



DENTAL SERVICE REPORT

Mail To:
Mutual Medical Plans, Inc.
P.O. Box 689
Peoria, IL 61652

PART 1: SUBSCRIBER INFORMATION	1. Patient Name: First Middle Initial Last			2. Relationship To Emp. Self Spouse Dtr. Son		3. Sex M F		4. Pt. Birth Date Mo. Day Yr.		5. If Full Time Student: School & City									
	6. Employee Name First Initial Last			7. PHONE			8. Employee Social Security Number												
	9. Mailing Address, Street, City, State, Zip Code																		
	10. Name of Employer or Group			10A. Place of Employment of Spouse															
	11. Is Patient Covered By Another Dental Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			If Yes, Policy Holder ID No.			12. Name and Address of Other Insurance Company												
PATIENTS AUTHORIZATION: I HEREBY ACCEPT THE FOLLOWING TREATMENT PLAN AND AUTHORIZE THE RELEASE OF ANY INFORMATION RELATIVE TO THIS CASE.										Signed (Patient, or Parent if Minor)			Date						
PART 2: DENTIST INFORMATION	13. Dentist Name			19. Is Treatment Result of Occupational Illness or Injury?			No		Yes		If Yes, Enter Brief Description And Dates								
	14. Mailing Address, Street, City, State, Zip Code			20. Is Treatment Result of Auto Accident? Other Accident?															
	15. Dentist Soc. Sec. or T, I, N.			22. Are Any Services Covered By Another Plan?															
	23. If Prosthesis, is This Initial Placement?										Date of Prior Placement								
	16. First Visit Dt. Current Series		17. Place of Treatment Office Hosp. ECF Other		18. Radiographs or Models Enclosed? (X-rays should be mounted)		No		Yes		How Many		24. Is Treatment For Orthodontics?		If Services Already Com-menced, Enter:		Date Appliance Placed		Mos. Treatment Remaining
DENTIST'S STATEMENT: I HEREBY CERTIFY THAT THE SERVICES LISTED HAVE BEEN OR WILL BE PROVIDED BY ME.				Dentist Signature				Lic. No.		Date		<input type="checkbox"/> I HAVE BEEN PAID <input type="checkbox"/> I HAVE NOT BEEN PAID							
PART 3: EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32 - USE CHARTING SYSTEM SHOWN.																			
IDENTIFY MISSING TEETH WITH "X" 		Tooth No. or Letter	Sur-faces	Description of Services, including X-Rays, Prophylaxis, Materials Used, Etc.				Date Service Performed Mo. Day Yr.		Procedure Code	Fee For Each Service		OFFICE USE ONLY						
		1																	
		2																	
		3																	
		4																	
		5																	
		6																	
		7																	
		8																	
		9																	
		10																	
26. Remarks For Unusual Services		11																	
										TOTAL FEE ON THIS FORM									