ATTENDING DENTIST'S STATEMENT

Exhibit 2 OAR 836-50-0110

Check one:										Carrie	Carrier name and address								
l		entist's pre-treat	ma	nt ac	timata														
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늗	_	. Patient name	וונ ט	I act	uai ser	rices		2. Relationship to emplo	ove c	13	Sex 4.F	atient	birthdat	В	5. If full time st	udent		· · · · · · · · · · · · · · · · · · ·	
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		8. Employee/subscriber r	name	and n	ealling add	ress	- 1	Employee/subscriber soc. sec. or i.D. numi		Employee birthdate	subscriber	9. 1	Employe	er (CO	mpany) name and a	doress	10. Group	number	
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1	1	dental plan? yes no						.											
Ņ		If yes, complete 12-a.																	
ģ	1	ls patient covered by a medical plan? yes no																	
- ZFORMAT	1	14-a. Employee/subscriber name					14-b. Employee/subsc	14-c, E	14-c. Employee/subscriber				15. Relationship to patient self parent						
Î	(if different than patient						soc. sec. or l.D. number		b M	birthdate MM DD YYYY									
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		e reviewed the followin claim. I understand that							ung to	below	named dem	al enti	ity.	10 00	etta benents other	mise paya	DIG EO IIIE	bilectly to the	
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В		Name of Billing Denti	ist or	Denta	I Entity							pational	- 1	188	If yes, enter brief de	scription ar	iu uatės		
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Ľ	1	Address where paym	ent s	should	be remitte	d					25. is treate of auto	ment res accident							
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E	1	18. Dentist Soc. Sec. or T.I.N. 19. Dentist license no. 20. Dentist phone no.								27.ff prosti				(if no, reason for replacement)			28. Date of prior placement		
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ı			- 1			Description						_	ate serv	_	Procedure	F	20	administrative	
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