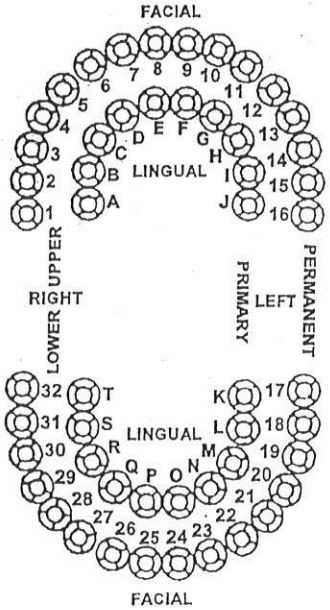
DENTAL EXAM

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 those procedures.

signed (dentist) _____ date _____

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

☐ 6 month recall ☐ 9 month recall

☐ 12 month recall

DHS: Original