The Argus Group
The Argus Building
14 Wesley St., P. O. Box HM 1064
Hamilton HM EX, Bermuda
Tel: (441) 295-2021 • Fax: (441) 292-6763
e-mail: insurance@argus.bm • www.argus.bm

ARGUS
Insurance • Pensions • Investments

ATTENDING DENTIST'S STATEMENT

CHECK ONE:

☐ DENTIST'S PRE-TREATMENT ESTIMATE
☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

PATIENT SECTION

PATIENT NAME	SURNAME	GIVEN NAMES	RELATIONSHIP TO EMPLOYEE: SELF / SPOUSE / CHILD / OTHER	SEX: M / F	PATIENT BIRTH DATE: MONTH / DAY / YEAR
EMPLOYEE NAME	SURNAME	GIVEN NAMES	IF PATIENT IS A FULL TIME STUDENT – NAME OF SCHOOL		
EMPLOYER (COMPANY) NAME			GROUP POLICY NUMBER		EMPLOYEE CERTIFICATE NUMBER

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

SIGNED (PATIENT OR PARENT IF MINOR) DATE (MM/DD/YY)

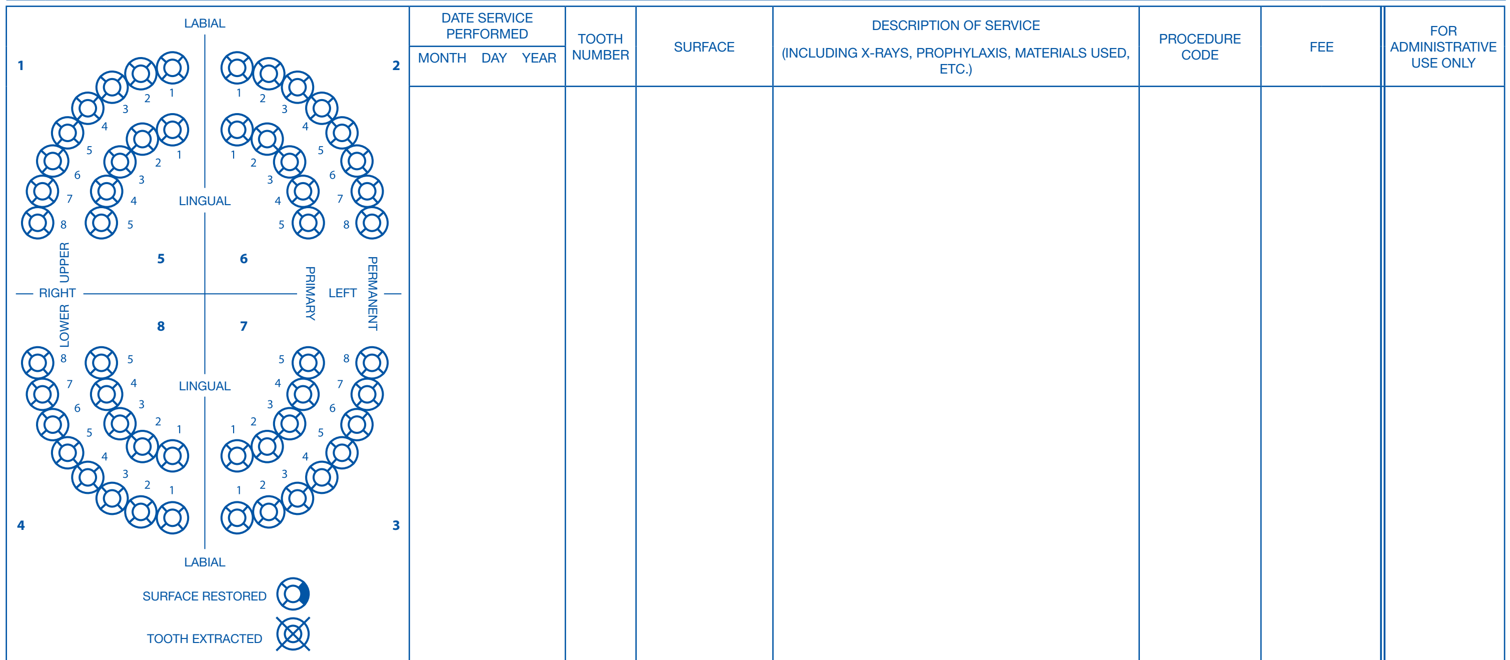
I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

SIGNED (PATIENT OR PARENT IF MINOR) DATE (MM/DD/YY)

DENTIST SECTION

DENTIST NAME	IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO	YES	IF YES, ENTER BRIEF DESCRIPTION AND DATES
MAILING ADDRESS	IS TREATMENT A RESULT OF AUTO ACCIDENT OR OTHER ACCIDENT?			
	IF DENTURE, CROWN OR BRIDGE, IS THIS THE INITIAL PLACEMENT?			
DENTIST'S PHONE NUMBER	IF NO, GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT.			

FIRST VISIT DATE CURRENT SERIES: MONTH / DAY / YEAR	PLACE OF TREATMENT: OFFICE / HOSP / OTHER	RADIOGRAPHS OR MODELS ENCLOSED	NO	YES	HOW MANY	IS TREATMENT FOR ORTHODONTICS?	NO	YES	IF SERVICES ALREADY COMMENCED ENTER DATE APPLIANCES PLACED: MONTH / DAY / YEAR	MOS, TREATMENT REMAINING



DATE SERVICE PERFORMED: MONTH / DAY / YEAR	TOOTH NUMBER	SURFACE	DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	PROCEDURE CODE	FEE	FOR ADMINISTRATIVE USE ONLY

FOR DENTIST'S USE ONLY. FOR ADDITIONAL INFORMATION RE: DIAGNOSIS, PROCEDURES, OR COMPLICATIONS AND TIME IN UNITS.

TOTAL FEE CHARGED	
MAX ALLOWABLE	
DEDUCTIBLE	
INSURER %	
INSURER PAYS	
PATIENT PAYS	

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THAT THE FEES SUBMITTED ARE THE ACTUAL FEES I HAVE CHARGED AND INTEND TO COLLECT FOR THOSE PROCEDURES

SIGNED (DENTIST) DATE (MM/DD/YY)

ELIGIBILITY FOR BENEFITS IS DETERMINED BY THE TERMS AND CONDITIONS OF YOUR POLICY. PRE-TREATMENT ESTIMATE FOR MAJOR RESTORATIVE WORK IS RECOMMENDED.