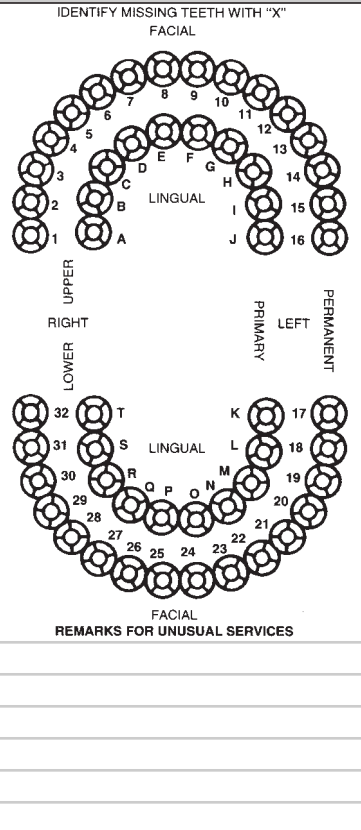


One Delta Drive
Mechanicsburg, PA 17055-6999
(717) 766-8500 (800) 932-0783 (TTY/TDD 888-373-3582)

EMPLOYEE MUST COMPLETE ITEMS 1 THROUGH 15

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

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



EXAMINATION AND TREATMENT RECORD - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32. USE CHARTING SYSTEM SHOWN.							
TOOTH # OR LETTER	SURFACES MOI DLF	Description Of Service Including X-Rays, Prophylaxis, Materials Used, Etc.	DATE SERVICE PERFORMED			ADA PROCEDURE NUMBER	FEE
			MO.	DAY	YR.		
1							
2							
3							
4							
5							
6							
7							
8							
9							
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20							
21							
22							
23							

<p>* PREDETERMINATION OF COSTS THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGMENT, AND I REQUEST PREDETERMINATION OF BENEFITS.</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>	TOTAL FEE CHARGED	
<p>DENTIST SIGNATURE _____ DATE _____</p>			PATIENT PAYS	
<p>** TREATMENT COMPLETED - PAYMENT REQUESTED THE TREATMENT LISTED ABOVE WAS COMPLETED, NECESSARY IN MY PROFESSIONAL JUDGMENT, AND I AM LEGALLY QUALIFIED TO PERFORM THE SERVICE. THE FEES LISTED ARE THOSE REGULARLY CHARGED IN MY OFFICE.</p>		PATIENT SIGNATURE _____	DELTA PAYS	
<p>DENTIST SIGNATURE _____ DATE _____</p>		DATE _____	AMOUNT APPLIED TO DEDUCTIBLE	