

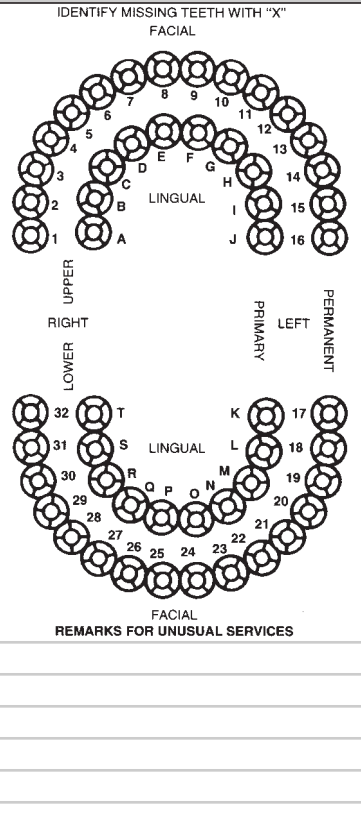
One Delta Drive
Mechanicsburg, PA 17055-6999
(717) 766-8500 (800) 932-0783 (TTY/TDD 888-373-3582)

EMPLOYEE MUST COMPLETE ITEMS 1 THROUGH 15

| | | | | | | | | | |
|---------------------------------|--|--|--|---|--|--|--|--|--|
| 1. PATIENT NAME | | 2. RELATIONSHIP TO EMPLOYEE SELF SPOUSE CHILD OTHER | | 3. SEX M F | | 4. PATIENT BIRTHDATE MO. DAY YEAR | | 5. IF FULL TIME STUDENT OVER 19 YEARS OF AGE, GIVE SCHOOL CITY | |
| 6. EMPLOYEE/SUBSCRIBER NAME | | LAST | | FIRST | | MIDDLE INT. | | 7. EMPLOYEE SOCIAL SECURITY NUMBER | |
| 8. EMPLOYEE HOME ADDRESS | | CITY, STATE ZIP | | ZIP CODE | | 9. EMPLOYER (COMPANY) NAME AND ADDRESS | | | |
| 10. GROUP NUMBER | | IF PATIENT COVERED BY ANOTHER DENTAL PLAN COMPLETE ITEMS 11 THROUGH 15 | | 11. DELTA - COVERED EMPLOYEE BIRTH DATE MO. DAY YEAR | | 12. SPOUSE NAME | | 13. SPOUSE BIRTHDATE MO. DAY YEAR | |
| 14. NAME AND ADDRESS OF CARRIER | | | | | | | | 15. SPOUSE SOCIAL SECURITY NUMBER | |

- OR 1 _____
- OR 2 _____
- OR 3 _____
- OR 4 _____
- OR 5 _____
- OR 6 _____

| | | | | | | |
|--|--|--|--|---|-----|---|
| DENTIST NAME | | IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? | | NO | YES | IF YES, ENTER BRIEF DESCRIPTION AND DATES |
| MAILING ADDRESS | | IS TREATMENT RESULT OF AUTO ACCIDENT? | | | | |
| CITY, STATE ZIP | | OTHER ACCIDENT? | | | | |
| DENTIST SOC. SEC. NO. OR FED. IDENT. NO. | | DENTIST LICENSE | | DENTIST PHONE NO. | | IF PROSTHESIS, IS THIS INITIAL PLACEMENT? |
| FIRST VISIT DATE CURRENT SERIES | | PLACE OF TREATMENT OFFICE OTHER | | RADIOGRAPHS OR MODELS ENCLOSED? NO <input type="checkbox"/> YES <input type="checkbox"/> | | DATE OF PRIOR PLACEMENT |
| | | | | | | IS TREATMENT FOR ORTHODONTICS? NO <input type="checkbox"/> YES <input type="checkbox"/> |
| | | | | | | IF SERVICES ALREADY COMMENCED, ENTER: DATE APPLIANCES PLACED MONTHS TREATMENT REMAINING |



| EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32. USE CHARTING SYSTEM SHOWN. | | | | | | | |
|--|------------------------|---|------------------------|-----|-----|----------------------|-----|
| TOOTH # OR LETTER | SURFACES MOI DLF | Description Of Service Including X-Rays, Prophylaxis, Materials Used, Etc. | DATE SERVICE PERFORMED | | | ADA PROCEDURE NUMBER | FEE |
| | | | MO. | DAY | YR. | | |
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| <p>* PREDETERMINATION OF COSTS THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGMENT, AND I REQUEST PREDETERMINATION OF BENEFITS.</p> | | <p>I ACCEPT THIS ATTENDING DENTIST'S STATEMENT AND AUTHORIZE RELEASE OF INFORMATION RELATED THERETO. I CERTIFY TRUTH OF ALL PERSONAL INFORMATION CONTAINED ABOVE. I AGREE TO BE RESPONSIBLE FOR SERVICES PROVIDED DURING ANY INELIGIBLE PERIOD OR SERVICES NOT COVERED BY MY GROUP DENTAL CONTRACT.</p> | TOTAL FEE CHARGED | |
| <p>DENTIST SIGNATURE _____ DATE _____</p> | | | PATIENT PAYS | |
| <p>** TREATMENT COMPLETED - PAYMENT REQUESTED THE TREATMENT LISTED ABOVE WAS COMPLETED, NECESSARY IN MY PROFESSIONAL JUDGMENT, AND I AM LEGALLY QUALIFIED TO PERFORM THE SERVICE. THE FEES LISTED ARE THOSE REGULARLY CHARGED IN MY OFFICE.</p> | | PATIENT SIGNATURE _____ | DELTA PAYS | |
| <p>DENTIST SIGNATURE _____ DATE _____</p> | | DATE _____ | AMOUNT APPLIED TO DEDUCTIBLE | |