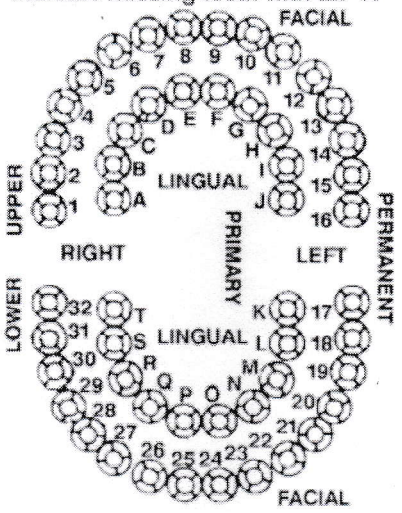
*Examination and Treatment Record - Use Charting System Shown*

Indicate missing teeth with an "X"




| I. | I. |
|---|---|
| Tooth No. or Letter: 1416 | Tooth No. or Letter: |
| Surfaces: Metal | Surfaces: |
| Description of Service including X-Rays, Prophylaxis Materials Used, etc.: G | Description of Service including X-Rays, Prophylaxis Materials Used, etc.: |
| Date Service Performed (DD/MM/YY): 04/04/19 | Date Service Performed (DD/MM/YY): |
| Fee($): 1600 | Fee($): |

*ADDITIONAL INFORMATION CAN BE NOTED ON A SEPARATE SHEET*

Note: If Medication is prescribed please provide diagnosis below:

**Diagnosis:**

**Orthodontics: (Give diagnosis, class of Malocclusion and describe appliances in above treatment section):**

**DATE FIRST APPLIANCE INSERTED (DD/MM/YY):** 02/01/20

**DATE LAST APPLIANCE REMOVED (DD/MM/YY):** 02/01/20

**TREATMENT PERIOD (number months):** 10 days **TOTAL FEE ($):** 1800

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**I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED**

**Dentist's Name:** Vishnu

**Dentist's Signature:** Vishnu **Dentist's Stamp:**

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**ASSIGNMENT OF INSURANCE BENEFITS: I HEREBY AUTHORIZE THE INSURANCE CORPORATION OF BARBADOS LIMITED TO PAY THE ABOVE NAMED DENTIST THE BENEFITS TO WHICH I MAY BE ENTITLED TO UNDER POLICY NO:** ICV/DEN/0014 **ALL CHARGES THAT ARE NOT COVERED BY THE POLICY SHALL BE BORNE BY ME.**

**DATE (DD/MM/YY):** 02/01/20

**SIGNATURE OF INSURED MEMBER/PATIENT:** Vishnu