ATTENDING DENTIST'S STATEMENT

CHECK ONE:

_____ DENTIST'S PRE-TREATMENT ESTIMATE

_____ DENTIST'S STATEMENT OF ACTUAL SERVICES

Please return to:
EBSO, Inc.
P.O. Box 928
Findlay, OH 45839
800-558-7798 Customer Service
Electronic Payor ID Number: 37257

1. EMPLOYEE NAME | 2. SOCIAL SECURITY NO.

3. ADDRESS | CITY | STATE OR PROVINCE | ZIP

4. PATIENT NAME (If a Dependent) | 5. RELATIONSHIP TO EMPLOYEE | 6. BIRTH DATE | 7. DATE FIRST VISIT (Current Series)

8. EMPLOYER NAME | 9. DOES PATIENT HAVE OTHER DENTAL COVERAGE? ____YES ____NO
If Yes, Please Identify:

10. GROUP DENTAL PLAN NAME | 11. GROUP NO.

12. DENTIST'S NAME (Print) | 13. LICENSE NO. | 14.
INDIVIDUALS PRACTITIONERS - SS# ____________________
ALL OTHERS - EMPLOYER I.D. # ____________________
Must Be Furnished Under Authority of Law

15. ADDRESS | CITY | STATE OR PROVINCE | ZIP

16. IS ANY OF THE TREATMENT FOR:
(a) ORTHODONTIC PURPOSES? ____YES ____NO
(b) ACCIDENTAL INJURY? ____YES ____NO
(c) OCCUPATIONAL INJURY? ____YES ____NO

17. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? ____YES ____NO
If No, Reason for Replacement:

DATE TEETH WERE EXTRACTED:

18. DATE OR PRIOR PLACEMENT:

19. ARE X-RAYS ENCLOSED? ____YES ____NO
If Yes, How Many?

LABIAL

LINGUAL

UPPER

RIGHT LEFT

LOWER

LINGUAL

LABIAL

INDICATE MISSING TEETH WITH AN "X"

REMARKS FOR UNUSUAL SERVICES

EXAMINATION AND TREATMENT RECORD - USE CHARTING SYSTEM SHOWN

TOOTH # OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS MATERIALS USED, ETC.)	DATE SERVICE DONE	ADA PROCEDURE NUMBER	FEE	FOR ADMIN. USE ONLY

ORTHODONTICS: (give diagnosis, class of malocclusion and describe appliance(s) in above treatment section)
DATE FIRST APPLIANCE INSERTED ____________________________
DATE LAST APPLIANCE REMOVED ____________________________
TREATMENT PERIOD (Number Months) ____________________________
TOTAL FEE $____________________________

TOTAL FEE ACTUALLY CHARGED		
PATIENT PAYS		
BALANCE		
CARRIER%		
CARRIER PAYS		

I HAVE REVIEWED THE FOREGOING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

DATE: ____________________

SIGNED (PATIENT, OR PARENT IF MINOR)

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE WILL BE____ HAVE BEEN____ PERFORMED.

DATE: ____________________

SIGNED (DENTIST)

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED DENTIST OF THE GROUP BENEFITS OTHERWISE PAYABLE TO ME, BUT NOT TO EXCEED THE CHARGES SHOWN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THIS AUTHORIZATION.

DATE: ____________________

SIGNED (INSURED PERSON)