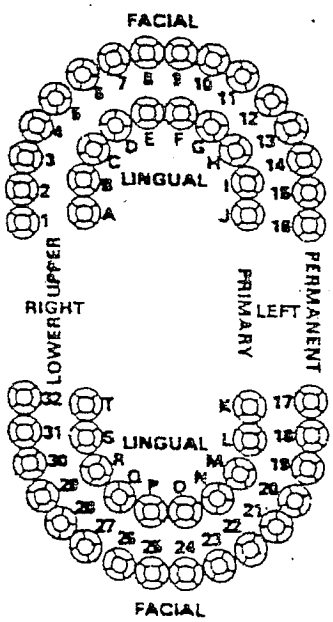
Patient Name	sex	birthdate (mm-dd-yy)	If full-time student: school, city	Medicaid ID
Mailing address:		City, State, Zip		Caseworker name:
Is patient covered by another plan? Y N	Name and address of Carrier			Group number

Dentist Name:		Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief description and date
Mailing Address:		Is treatment result of auto accident?			
City, State, Zip:		Other Accident?			
Phone Number:		Are any services covered by another plan?			
Dentist Soc Sec or T.I.N.	Dentist License Number	If prosthesis, is this initial placement?			
First visit date:	Place of treatment:				

IDENTIFY MISSING TEETH WITH "X"



32. REMARKS FOR UNUSUAL SERVICES

Examination and treatment plan–list in order from tooth no. 1 through tooth no. 32–use charting system shown

tooth # or letter	surface	description of service (including x-rays, prophylaxis, materials used, etc. Line no.	Date service performed (mm-dd-yy)			procedure number	fee
		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 and that the fees submitted are the actual fees I have charged and intend to collect for these procedures.

signed (dentist) _____ date _____

☐ 6 month recall ☐ 9 month recall

☐ 12 month recall

total fee charged	
max allowable	
deductible	
carrier %	
carrier pays	
patient pays	