Dental Claim Form

Check one:

☐ Dentist's pre-treatment estimate

☐ Dentist's statement of actual services

Carrier name and address

PATIENT COVERAGE INFORMATION

1. Patient name — first / m.i. / last
2. Relationship to employee — ☐ self ☐ child ☐ spouse ☐ other
3. Sex — m f
4. Patient birthdate — MM DD YYYY
5. If full time student — school / city
6. Employee/subscriber name and mailing address
7. Employee/subscriber soc. sec. or I.D. number
8. Employee/subscriber birthdate — MM DD YYYY
9. Employer (company) name and address
10. Group number
11. Is patient covered by another dental plan? ☐ yes ☐ no — If yes, complete 12-a. — Is patient covered by a medical plan? ☐ yes ☐ no
12-a. Name and address of carrier(s)
12-b. Group no.(s)
13. Name and address of other employer(s)
14-a. Employee/subscriber name (if different than patient's)
14-b. Employee/subscriber soc. sec. or I.D. number
14-c. Employee/subscriber birthdate — MM DD YYYY
15. Relationship to patient — ☐ self ☐ parent ☐ spouse ☐ other

I have reviewed 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) Date

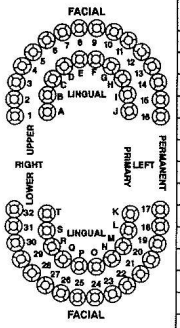
I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

▶ Signed (Insured person) Date

BILLING DENTIST

16. Name of Billing Dentist or Dental Entity: **PHILIP M. SOBO, D.D.S., P.A.**
17. Address where payment should be remitted: 2320 CONCORD LAKE ROAD
City, State, Zip: CONCORD, NC 28025
18. Dentist Soc. Sec. or T.I.N.: 56-1355645
19. Dentist license no.: 4953
20. Dentist phone no.: (704) 786-9100
21. First visit date current series
22. Place of treatment — Office Hosp. ECF Other
23. Radiographs or models enclosed? No Yes How many?
24. Is treatment result of occupational illness or injury? No Yes — If yes, enter brief description and dates.
25. Is treatment result of auto accident?
26. Other accident?
27. If prosthesis, is this initial placement? — (If no, reason for replacement)
28. Date of prior placement
29. Is treatment for orthodontics? — If services already commenced enter: Date appliances placed — Mos. treatment remaining

Identify missing teeth with "x"



30. Examination and treatment plan — List in order from tooth no. 1 through tooth no. 32—Use charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	Fee

For administrative use only

31. Remarks for unusual services

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 intend to collect for those procedures.

▶ Signed (Treating Dentist) License Number Date

Total Fee Charged	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	