MAIL TO:

EMPLOYEE BENEFIT SYSTEMS
P.O. BOX 1053
BURLINGTON, IA 52601
(319) 752-3200

DENTAL SERVICE REPORT

CHECK ONE: ☐ DENTIST'S PRE-TREATMENT ESTIMATE
☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

PART 1: SUBSCRIBER INFORMATION

1. Patient Name: First / Middle Initial / Last	2. Relationship To Emp. Self / Spse. / Dtr. / Son	3. Sex M / F	4. Pt. Birth Date Mo. / Day / Yr.	5. If Full Time Student: School & City	
6. Employee Name First / Initial / Last		7. PHONE		8. Employee Social Security Number	
9. Mailing Address, Street, City, State Zip Code					
10. Name of Employer or Group		10A. Place of Employment of Spouse			
11. Is Patient Covered By Another Dental Plan? ☐ Yes ☐ No	If Yes, Policy Holder ID No.	12. Name and Address of Other Insurance Company			
PATIENTS AUTHORIZATION: I HEREBY ACCEPT THE FOLLOWING TREATMENT PLAN AND AUTHORIZE THE RELEASE OF ANY INFORMATION RELATIVE TO THIS CASE.		Signed (Patient, or Parent if Minor)		Date	

PART 2: DENTIST INFORMATION

13. Dentist Name		19. Is Treatment Result of Occupational Illness or Injury?	No	Yes	If Yes, Enter Brief Description And Dates
14. Mailing Address, Street, City, State, Zip Code		20. Is Treatment Result of Auto Accident? Other Accident?			
		22. Are Any Services Covered By Another Plan?			
15. Dentist Soc. Sec. or T.I. N.		23. If Prosthesis, Is This Initial Placement?	(If No, Reason For Replacement)		Date of Prior Placement
16. First Visit Dt. Current Series	17. Place of Treatment Office / Hosp / ECF / Other	18. Radiographs or Models Enclosed? (X-rays should be mounted) No / Yes / How Many	24. Is Treatment For Orthodontics?	If Services Already Commenced, Enter: Date Appliance Placed	Mos. Treatmt. Remaining
DENTIST'S STATEMENT: I HEREBY CERTIFY THAT THE SERVICES LISTED HAVE BEEN OR WILL BE PROVIDED BY ME.	Dentist Signature	Lic. No.	Date	25. ☐ I Have Been Paid ☐ I Have Not Been Pd.	

PART 3: EXAMINATION AND TREATMENT PLAN — LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32

	Tooth No. or Letter	Surfaces	Description of Services, including X-Rays, Prophylaxis, Materials Used, Etc.	Date Service Performed Mo. / Day / Yr.	Procedure Code	Fee For Each Service	OFFICE USE ONLY
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							

26. Remarks for Unusual Services

TOTAL FEE ON THIS FORM