1. PLEASE TYPE OR PRINT
2. DO NOT USE A HIGHLIGHTER
3. STAPLE X-RAYS TO TOP RIGHT CORNER
4. SEND PAGE 1 TO DELTA

DELTA DENTAL OF CALIFORNIA ENCOURAGES DENTAL OFFICES TO SUBMIT CLAIMS ELECTRONICALLY.

DELTA DENTAL®
Delta Dental of California

P.O. Box 997330
Sacramento, CA 95899-7330
Customer Service (888) 335-8227

DELTA USE ONLY

PLEASE MAKE SURE EMPLOYEE'S MAILING ADDRESS IS LEGIBLE, CURRENT & COMPLETE

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 AND OVER AGE 18, INDICATE: SCHOOL CITY

6. EMPLOYEE/SUBSCRIBER NAME: FIRST MIDDLE LAST

7. EMPLOYEE SOCIAL SECURITY NUMBER

8. EMPLOYEE BIRTHDATE: MO. DAY YEAR

9. EMPLOYER (COMPANY) NAME AND ADDRESS/UNION LOCAL

10. GROUP NUMBER

EMPLOYEE MAILING ADDRESS — APT. NO. — PHONE NO.

CITY, STATE, ZIP — ZIP CODE

11. IS PATIENT COVERED BY ANOTHER PLAN OF BENEFITS? IF YES, COMPLETE ITEMS 12 THROUGH 15. YES _____ NO _____

12a. NAME AND ADDRESS OF DENTAL CARRIER(S), ITEM 11.

12b. GROUP NUMBER

13. NAME AND ADDRESS OF EMPLOYER, ITEM 11

14a. EMPLOYEE NAME, ITEM 11 (IF DIFFERENT FROM PATIENT'S)

14b. EMPLOYEE SOCIAL SECURITY NUMBER

14c. EMPLOYEE BIRTHDATE: MO. DAY YEAR

15. RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT OTHER ____

16. DENTIST NAME — LICENSE NUMBER

17. MAILING ADDRESS — PHONE NO.

CITY, STATE, ZIP — ZIP CODE

18. DENTIST SOC. SEC. NO. OR T.I.N.

19. DENTIST LICENSE NO.

20. DENTIST PHONE NO.

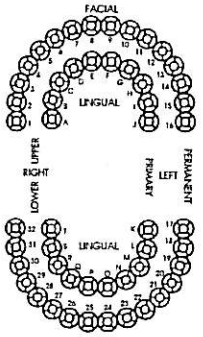
	NO	YES	IF YES, ENTER DATES, BRIEF DESCRIPTION AND ANY AMOUNT PAID.
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?			
25. IS TREATMENT RESULT OF AUTO ACCIDENT?			
26. OTHER ACCIDENT?			
27. ARE ANY SERVICES COVERED BY A NON-DENTAL PLAN?			
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? IF NO, ENTER REASON FOR REPLACEMENT.			29. DATE OF PRIOR PLACEMENT
30. IS TREATMENT FOR ORTHODONTICS?			IF SERVICES ALREADY COMMENCED, ENTER → DATE APPLIANCES PLACED — MOS. TREATMENT REMAINING

21. FIRST VISIT DATE CURRENT SERIES

22. PLACE OF TREATMENT: OFFICE HOSP. ECF OTHER

23. RADIOGRAPHS OR MODELS ENCLOSED? NO ☐ YES ☐ HOW MANY?

IDENTIFY MISSING TEETH WITH "X"



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

TOOTH NO. OR LETTER	SURFACES	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE COMPLETED M D Y		PROCEDURE NUMBER	FEE	
		1					
		2					
		3					
		4					
		5					
		6					
		7					
		8					
		9					
		10					
		11					
		12					
		13					
		14					
		15					

32. REMARKS FOR UNUSUAL SERVICES OR **AMOUNT PAID BY OTHER COVERAGE**

MY DENTIST MAY GIVE DELTA AND ANY OTHER CARRIER NAMED ABOVE INFORMATION ABOUT MY DENTAL CONDITION OR TREATMENT NEEDED TO DETERMINE BENEFITS FOR UP TO 5 YEARS FROM THIS DATE.

SIGNATURE OF PATIENT (OR PARENT OR GUARDIAN) _____ DATE _____

You may receive a copy of this authorization on request.

TOTAL FEE CHARGED	
PATIENT PAYS	
PLAN PAYS	
AMOUNT APPLIED TO DEDUCTIBLE	

PREDETERMINATION OF COST

THE TREATMENT LISTED IS NECESSARY IN MY PROFESSIONAL JUDGMENT AND I REQUEST A PREDETERMINATION OF COST.

DENTIST SIGNATURE _____ DATE _____

TREATMENT COMPLETED - PAYMENT REQUESTED

THE TREATMENT LISTED WAS COMPLETED. I WILL CHARGE AND INTEND TO COLLECT THE ENTIRE PORTION OF THE FEES STATED ABOVE WHICH DELTA DETERMINES TO BE THE PATIENT'S RESPONSIBILITY, AND I WILL NOT WAIVE, REDUCE OR REBATE ANY OF THAT PORTION UNLESS I EXPRESSLY SO STATE ON THIS FORM.

DENTIST SIGNATURE _____ DATE _____

SEE DENTIST'S HANDBOOK FOR PARTICIPATION RULES.

ATTENDING DENTIST'S STATEMENT
DELTA 105 Rev. 7/03

1. SUBMIT PAGE 1 TO DELTA.
2. RETAIN PAGE 2 FOR YOUR FILES.