MUTUAL MEDICAL

DENTAL SERVICE REPORT

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

PART 1: SUBSCRIBER INFORMATION

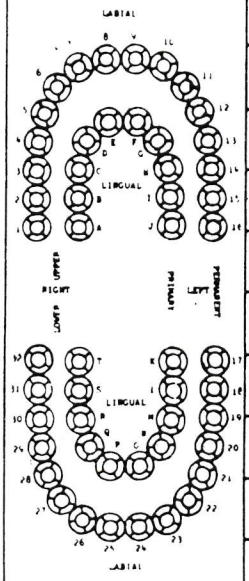
1. Patient Name: First Middle Initial Last		2. Relationship To Emp. Self / Spse. / Dtr. / Son	3. Sex M / F	4. Pt. Birth Date Mo. / Day / Yr.	5. If Full Time Student: School & City
6. Employee Name First Initial Last			7. PHONE		8. Employee Social Security Number
9. Mailing Address, Street, City, State, 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