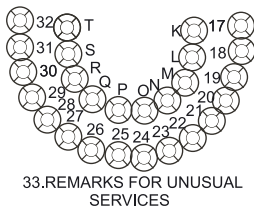
## DENTIST INFORMATION

17. DENTIST NAME		25. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES	
18. MAILING ADDRESS		26. IS TREATMENT RESULT OF AUTO ACCIDENT?					
CITY, STATE, ZIP		27. OTHER ACCIDENT?					
19. DENTIST SS# OR T.I.N.		20. DENTIST LIC. #	21. DENTIST PHONE#	28. ARE SERVICES COVERED BY ANOTHER PLAN?			
						(IF NO, REASON FOR REPLACEMENT)	30. DATE OF PRIOR PLACEMENT
22. FIRST VISIT DAY	23. PLACE OF TREATMENT OFFC.; HOSP; ECF; OTHER	24. RADIOGRAPHS OR MODELS ENCLOSED?	NO	YES	31. IS TREATMENT FOR ORTHODONTICS?		
					IF SERVICES ALREADY COMMENCED	DATE PLACED	APPLIANCES REMAINING



32. EXAMINATION AND TREATMENT PLAN-LIST IN ORDER FROM TOOTH NO. 1 THROUGH NO. 32-USE CHARTING SYSTEM

TOOTH # OR LETTER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAY, MATERIALS, PROPHYLAXIS...)	DATE SERVICE PERFORMED	PROCEDURE	FEE	INSURANCE USE
		1.				
		2.				
		3.				
		4.				
		5.				
		6.				
		7.				
		8.				
		9.				
		10.				
		11.				
		12.				
		13.				
		14.				
		15.				



I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED.

SIGNED (DENTIST)	DATE	TOTAL CHARGED	
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