Dental Claim Form

To be completed wholly by the dentist

Patient name: _____ Date of treatment: _____

Address: _____

Diagnosis: _____

1. Please complete the tooth chart for dental services

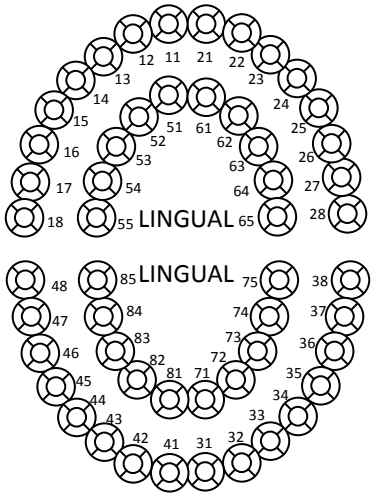
2. In case of accident or injury:
   Were teeth natural and free from decay, defects, or prior restoration/appliances of the time of the accident? If unknown, please state your opinion.
   ☐ No ☐ Yes (please explain)

   _____

   Was the accident in any way connected with the patient's employment or job duties?
   ☐ No ☐ Yes (please explain)

   _____

Tooth Chart



Directions

1. Mark fillings by shading in the appropriate space
2. Mark extractions with "X"
3. Mark crowns with a "C"
4. Mark bridges with a "B"

Itemization of Services

Tooth	Surface	Description of Services	Date	Fee

Name and address of Dentist: Signature and stamp: Date:

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