ATTENDING DENTI	IST'S	STAT	EMENT														
CHECK ONE:								INSURANCE CO. NAME AND ADDRESS									
	DENTIST'S PRE-TREATMENT ESTIMATE								CWA Local 1014 "Freedom of Choice" Dental								
DENTIST'S STATEMENT OF ACTUAL SERVICES								658 W. Cuthbert Blvd.									
T. SATISTIC NAME				2 DELATIONS	UID TO	EMPLOY	FF 9 61	Westmont,			. 15	FILL	L TIME STUDE	NT			
1. PATIENT NAME				2. RELATIONS SELF ISPOUS	EI CHILD	OTHER	EE 3. SI	F NO. DAY	YEA	R). IF	FUL	SCHOOL		CI	TY	
6. EMPLOYEE/SUBSCRIBER NAME				1 1. 7. EMI	PLOYEE/	SIIBECE	IDED	9. NAME OF GR	OILB DE	ENTAL	PPOG	DAM					
FIRST MIDD	LE		LAST	soc	CIAL SEC	URITY	NO.		.001 21		,						
8. EMPLOYEE/SUBSCRIBER MAILING ADDRESS								10. EMPLOYER (COMPANY) NAME AND ADDRESS									
CITY, STATE, ZIP																	
11. GROUP NUMBER 12. LO	CATION	(LOCAL)	13. ARE OT	HER FAMILY MEM	BERS EM	PLOYED	17	14.	NAME	AND A	DDRE	ss o	F EMPLOYER	IN ITEM 13			
			EMPLOTI	EE NAME		50C. 5EC	NO.										
15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN?	DENTA	L PLAN NAI	ME	UNION LOCAL	GROL	JP NO.	NAM	E AND ADDRESS	OF CA	RRIER							
ANOTHER DENIAL PEAR																	
I HAVE REVIEWED THE FO			TMENT PLA	N. I AUTHORIZ	ZE REL	EASE	OF ANY	I HEREBY AL	THORI	ZE PA	YME	NT S O	DIRECTLY TO	O THE BEL	OW - N.	AMED DENTIST OF THE	
															•		
SIGNED (PAT	TENT, (OR PARENT	IF MINOR)			DATE		SIGNED (INSURED PERSON) 24. IS TREATMENT RESULT NO TYES IF YES, ENTER BRIEF DESCRIPTION AND DATES									
16. DENTIST NAME								24. IS TREATMEN OF OCCUPATI ILLNESS OR	ONAL		YES	iF \	TES, ENTER B	RIEF DESCR	HIION	AND DAIRS	
17 MAILING ADDRESS								25. IS TREATMEN		\perp		-					
17. MAILING ADDRESS								OF AUTO ACC			-						
CITY, STATE, ZIP								27. ARE ANY SE	RVICES	+	\vdash	-					
								COVERED B	Y LAN?								
18. DENTIST SOC. SEC. OR T.I.	N. 19	. DENTIST	LICENSE NO	. 20. DENTI	ST PHON	IE NO.		28.1F PROSTHE	SIS, IS	+		(IF	NO, REASON	FOR REPLA	CEMENT)		
								THIS INITIA PLACEMENT								PLACEMENT	
21. FIRST VISIT DATE 22. PLAC CURRENT SERIES OFFICE				RADIOGRAPHS OR Models Enclose		NO YE	S HOW	30. IS TREATME		1			SERVICES	DATE APPLI	ANCES F	PLACED MOS. TREATMEN' REMAINING	
												COL	MMENCED, Ter				
IDENTIFY MISSING TEETH WITH "X"	T						M TOOTH		TOOTH	NO. 3	32 - U	JSE (CHARTING SYS	TEN CHOWN		FOR	
	31. 1	CHAMINATIO	N AND TREAT	MENT PLAN - LIST				NO. 1 THROUGH	100111					TEM SHOWN		ADMINISTRATIVE	
FACIAL	TOOTH	SURFACE		DESCRIP DING X-RAYS, PRO	PTION C	F SER	VICE	· · · · · · · · · · · · · · · · · · ·	DATE	SERVI		PI	ROCEDURE	FEE		ADMINISTRATIVE USE ONLY	
	тоотн			DESCRIP	PTION C	OF SER	VICE	· · · · · · · · · · · · · · · · · · ·	DATE	SERVI	D	PI					
	TOOTH			DESCRIP	PTION COPHYLAX	OF SER	VICE	· · · · · · · · · · · · · · · · · · ·	DATE	SERVI	D	PI	ROCEDURE				
FACIAL (C)	TOOTH # OR LETTER			DESCRIP	PTION COPHYLAX	OF SER	VICE	· · · · · · · · · · · · · · · · · · ·	DATE	SERVI	D	PI	ROCEDURE				
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