PART 1 DENTIST

Dentist's Name	Patient's Last Name	Given Names
Address	Address	Apt.
City, Province	City, Province	
Postal Code	Postal Code	
Telephone		

Date of Service D M Y	Int. Tooth Code	Procedure Code	Tooth Surfaces	Laboratory Charge	Dentist's Fee	Total Charge

This is an accurate statement of services performed and fees charges. E. & OE.	Total Submitted Fee
Dentist's Signature	Date: Day Month Year

FOR DENTIST'S USE ONLY.

For additional information Re: diagnosis, procedures or complications and special considerations.

I understand that the fees listed in this claim may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to my dentist for the entire cost of the treatment. I authorize release of the information contained in this claim form to my insuring company or its agents.	I hereby assign benefits payable from this claim to the above named dentist and authorize payment directly to him.
Signature of Patient (or Parent/Guardian)	Signature of Subscriber

FOR PLAN ADMINSTRATOR USE ONLY:

NOTICE TO DENTIST:

Please Note – Under the terms of the Policy, this report must be forwarded to the Company within 90 days of the date of the accident. Your co-operation will be appreciated.

CLAIM APPROVED:

Day Month Year

Assessor

PART 2. DENTIST'S SUPPLEMENTARY REPORT

1. Description of Damage

2. Is further treatment indicated? NO ☐ YES ☐ If "Yes" please indicate:

Int. Tooth Code		Treatment Indicated – use procedure code if possible	Est. Date – Treatment Day	Mo.	Yr.

3. Describe further potential problems and indicate time frame.

Date: Day Month Year

Dentist's Signature

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL