Attending Dentist's Statement

Check one:

- **Dentist's pre-treatment estimate**
- **Dentist's statement of actual services**

Lockard & Williams Insurance Services, P .A.
P.O. Box 1688
Pascagoula, MS 39568-1688
228-762-2500

PATIENT SECTION

1. Patient name (first, mi., last)	2. Relationship to employee	3. Sex (m / f)	4. Patient birthdate (MM DD YYY)	5. If full time student (school, city)
	☐ self ☐ child ☐ spouse ☐ other _____			

6. Employee subscriber name and mailing address	7. Employee/subscriber soc. sec. number	8. Patient subcriber birthdate (MM DD YYY)	9. Employer (company)	10. Group number name and address

11. Is patient covered by another plan of benefits?	12-a. Name and address of carrier(s)	12-b. Group no.(s)	13. Name and address of employer
Dental _____ Medical _____			

14-a. Employee subscriber name (if different than patient's)	14-b. Employee/subscriber soc. sec. number	14-c. Employee/subscriber birthdate (MM DD YYY)	15. Relationship to patient
			☐ self ☐ child ☐ spouse ☐ other _____

I have received the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

▶ _____
Signed (Patient, or parent if minor)

I hereby authorize payment directly to the below named dentist of the group insurance benefits otherwise payable to me.

▶ _____
Signed (Patient, or parent if minor)

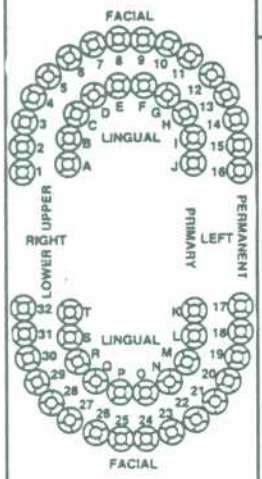
DENTIST SECTION

16. Dentist name	24. Is treatment result of occupational illness or injury?	Yes	No	If yes, enter brief description and dates.
17. Mailing address	25. Is treatment result of auto accident? 26. Other accident?			
City, State, Zip	27. Are any services covered by another plant?			

18. Dentist Soc. Sec. or TIN	19. Dentist license no.	20. Dentist phone no.	28. If prosthesis, is this initial placement?		(If no, 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 models enclosed? (Yes / No)	How many?	30. Is treatment for orthodontics?		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 plan - List in order from tooth no. 32 - Use charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylasis, materials used, etc.) Line no.	Date of service performed Mo. Day Year	Procedure number	Fee	For administrative use only

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intent to collect for those procedures.

▶ _____ _____
Signed (Dentist) Date

Total Fee Charged