ATTENDING DENTIST'S STATEMENT | ***FOR DELTA DENTAL USE ONLY:***

CHECK ONE: ☐ FOR PREDETERMINATION ☐ FOR PAYMENT

DELTA DENTAL®

Delta Dental of Oklahoma
PO BOX 548809
OKLAHOMA CITY, OK 73154-8809
405-607-2100 - 800-522-0188 *(OUTSIDE OKC)*

PATIENT SECTION

1. PATIENT NAME:

2. RELATIONSHIP TO MEMBER: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

3. MALE ☐ FEMALE ☐

4. PATIENT BIRTHDATE: – –

5. IF FULL TIME STUDENT: SCHOOL CITY

6. EMPLOYEE/SUBSCRIBER NAME:

7. EMP./SUB. SOC. SEC. NO.:

EMP./SUB. BIRTHDATE: – –

9. NAME OF GROUP DENTAL PLAN:

8. EMPLOYEE/SUBSCRIBER MAILING ADDRESS:

TELEPHONE NO:

CITY, STATE, ZIP

10. EMPLOYER (COMPANY) NAME & ADDRESS:

CITY, STATE, ZIP

11. GROUP NUMBER:

12. LOCATION (LOCAL):

13. ARE OTHER FAMILY MEMBERS EMPLOYED? IF YES, EMPLOYEE NAME:

SOCIAL SEC. NO.:

BIRTHDATE: – –

14. NAME & ADDRESS OF EMPLOYER IN ITEM 13:

EMPLOYER TELEPHONE NO.:

15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN: ☐ YES ☐ NO

DENTAL PLAN NAME:

UNION LOCAL:

GROUP NO.:

NAME & ADDRESS OF CARRIER:

16. I have reviewed the folllowing treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefits plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

Signed (Parent or Guardian) Date

17. I hereby authorize payment directly to the above-named dentist of the group insurance benefits otherwise payable to me.

Signed (Employee/Subscriber) Date

DENTIST SECTION

18. NAME OF BILLING DENTIST OR DENTAL ENTITY:

19. ADDRESS:

20. CITY, STATE, ZIP:

21. DENTIST SOC. SEC. # OR TIN:

22. DENTIST LIC. NO.:

23. PHONE:

24. FIRST VISIT DATE CURRENT SERIES:

25. PLACE OF TREATMENT: OFFICE HOSP ECF OTHER

26. RADIOGRAPHS OR MODELS ENCL.? YES NO QTY.

27. Is treatment a result of occupational illness or injury? NO ☐ YES ☐ If yes, enter brief description and dates:

28. Is treatment the result of an auto accident? NO ☐ YES ☐

29. Other accident? NO ☐ YES ☐

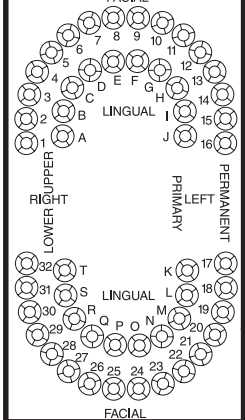
30. If prothesis, is this initial placement? NO ☐ YES ☐ If no, reason for placement:

31. DATE OF PRIOR PLACEMENT: – –

32. Is treatment for orthodontics? NO ☐ YES ☐ If service has already commenced, enter the: Date appliances placed: Months of treatment remaining:

DIAGNOSTIC SECTION

33. I.D MISSING TEETH with "X" - Administrative:



34. EXAMINATION AND TREATMENT PLAN - List in order from TOOTH 1 to TOOTH 32 Using charting system below:

TOOTH #/LTR	SURFACE	DESCRIPTION OF SERVICE *(INCL. X-RAYS, PROPHYLAXIS, MATERIALS USED)*	DATE SERVICE PERFORMED	PROCEDURE #	FEE

35. Remarks for unusual services:

38. Total fee charged:	
39. Payment by other plan:	
Max. Allowable:	
Deductable:	
Carrier %:	
Carrier Pays:	
Patient Pays:	

36. I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures:

Signed (Treating Dentist) License No. Date

37. Address where treatment was performed: City State Zip