PART 1 DENTIST

Dentist's Name _____

Address _____

City, Province _____

Postal Code _____

Telephone _____

Patient's Last Name _____ Given Names _____

Address _____ Apt. _____

City, Province _____

Postal Code _____

Date of Service D M Y	Int. Tooth Code	Procedure Code	Tooth Surfaces	Laboratory Charge	Dentist's Fee	Total Charge

This is an accurate statement of services performed and fees charges. E. & OE.	Total Submitted Fee
Dentist's Signature	Date: Day Month Year

FOR DENTIST'S USE ONLY.

For additional information Re: diagnosis, procedures or complications and special considerations.

I understand that the fees listed in this claim may not be covered by or may exceed my policy benefits. I understand that I am financially responsible to my dentist for the entire cost of the treatment. I authorize release of the information contained in this claim form to my insuring company or its agents.	I hereby assign benefits payable from this claim to the above named dentist and authorize payment directly to him.	CLAIM APPROVED:
Signature of Patient (or Parent/Guardian)	Signature of Subscriber	Day Month Year Assessor

FOR PLAN ADMINSTRATOR USE ONLY:

NOTICE TO DENTIST:

Please Note – Under the terms of the Policy, this report must be forwarded to Gymnastics BC within 90 days of the date of the accident. Your co-operation will be appreciated.

PART 2. DENTIST'S SUPPLEMENTARY REPORT

1. Description of Damage _____

2. Is further treatment indicated? NO ☐ YES ☐ If "Yes" please indicate:

Int. Tooth Code		Treatment Indicated – use procedure code if possible	Est. Date – Treatment Day	Mo.	Yr.

3. Describe further potential problems and indicate time frame. _____

Date: Day Month Year

Dentist's Signature _____

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

ATTENDING PHYSICIAN'S STATEMENT

Please complete this claim form and return it to your patient.

Patient's Name: _____ Age: _____

Address: _____

Diagnosis: Please indicate the name(s) of the bone(s) fractured or dislocated:

If Hospitalized, give name of hospital: _____

Date Admitted: _____ Discharged: _____

If referred to you, give name of referring physician:

Operations (or other procedures performed): _____

Date: _____

Date: _____

Date: _____

Date of first consultation for above: _____

Date of first symptoms: _____ Date of Accident: _____

Has the patient ever had same or similar condition? _____

If yes, please state when and describe: _____

Is there any other disease or infirmity affecting the present condition?

Date: _____ Signature _____ (M.D.)

Address: _____

Certified Specialist _____

Phone: _____