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 USE ONLY

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/ 10. GROUP NUMBER UNION LOCAL
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.
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**
24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY? NO YES
25. IS TREATMENT RESULT OF AUTO ACCIDENT? NO YES
26. OTHER ACCIDENT? NO YES
27. ARE ANY SERVICES COVERED BY A NON-DENTAL PLAN? NO YES
IF YES, ENTER DATES, BRIEF DESCRIPTION AND ANY AMOUNT PAID.
18. DENTIST SOC. SEC. NO. OR T.I.N.
19. DENTIST LICENSE NO.
20. DENTIST PHONE NO.
28. IF PROSTHESIS, IS THIS INITIAL PLACEMENT? IF NO, ENTER REASON FOR REPLACEMENT. NO YES
29. DATE OF PRIOR PLACEMENT
21. FIRST VISIT DATE CURRENT SERIES
22. PLACE OF TREATMENT OFFICE HOSP. ECF OTHER
23. RADIOGRAPHS OR MODELS ENCLOSED? NO ☐ YES ☐ HOW MANY?
30. IS TREATMENT FOR ORTHODONTICS? NO YES
IF SERVICES ALREADY COMMENCED, ENTER →
DATE APPLIANCES PLACED
MOS. TREATMENT REMAINING