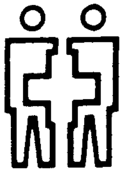


MUTUAL MEDICAL

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 / Spse. / 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? ☐ Yes ☐ 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

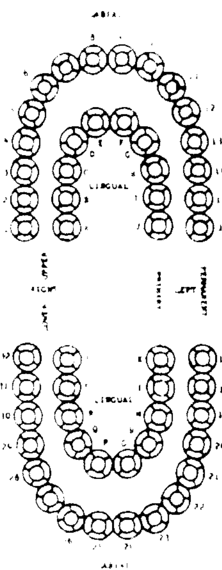
13. Dentist Name		19. Is Treatment Result of Occupational Illness or Injury?	No	Yes	If Yes, Enter Brief Description And Dates
14. Mailing Address, Street, City, State, Zip Code		20. Is Treatment Result of Auto Accident? Other Accident?			
		22. Are Any Services Covered By Another Plan?			
15. Dentist Soc. Sec. or T.I.N.		23. If Prosthesis, Is This Initial Placement?			(If No, Reason For Replacement) / 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 Commenced, 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 | 25. ☐ I HAVE BEEN PAID ☐ I HAVE NOT BEEN PD

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	Surfaces	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							
11							
					TOTAL FEE ON THIS FORM		

26. Remarks For Unusual Services