STANDARD DENTAL TREATMENT FORM

APPROVED BY THE CANADIAN DENTAL ASSOCIATION

	UNIQUE NO.	SPEC.	PATIENT'S OFFICE ACCOUNT NO.	DATE PREPARED DAY MO YEAR	THIS ESTIMATE IS VALID UNTIL DAY MO YEAR

PATIENT

LAST NAME _____ GIVEN NAME _____

ADDRESS _____ APT. _____

CITY _____ PROV. _____ POSTAL CODE _____

DENTIST

Tel. No.

_____
OFFICE VERIFICATION

Examination: (Fees Only) _____ $ _____

Radiographs: (Fees Only) _____ $ _____

Other Diagnostic Services: (Total Fee Only) _____ $ _____ +L

Oral Hygiene Instructions: (Fees Only) _____ $ _____

Other Preventive Services: _____ $ _____

Prophylaxis/Fluoride: (Fee Only) _____ $ _____

Basic Restorative Services:
(Do not itemize surfaces, fees or teeth here. Total Fee Only) _____ $ _____

Surgery: (Total Fee Only) _____ $ _____ +L

Periodontal Services: (Total Fee Only) _____ $ _____ +L

Endodontic Services: Tooth _____ $ _____

(Give Fee per Tooth) Tooth _____ $ _____

Tooth _____ $ _____

Tooth _____ $ _____

Tooth _____ $ _____

Tooth _____ $ _____

Anesthetic Services: (Total Fee Only) _____ $ _____ +Drugs

Orthodontic Services: (Total Fee Only) _____ $ _____ +L

Other Services, including Crowns, Bridges and Dentures (Itemize tooth, service and professional fee, but not commercial lab charge.)

_____ $ _____ +L

_____ $ _____ +L

_____ $ _____ +L

_____ $ _____ +L

_____ $ _____ +L

_____ $ _____ +L

_____ $ _____ +L

_____ $ _____ +L

_____ $ _____ +L

Total Estimated Lab Charges $ _____

TOTAL ESTIMATE $ _____

L SERVICES MARKED (L) ARE APPROXIMATIONS ONLY. FINAL LABORATORY CHARGES WILL BE INCLUDED ON CLAIM FORM.

H SERVICES MARKED (H) WILL BE PERFORMED IN HOSPITAL.

ADDITIONAL COMMENTS: Use this space to provide other information pertinent to the treatment plan.

THIS SECTION TO BE COMPLETED BY PATIENT

SUBSCRIBER

NAME _____

ADDRESS _____

_____

EMPLOYER _____

ADDRESS _____

GROUP POLICY	CERTIFICATE NO.	SOCIAL INSURANCE NO.

PATIENT'S DATE OF BIRTH	DAY	MO	YEAR	RELATIONSHIP TO SUBSCRIBER

I authorize the release of the information outlined in this treatment form to my insurance company or its agents. I also authorize the release of information related to the coverage of services (as described on this form) to the named dentist.

_____
SIGNATURE OF PATIENT (OR GUARDIAN/PARENT)