



Delta Dental of New York
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ATTENDING DENTIST'S STATEMENT

SIGN BELOW
 FOR PREDETERMINATION *
 OR PAYMENT **

STAPLE X-RAYS TO FORM

EMPLOYEE MUST COMPLETE ITEMS 1 THROUGH 15

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

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

IDENTIFY MISSING TEETH WITH "X" FACIAL	EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 USE CHARTING SYSTEM SHOWN.									
	TOOTH # OR LETTER	SURFACES MOJ DLF	Description Of Services Including X-Rays, Prophylaxis, Materials Used, Etc.	DATE SERVICE PERFORMED MO. DAY YR.	ADA PROCEDURE NUMBER	FEE				
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<p>* PREDETERMINATION OF COSTS THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGEMENT, AND I REQUEST PREDETERMINATION OF BENEFITS</p> <p>DENTIST SIGNATURE _____ DATE _____</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> <p>PATIENT SIGNATURE _____</p> <p>DATE _____</p>		<p>TOTAL FEE CHARGED</p>	
<p>** TREATMENT COMPLETED - PAYMENT REQUESTED THE TREATMENT LISTED ABOVE WAS COMPLETED, NECESSARY IN MY PROFESSIONAL JUDGEMENT, AND I AM LEGALLY QUALIFIED TO PERFORM THE SERVICE. THE FEES LISTED ARE THOSE REGULARLY CHARGED IN MY OFFICE.</p> <p>DENTIST SIGNATURE _____ DATE _____</p>		<p>PATIENT SIGNATURE _____</p> <p>DATE _____</p>		<p>PATIENT PAYS</p>	
				<p>DELTA PAYS</p>	
				<p>AMOUNT APPLIED TO DEDUCTIBLE</p>	

FORM DD/NY-0016-04-10