Insurance Copy- attach this statement to your insurance claim form

Complete the personal information requested on the form. This statement contains all the information the doctor is required to supply. It is not necessary for this office to fill out the insurance company claim form.

PATIENT NAME: ______________________

ATTENDING DENTIST STATEMENT

ADA Dental Procedures and Nomenclature

DATE OF SERVICE:_______________________

CPT	DIAGNOSTIC	FEE
☐ D0120	Periodic Exam	
☐ D0140	Limited Oral Evaluation	
☐ D0210	Full Mouth X-Ray Series	
☐ D0220	Periapical X-Ray Single	
☐ D0230	Periapical X-Ray Additional	
☐ D0270	Bw X-Rays Single	
☐ D0272	Bw 2 X-Rays	
☐ D0460	Pupal Vitality Tests	
☐ D0470	Diagnostic Cast Model	
☐ ____	Miscellaneous	

CPT	PREVENTIVE	FEE
☐ D1110	Prophylaxis	
☐ ____	Scaling & Curettage with above	
☐ D4910	Periodontal Prophylaxis	
☐ D1203	Fluoride Treatment	
☐ D1330	Oral Hygiene Instruction	
☐ D1351	Sealant	
☐ D1120	Child Prophylaxis	
☐ _____	Miscellaneous____________________	

CPT	PERIODONTICS	FEE
☐ D4340	Perio Scaling / Root Planing Complete	
☐ D4341	Perio Scaling/Quadrant	
☐ D4210	Gingivectomy Quadrant	
☐ D4220	Gingival Curettage Quadrant	
☐ D4330	Occlusal Adjustment Limited	
☐ D4331	Occlusal Adjustment Complete	
☐ D4355	Gross Scale	
☐ D4345	Adjunctive Periodontal	

CPT	ENDODONTICS	TOOTH #	FEE
☐ ___	Pulp Capping (Excluding Restoration)		
☐ D3110	Direct Pulp Cap		
☐ D3120	Indirect Pulp Cap		
☐ D3220	Pulpotomy Excl. Restor.		
☐ D3960	Bleaching Excl Restor.		
☐ D3310	Root Canal 1 Canal		
☐ D3320	(Excluding Restoration) 2 Canals		
☐ D3330	(Excluding Restoration) 3 Canals		
☐ D7130	Root Removal		

CPT	ORAL SURGERY	TOOTH #	FEE
☐ D7140	Extraction Single Tooth		
☐ D7140	Each Additional Tooth		
☐ D7220	Surgical Extraction		
☐ D7280	Surgical Exp. For Eruption		
☐ D7270	Tooth Replanation		
☐ ____	Miscellaneous____________		

RETURN: ____DAYS ____WEEKS ____MONTHS

NEXT APPT: _______ _______ _______ _______ AM PM

DAY MONTH DATE TIME

CPT	PROSTHETIC	TOOTH #	FEE
Crowns-Single:			
☐ D2790	Full Gold		
☐ D2740	Porcelain Jacket		
☐ D2750	Porcelain & Gold		
☐ D2720	Acrylic & Gold		
☐ D2960	Porcelain Veneer		
Bridge Abutments:			
☐ D6790	Gold		
☐ D6750	Porcelain & Gold		
☐ D6720	Acrylic & Gold		
Bridge Pontics:			
☐ D6210	Gold		
☐ D6240	Porcelain & Gold		
☐ D6250	Acrylic & Gold		
☐ D6545	Maryland Bridge		
☐ D2891	Post & Core Gold		
☐ D2952	Steel Post & Core		
Partial Dentures:			
☐ D5213	Upper Cast		
☐ D5214	Lower Cast		
☐ D5211	Upper Acrylic		
☐ D5212	Lower Acrylic		
☐ D5281	Nesbitt		
☐ D5820	Flipper		
Complete Dentures:			
☐ D5110	Upper		
☐ D5120	Lower		
☐ D5130	Immediate Upper		
☐ D5140	Immediate Lower		
Adjustments:			
☐ D5411	Full Lower		
☐ D5410	Full Upper		
☐ D5421	Partial Upper		
☐ D5422	Partial Lower		
Repairs:			
☐ D56__	Partial		
☐ D55__	Denture		
Reline Procedures:			
☐ D5730	Upper/ Lower Full		
☐ D5740	Upper/ Lower Partial		
☐ _____	Miscellaneous		

TO OUR PATIENTS: Please retain this form for your records. It is an exact copy of your fees and services rendered at each office visit.

TODAY'S CHARGE: ____________

IF UNABLE TO KEEP THIS APPOINTMENT KINDLY GIVE 24 HOURS NOTICE OTHERWISE A CHARGE MAY BE MADE FOR TIME RESERVED

CPT	ORTHODONTICS	FEE
☐ D8100	Tooth Movement	
☐ D8350	Interceptive Tx	
☐ D1510	Space Maintainer Fixed	
☐ D1525	Space Maintainer Removable	
☐ D9940	Occlusal Guard	
☐ D9972	Bleaching - Arch	

CPT	ADJUNCTIVE SERVICES	FEE
☐ D9110	Palliative Emer. Tx	
☐ D9910	Desensitizing	
☐_____	____________________	

CPT	RESTORATIVE	SURFACE	TOOTH #	FEE
Amalgam				
☐ D2140	1 Surf.			
☐ D2150	2 Surf.			
☐ D2160	3 Surf.			
☐ D2161	4 Surf.			
Comp Res. Ant.				
☐ D2330	1 Surf.			
☐ D2331	2 Surf.			
☐ D2332	3 Surf.			
Comp Res. Post				
☐ D2391	1 Surf.			
☐ D2392	2 Surf.			
☐ D2393	3 Surf.			
☐ D2394	4 + Surf.			
☐ D2333	Recon. of Fract Tooth			
☐ D2951	Pin Only			
☐ D2340	Acid Etch			
☐ D2510	Gold In. 1 Surf.			
☐ D2520	Gold In. 2 Surf.			
☐ D2530	Gold In. 3 Surf.			
☐ D6930	Recement Bridge			
☐ D2910	Recement Inlay			
☐ D2920	Recement Crown			
☐ D6999	Recem. Maryland Bridge			
☐ D2940	Sedative Filling			
☐ D2950	Crown Build-Up Pins			

☐ **THIS IS A PRE-TREATMENT ESTIMATE**

NOTE TO INSURANCE CARRIERS: This form has been adopted to reduce the costs of paperwork. If you require your own form or itemized bill, they will be completed upon receipt of $10.00 service charge.

FL LIC #000-522-1 T.I.N. #14-12345689

Miles Shifrin, D.M.D.

P.O. BOX 2000
3000 TEMPLE AVENUE
DELRAY BEACH, FLORIDA, 11111
PHONE: (561) 395-4000