



<b>PART 1 DENTIST</b>		UNIQUE NO.	SPEC.	PATIENT'S OFFICE ACCOUNT NO.	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER.
P A T I E N T	LAST NAME _____ GIVEN NAME _____ ADDRESS _____ APT. _____ CITY _____ PROV. _____ POSTAL CODE _____	D E N T I S T	PHONE NO. _____		
					SIGNATURE OF SUBSCRIBER _____

FOR DENTIST'S USE ONLY, FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES, OR SPECIAL CONSIDERATION.	I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT. I ACKNOWLEDGE THAT THE TOTAL FEE OF \$ _____ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR SERVICES RENDERED. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR.
SIGNATURE OF PATIENT (PARENT/GUARDIAN) _____	
OFFICE VERIFICATION / DENTIST'S SIGNATURE _____	
DUPLICATE FORM <input type="checkbox"/>	

DATE OF SERVICE			PROCEDURE CODE			INTL. TOOTH CODE		TOOTH SURFACES		DENTIST'S FEE			LABORATORY CHARGE			TOTAL CHARGES			INSTRUCTIONS																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																									
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