SHADED AREAS FOR DELTA USE ONLY

DELTA USE ONLY

DELTA DENTAL

Delta Dental Plan of California

P.O. Box 7736
San Francisco, California 94120-7736

PLEASE MAKE SURE EMPLOYEE'S MAILING ADDRESS IS LEGIBLE, CURRENT & COMPLETE

1. PATIENT NAME | 2. RELATIONSHIP TO EMPLOYEE: SELF, SPOUSE, CHILD, OTHER _____ | 3. SEX: M, F | 4. PATIENT BIRTHDATE: MO, DAY, YEAR | 5. IF FULL TIME STUDENT AND OVER AGE 18, INDICATE: SCHOOL, CITY

6. EMPLOYEE/SUBSCRIBER NAME: FIRST, MIDDLE, LAST | 7. EMPLOYEE SOCIAL SECURITY NUMBER | 8. EMPLOYEE BIRTHDATE: MO, DAY, YEAR | 9. EMPLOYER (COMPANY) NAME AND ADDRESS/UNION LOCAL | 10. GROUP NUMBER

EMPLOYEE MAILING ADDRESS | APT. NO. | PHONE NO.

CITY, STATE, ZIP | ZIP CODE

11. IS PATIENT COVERED BY ANOTHER PLAN OF BENEFITS? IF YES, COMPLETE ITEMS 12 THROUGH 15. YES _____ NO _____ | 12a. NAME AND ADDRESS OF DENTAL CARRIER(S), ITEM 11. | 12b. GROUP NUMBER | 13. NAME AND ADDRESS OF EMPLOYER, ITEM 11

14a. EMPLOYEE NAME, ITEM 11 (IF DIFFERENT FROM PATIENT'S) | 14b. EMPLOYEE SOCIAL SECURITY NUMBER | 14c. EMPLOYEE BIRTHDATE: MO, DAY, YEAR | 15. RELATIONSHIP TO PATIENT: SELF, SPOUSE, PARENT, OTHER _____

16. DENTIST NAME | LICENSE NUMBER

17. MAILING ADDRESS | PHONE NO.

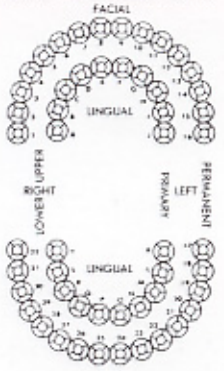
CITY, STATE, ZIP | ZIP CODE

	NO	YES	IF YES, ENTER DATES, BRIEF DESCRIPTION AND ANY AMOUNT PAID.
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
25. IS TREATMENT RESULT OF AUTO ACCIDENT?			
26. OTHER ACCIDENT?			
27. ARE ANY SERVICES COVERED BY A NON-DENTAL PLAN?			
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? IF NO, ENTER REASON FOR REPLACEMENT.			29. DATE OF PRIOR PLACEMENT

18. DENTIST SOC. SEC. NO. OR TIN | 19. DENTIST LICENSE NO. | 20. DENTIST PHONE NO.

21. FIRST VISIT DATE CURRENT SERIES | 22. PLACE OF TREATMENT: OFFICE, HOSP., ECT, OTHER | 23. RADIOGRAPHS OR MODELS ENCLOSED? NO ☐ YES ☐ HOW MANY? | 30. IS TREATMENT FOR ORTHODONTICS? NO YES | IF SERVICES ALREADY COMMENCED ENTER → DATE APPLIANCES PLACED | MOS. TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X"



31. EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32, USE CHARTING SYSTEM SHOWN.

TOOTH NO. OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE COMPLETED M D Y		PROCEDURE NUMBER	FEE	
		1					
		2					
		3					
		4					
		5					
		6					
		7					
		8					
		9					
		10					
		11					
		12					
		13					
		14					
		15					

32 REMARKS FOR UNUSUAL SERVICES **OR AMOUNT PAID BY OTHER COVERAGE**

MY DENTIST MAY GIVE DELTA AND ANY OTHER CARRIER NAMED ABOVE INFORMATION ABOUT MY DENTAL CONDITION OR TREATMENT NEEDED TO DETERMINE BENEFITS FOR UP TO 5 YEARS FROM THIS DATE.

SIGNATURE OF PATIENT (OR PARENT OR GUARDIAN) _____ DATE _____

You may receive a copy of this authorization on request.

TOTAL FEE CHARGED	
PATIENT PAYS	
PLAN PAYS	
AMOUNT APPLIED TO DEDUCTIBLE	

PAYMENT SUBJECT TO PERCENT WITHHOLD AS APPROVED BY PLAN BOARD OF DIRECTORS.

PREDETERMINATION OF COST

THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGMENT AND I REQUEST AUTHORIZATION IN ACCORDANCE WITH DELTA PARTICIPATING DENTIST RULES.

DENTIST SIGNATURE _____ DATE _____

TREATMENT COMPLETED - PAYMENT REQUESTED

THE TREATMENT LISTED WAS COMPLETED. I WILL CHARGE AND INTEND TO COLLECT THE ENTIRE PORTION OF THE FEES STATED ABOVE WHICH DELTA DETERMINES TO BE THE PATIENT'S RESPONSIBILITY, AND I WILL NOT WAIVE, REDUCE OR REBATE ANY OF THAT PORTION UNLESS I EXPRESSLY SO STATE ON THIS FORM.

DENTIST SIGNATURE _____ DATE _____

SEE DENTIST'S HANDBOOK FOR PARTICIPATION RULES.