STAPLE X-RAYS FOR ALL MAJOR SERVICES TO TOP LEFT CORNER OF FORMS. X-RAYS MUST BE LABELED WITH PATIENT NAME, DENTIST NAME AND ADDRESS.

DELTA DENTAL®
Delta Dental Insurance Company

P.O. Box 1809
Alpharetta, GA 30023-1809
1-800-893-3582

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

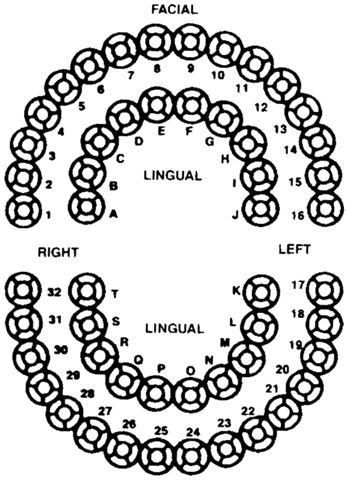
1. PATIENT NAME	2. RELATIONSHIP TO EMPLOYEE: SELF / SPOUSE / CHILD / OTHER	3. SEX: M / F	4. PATIENT BIRTHDATE: MO. / DAY / YEAR	**5. IF FULL TIME STUDENT**: SCHOOL / CITY
6. EMPLOYEE/ SUBSCRIBER NAME	FIRST / MIDDLE / LAST	**7. EMPLOYEE SOCIAL SECURITY NUMBER**	7A. EMPLOYEE BIRTHDATE: MO. / DAY / YEAR	9. NAME OF GROUP DENTAL PROGRAM: **The University of Texas System**
8. EMPLOYEE MAILING ADDRESS			7B. SPOUSE BIRTHDATE: MO. / DAY / YEAR	10. EMPLOYER (COMPANY) NAME AND ADDRESS
CITY, STATE, ZIP				

11. EMPLOYEE GROUP NUMBER	12. LOCATION (LOCAL)	13. ARE OTHER FAMILY MEMBERS EMPLOYED? EMPLOYEE NAME / SOC. SEC. NO.	14. NAME AND ADDRESS OF EMPLOYER, ITEM 13

15. IS PATIENT COVERED BY ANOTHER DENTAL PLAN?	DENTAL PLAN NAME	UNION LOCAL	GROUP NO.	NAME AND ADDRESS OF CARRIER

16. DENTIST NAME		**24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?**	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
17. MAILING ADDRESS		**25. IS TREATMENT RESULT OF AUTO ACCIDENT?**			
		26. OTHER ACCIDENT?			
CITY, STATE, ZIP	**IS THIS ADDRESS NEW?** YES ❑ NO ❑	**27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?**			
18. DENTIST SOC. SEC. NO. OR T.I.N. / **19. DENTIST LICENSE NO.**	**20. DENTIST PHONE NO.**	**28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? IF NO, ENTER REASON FOR REPLACEMENT.**			**29. DATE OF PRIOR PLACEMENT**
21. FIRST VISIT DATE CURRENT SERIES / 22. PLACE OF TREATMENT: OFFICE / HOSP / ECF / OTHER	**23. RADIOGRAPHS OR MODEL 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"



32. REMARKS FOR UNUSUAL SERVICES

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

TOOTH # OR LETTER	SURFACES	**DESCRIPTION OF SERVICE** (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	**DATE SERVICE COMPLETED** MO.	DAY	YEAR	**PROCEDURE NUMBER**	**FEE**

I ACCEPT THIS ATTENDING DENTIST'S STATEMENT AND AUTHORIZE RELEASE OF INFORMATION RELATING HERETO. I CERTIFY THE TRUTH OF ALL PERSONAL INFORMATION CONTAINED ABOVE. I AGREE TO BE RESPONSIBLE FOR PAYMENT FOR SERVICES PROVIDED DURING ANY INELIGIBLE PERIOD.

PATIENT (PARENT OR EMPLOYEE) SIGNATURE **X** ____________________

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED DENTIST OF THE BENEFITS OTHERWISE PAYABLE TO ME.

X ____________________
EMPLOYEE SIGNATURE DATE

TOTAL FEE CHARGED	
PATIENT PAYS	
PLAN PAYS	
AMOUNT APPLIED TO DEDUCTIBLE	

NOTICE: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

PREDETERMINATION OF COST	**TREATMENT COMPLETED - PAYMENT REQUESTED**
THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGMENT AND I REQUEST PREDETERMINATION OF BENEFITS.	THE TREATMENT LISTED WAS COMPLETED ON DATES INDICATED AND WAS NECESSARY IN MY PROFESSIONAL JUDGMENT.
DENTIST SIGNATURE / DATE	DENTIST SIGNATURE / DATE

ATTENDING DENTIST'S STATEMENT

FORM 3105 (REV. 5-02)