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 ENROLLEE: 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

CITY, STATE, ZIP

7B. SPOUSE BIRTHDATE: MO. | DAY | YEAR

10. EMPLOYER (COMPANY) NAME AND ADDRESS

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 ❑

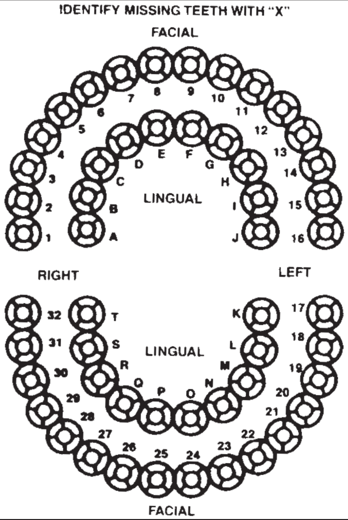
	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
24. **IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?**			
25. **IS TREATMENT RESULT OF AUTO ACCIDENT?**			
26. **OTHER ACCIDENT?**			
27. **ARE ANY SERVICES COVERED BY ANOTHER PLAN?**			
28. **IF PROSTHESIS, IS THIS INITIAL PLACEMENT? IF NO, ENTER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

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?

30. **IS TREATMENT FOR ORTHODONTICS?** NO | YES | **IF SERVICES ALREADY COMMENCED ENTER ⟶** | **DATE APPLIANCES PLACED** | **MOS. TREATMENT REMAINING**

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)