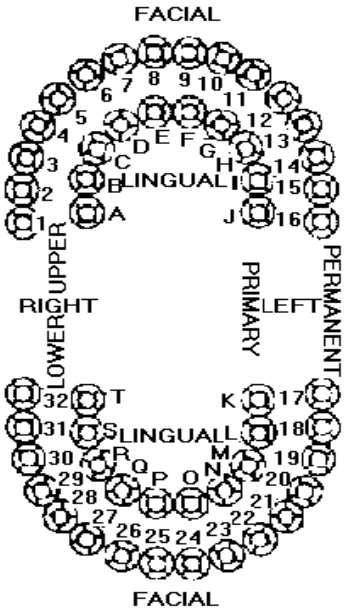
Date exam scheduled: _____

Patient Name:	Sex	Birth date (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 the result of an occupational illness or injury?:	No	Yes	If yes, enter a brief description and date
Mailing Address:		Is treatment the result of an auto accident?			
City, State, Zip:		Other Accident?			
Phone Number:		Are any services covered by another plan?			
Dentist SSN or TIN:	Dentist License No.:	If prosthesis, is this initial placement?			
First Visit Date:	Place of Treatment:				

IDENTIFY MISSING TEETH WITH AN "X"



32. REMARKS FOR UNUSUAL SERVICE

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 by line number. (including x-rays, prophylaxis, materials used, etc.)	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

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

☐ 6 month recall

☐ 9 month recall

☐ 12 month recall