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®

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 PATIENT: SELF | SPOUSE | CHILD | OTHER
3. SEX: M | F
4. PATIENT BIRTHDATE: MO. | DAY | YEAR
5. IF FULL TIME STUDENT: SCHOOL | CITY

6. PRIMARY ENROLLEE EMPLOYEE/ NAME: FIRST | MIDDLE | LAST
7. PRIMARY ENROLLEE ID NUMBER
7A. PRIMARY ENR. BIRTHDATE: MO. | DAY | YEAR
9. NAME OF GROUP DENTAL PROGRAM

8. ENROLLEE 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? ENROLLEE NAME | ENROLLEE ID NUMBER
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

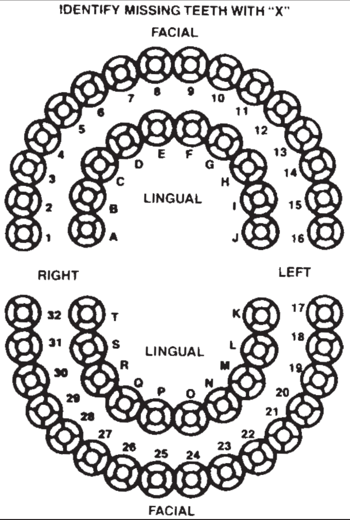
IS THIS ADDRESS NEW? YES ❑ NO ❑

	NO	YES	
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			IF YES, ENTER BRIEF DESCRIPTION AND DATES
25. IS TREATMENT RESULT OF AUTO ACCIDENT?			
26. OTHER ACCIDENT?			
27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?			
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? IF NO, ENTER REASON FOR REPLACEMENT.			29. DATE OF PRIOR PLACEMENT
30. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED ENTER ⟶ DATE APPLIANCES PLACED / MOS. TREATMENT REMAINING

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

21. FIRST VISIT DATE CURRENT SERIES
22. PLACE OF TREATMENT: OFFICE | HOSP | ECF | OTHER
23. RADIOGRAPHS OR MODEL ENCLOSED? NO ❑ YES ❑ | HOW MANY?

IDENTIFY MISSING TEETH WITH "X"



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

32. REMARKS FOR UNUSUAL SERVICES

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 ENROLLEE) SIGNATURE X ______________________

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

X ______________________
ENROLLEE 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. 6-06)