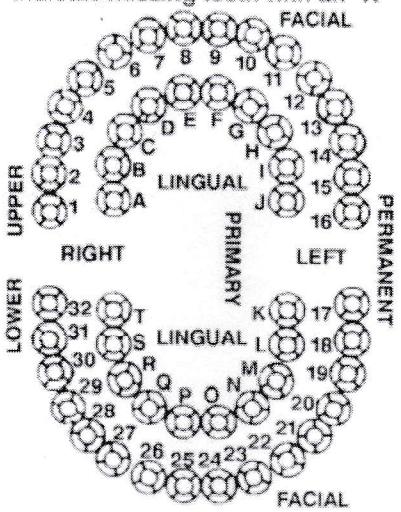
Examination and Treatment Record - Use Charting System Shown

Indicate missing teeth with an "X"



I.	I.
Tooth No. or Letter: 1514	Tooth No. or Letter: 1514
Surfaces: metal	Surfaces: metal
Description of Service including X-Rays, Prophylaxis Materials Used, etc.:	Description of Service including X-Rays, Prophylaxis Materials Used, etc.:
Date Service Performed (DD/MM/YY): 18/02/20	Date Service Performed (DD/MM/YY): 18/02/20
Fee($): 1500	Fee($): 1500

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): 15/04/19

DATE LAST APPLIANCE REMOVED (DD/MM/YY): 18/04/19

TREATMENT PERIOD (number months): 20 days TOTAL FEE ($): 1800

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED

Dentist's Name: Brian Key

Dentist's Signature: Brian Dentist's Stamp: _____

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: _____ ALL CHARGES THAT ARE NOT COVERED BY THE POLICY SHALL BE BORNE BY ME.

DATE (DD/MM/YY): 19/04/19

SIGNATURE OF INSURED MEMBER/PATIENT: Brian Dey