

ATTENDING DENTIST'S STATEMENT

CARRIER NAME AND ADDRESS

GOLDEN WEST DENTAL & VISION
 PO BOX 5347
 OXNARD, CA 93031-5347

CHECK ONE:
 _____ DENTIST'S PRE-TREATMENT ESTIMATE
 _____ DENTIST'S STATEMENT OF ACTUAL SERVICES

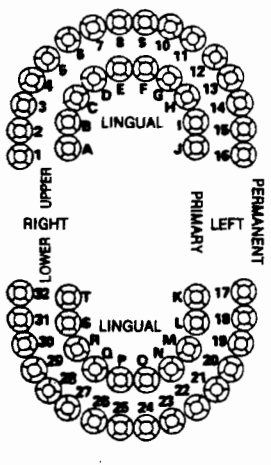
1. PATIENT NAME FIRST M.I. LAST			2. RELATIONSHIP TO INSURED <input type="checkbox"/> SELF <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER		3. SEX M F	4. PATIENT BIRTHDATE MO. DAY YEAR	5. IF FULL TIME STUDENT SCHOOL CITY
6. EMPLOYEE/SUBSCRIBER NAME AND MAILING ADDRESS			7. EMPLOYEE/SUBSCRIBER SOC. SEC. OR I.D. NUMBER	8. EMPLOYEE/SUBSCRIBER BIRTHDATE MO. DAY YEAR	9. EMPLOYER (COMPANY) NAME AND ADDRESS SB COUNTY 105 E Anapamu St., Rm 102 Santa Barbara, CA 93101		10. GROUP NUMBER NP 8059
11. IS PATIENT COVERED BY ANOTHER PLAN OF BENEFITS? DENTAL _____ MEDICAL _____			12-A. NAME AND ADDRESS OF CARRIER(S)		12-B. GROUP NO.(S)		13. NAME AND ADDRESS OF EMPLOYER
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 MO. DAY YEAR		15. RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> PARENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> 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.

I HEREBY AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE BELNAMED DENTAL ENTITY.

SIGNED (PATIENT, OR PARENT IF MINOR) _____ DATE _____ SIGNED (INSURED PERSON) _____ DATE _____

16. NAME OF BILLING DENTIST OR DENTAL ENTITY			24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES.
17. ADDRESS WHERE PAYMENT SHOULD BE REMITTED CITY, STATE, ZIP			25. IS TREATMENT RESULT OF AUTO ACCIDENT?				
18. DENTIST SOC. SEC. OR T.I.N. 19. DENTIST LICENSE NO. 20. DENTIST PHONE NO.			26. OTHER ACCIDENT?				
21. FIRST VISIT DATE CURRENT SERIES			27. ARE ANY SERVICES COVERED BY ANOTHER PLAN?				
22. PLACE OF TREATMENT OFFICE HOSP. ECF OTHER			28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?				(IF NO, REASON FOR REPLACEMENT) 29. DATE OF PRIOR PLACEMENT
23. RADIOGRAPHS OR MODELS ENCLOSED? NO YES HOW MANY?			30. IS TREATMENT FOR ORTHODONTICS?				IF SERVICES ALREADY COMMENCED, ENTER: DATE APPLIANCES PLACED MOS. TREATMENT REMAINING

IDENTIFY MISSING TEETH WITH "X" FACIAL  FACIAL	31. 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 SERVICES PERFORMED MO. DAY YEAR	PROCEDURE NUMBER	FEE	FOR ADMINISTRATIVE USE ONLY
32. 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
	PATIENT PAYS