A TRADITION OF EXCELLENCE

NEWMAN COMPANY
925 Hempstead Avenue
Franklin Square, NY 11010
(516) 488 - 1100

PATIENT'S INFORMATION

1 PATIENT NAME

2 RELATIONSHIP TO EMPLOYEE: SELF | SPOUSE | CHILD | OTHER

3 SEX: M | F

4 PATIENT BIRTHDATE: MO | DAY | YEAR

5 IF FULL TIME STUDENT: SCHOOL | CITY

6 EMPLOYEE NAME: FIRST | MIDDLE | LAST

7 EMPLOYEE SOC. SEC. NO.

9 NAME OF GROUP DENTAL PROGRAM

8 EMPLOYEE MAILING ADDRESS

10 EMPLOYER (COMPANY) NAME AND ADDRESS

CITY, STATE, ZIP

11a DATE OF BIRTH EMPLOYEE

11b DATE OF BIRTH SPOUSE

12 ARE ANY DEPENDENTS EMPLOYED ☐ YES ☐ NO

DEPENDENT SOC. SEC. NO.

13 NAME AND ADDRESS OF EMPLOYER IN ITEM 12

14 IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐ YES ☐ NO | DENTAL PLAN NAME | EFFECTIVE DATE | GROUP NO. | NAME AND ADDRESS OF EMPLOYER

IS PATIENT COVERED BY A MEDICAL PLAN? ☐ YES ☐ NO | MEDICAL PLAN NAME | EFFECTIVE DATE | GROUP NO. | NAME AND ADDRESS OF CARRIER

14a. I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT. I UNDERSTAND THAT BENEFITS WILL BE PAID DIRECTLY TO ME UNLESS THE BOX BELOW (14b) IS SIGNED.
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a c rime, and shall also be subject to a civil penalty of five thousand dollars and the stated value of the claim for each such violation.

SIGNED EMPLOYEE ____________ DATE

14b. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

SIGNED (PATIENT OR PARENT IF MINOR)

15 I HAVE RECEIVED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

SIGNED ____________ DATE

☐ DENTIST'S PRE-TREATMENT ESTIMATE

DENTIST'S INFORMATION

☐ STATEMENT OF ACTUAL SERVICES

16 DENTIST NAME

17 MAILING ADDRESS

CITY, STATE, ZIP

18 DENTIST SOC. SEC. OR TIN

19 DENTIST LICENSE NO.

20 DENTIST PHONE NO.

21 FIRST VISIT DATE CURRENT SERIES

22 PLACE OF TREATMENT: OFFICE | HOSP | ECF | OTHER

23 RADIOGRAPHS OR MODELS ENCLOSED? NO | YES | HOW MANY?

	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
24 IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
25 IS TREATMENT RESULT OF AUTO ACCIDENT?			
26 OTHER ACCIDENT?			
27 ARE ANY SERVICES COVERED BY ANOTHER PLAN?			(IF NO, REASON FOR REPLACEMENT) / 29 DATE OF PRIOR PLACEMENT
28 IF PROSTHESIS, IS THIS INITIAL PLACEMENT?			IF SERVICES ALREADY COMMENCED ENTER / DATE APPLIANCES PLACED / MOS TREATMENT REMAINING
30 IS TREATMENT FOR ORTHODONTICS?			

IDENTIFY MISSING TEETH WITH "X"

FACIAL — LINGUAL — UPPER — LOWER — RIGHT — LEFT — PRIMARY — PERMANENT — LINGUAL — FACIAL

31 EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO 1 THROUGH TOOTH NO 32 - USE CHARTING SYSTEM SHOWN

TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF SERIVCE (INCLUDING X-RAYS, PROPHYLAXZIS, AMTERIALS USED, ETC) LINE NO.	DATE SERVICE PERFORMED MO DAY YEAR	PROCEDURE NUMBER	*USUAL FEE	MAXIMUM PREFERRED PROVIDER CHARGE
		1				
		2				
		3				
		4				
		5				
		6				
		7				
		8				
		9				
		10				
		11				
		12				

ORTHODONTICS (give diagnosis, class of malocclusion and describe appliance(s) in above treatment section)

DATE FIRST APPLIANCE INSERTED ____________

DATE LAST APPLIANCE REMOVED ____________

TREATMENT PERIOD (NUMBER MONTHS) ____________

TOTAL FEE $ ____________

32 REMARKS FOR UNUSUAL SERVICES

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEE COMPLETED

Signed (Dentist) ____________ Date ____________

TOTAL FEE CHARGED	
CHARGES	
CHARGES	
LESS DEDUCTIBLE	
TOTAL BENEFIT	
OTHER INS. ADJ.	
NET BENEFIT	

**If you are a Network Dental Preferred Provider, please indicate your usual charge for each procedure.

Form Approved by the Council on Dental; Programs of the A.D.A. 1975
ADS (75)