

DENTAL EXAMINATION REPORT

(All sections must be completed)

SECTION A – PARTICULARS OF THE PATIENT

Name of Patient: _____ Sex: _____

Date of Birth (day/month/year): _____ Member No.: _____ Policy No.: _____

If group insurance, name of the Policyholder: _____

SECTION B – STATEMENT BY THE PATIENT

1. If any the above treatments or services were necessitated as a result of an accident, please state the occurrence of the incident.

2. When and where did the accident occur?

3. Was the accident of nature requiring report to the police?

If so, was the accident reported?

☐ Yes

☐ No

When and where was it reported?

SECTION C – AUTHORIZATION & DECLARATION

I hereby authorize any hospital or dentist or other person who has attended me to furnish to insurance company (and its representative) and permit the said insurance company (and its representative) to review any and all information requested with respect to any illness, or accident, dental history, consultation, prescription or treatment and copies of all hospital or dental records and the records of any governmental agency with which a report of any such accident or illness is lodged. I agree that a photostatic copy of this authorization shall be considered as effective and valid as the original.

I hereby declare to the best of my knowledge and belief that the particulars stated on this form to be true and correct.

I understand that if I fail to provide any information requested in this form, it may result in the inability of the Company to accept or process this claim.

Date (day/month/year)

Signature of Patient (or Parent if a minor)

SECTION D- ATTENDING DENTIST'S REPORT

Treatment Date	Treatment Provided	No. of Tooth	Charges
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____
9. _____	_____	_____	_____
10. _____	_____	_____	_____

Please mark teeth treated or area of oral treatment on the following chart:

LABIAL

RIGHT LINGUAL LEFT

LABIAL

Name of Dentist: _____

Address: _____

Telephone No.: _____

E-mail: _____

Signature of Dentist

Date (day/month/year): _____

** Please attach all invoices and other relevant documents*