Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check (✓) yes or no if you have had problems with any of the following:

❑ Y ❑ N Bad breath
❑ Y ❑ N Bleeding gums
❑ Y ❑ N Clicking or popping jaw
❑ Y ❑ N Food collection between teeth
❑ Y ❑ N Grinding or clenching teeth
❑ Y ❑ N Loose teeth or broken fillings
❑ Y ❑ N Periodontal treatment
❑ Y ❑ N Sensitivity to cold
❑ Y ❑ N Sensitivity to hot
❑ Y ❑ N Sensitivity to sweets
❑ Y ❑ N Sensitivity when biting
❑ Y ❑ N Sores or growths in mouth

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Other information about your dental health or previous treatment _____

Medical History

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? ❑ Y ❑ N

If yes, describe _____

Are you currently under physician care? ❑ Y ❑ N If yes, describe _____

Have you ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? ❑ Y ❑ N

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ❑ Y ❑ N

Women: Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

Check (✓) yes or no whether you have had any of the following:

❑ Y ❑ N AIDS/HIV Positive
❑ Y ❑ N Anaphylaxis
❑ Y ❑ N Anemia
❑ Y ❑ N Arthritis, Rheumatism
❑ Y ❑ N Artificial heart valves
❑ Y ❑ N Artificial joints
❑ Y ❑ N Asthma
❑ Y ❑ N Atopic (allergy prone)
❑ Y ❑ N Back problems
❑ Y ❑ N Blood disease
❑ Y ❑ N Cancer
❑ Y ❑ N Chemical dependency
❑ Y ❑ N Chemotherapy
❑ Y ❑ N Circulatory problems
❑ Y ❑ N Cortisone treatments
❑ Y ❑ N Cough, persistent
❑ Y ❑ N Cough up blood
❑ Y ❑ N Diabetes
❑ Y ❑ N Epilepsy
❑ Y ❑ N Fainting
❑ Y ❑ N Food allergies
❑ Y ❑ N Glaucoma
❑ Y ❑ N Headaches
❑ Y ❑ N Heart murmur
❑ Y ❑ N Heart problems
Describe _____
❑ Y ❑ N Hemophilia/ Abnormal bleeding
❑ Y ❑ N Herpes
❑ Y ❑ N Hepatitis
❑ Y ❑ N High blood pressure
❑ Y ❑ N Jaw pain
❑ Y ❑ N Kidney disease or malfunction
❑ Y ❑ N Liver disease
❑ Y ❑ N Material allergies (latex, wool, metal, chemicals)
❑ Y ❑ N Mitral valve prolapse
❑ Y ❑ N Nervous problems
❑ Y ❑ N Pacemaker/ Heart surgery
❑ Y ❑ N Psychiatric care
❑ Y ❑ N Rapid weight gain or loss
❑ Y ❑ N Radiation treatment
❑ Y ❑ N Respiratory disease
❑ Y ❑ N Rheumatic/Scarlet fever
❑ Y ❑ N Shingles
❑ Y ❑ N Shortness of breath
❑ Y ❑ N Skin rash
❑ Y ❑ N Spina Bifida
❑ Y ❑ N Stroke
❑ Y ❑ N Surgical implant
❑ Y ❑ N Swelling of feet or ankles
❑ Y ❑ N Thyroid disease or malfunction
❑ Y ❑ N Tobacco habit
❑ Y ❑ N Tonsillitis
❑ Y ❑ N Tuberculosis
❑ Y ❑ N Ulcer/Colitis
❑ Y ❑ N Venereal disease

Is patient currently taking any medications? If yes, list all:

_____

_____

Does patient have drug allergies? If yes, list all:

_____

_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

GENERAL DENTISTRY INFORMED CONSENT

1. WORK TO BE DONE
I understand that I am having the following work done: Exam, X-rays, Prophylaxis (Cleaning), and Other _____
X (Initials _____

2. DRUGS AND MEDICATION
I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock.
X (Initials _____

3. CHANGES OF TREATMENT PLAN
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were discovered during examination. For example, root canal therapy following routine restorative procedures
X (Initials _____

4. REMOVAL OF TEETH
Alternatives to removal of teeth have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.), and I authorize the Dentist to remove the following teeth _____ and any other necessary for the reasons in paragraph #3. I understand removing teeth does not always remove all of the infection, if present and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesis) that can last for an indefinite period of time or fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.
X (Initials _____

5. CROWN, BRIDGES AND CAPS
I understand that no guarantee had been given that the proposed treatment will be to my complete satisfaction. I understand that sometimes it is not possible to match the color of natural teeth. I further understand the I may be wearing temporary crowns which may come off easily and I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color will be before cementation. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge or cap. I understand there will be additional charges for remakes due to my delaying cementation. I understand that in some instances a root canal may be necessary during or after a crown or bridge procedure.
X (Initials _____

6. ENDODONTIC TREATMENT (ROOT CANAL)
I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from treatment, and hat occasionally root canal filling material may extend through the tooth, which does not necessarily affect the success of the treatment. I understand the endodontic files and reamers are very fine instruments and stresses vented in their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it.
X (Initials _____

7. PERIODONTAL LOSS (TISSUE AND DONE):
I understand that I have a serious condition, causing gum and bone inflammation or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacement and/or extractions, and I understand that undertaking any dental procedures may have a future adverse affect on my periodontal condition.
X (Initials _____

8. FILLINGS
I understand that care must be exercised in chewing on fillings, especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect of a newly placed filling. I understand that if a filling fails, a crown or alternative treatment may be necessary.
X (Initials _____

9. DENTURES
I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in eating are common problems. Immediate denture (placements of denture immediately after extractions) may be painful. Immediate denture may require considerable adjusting and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted denture(s). If a remake is required due to my delays of more than 30 days, there will be additional charges.
X (Initials _____

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding dental treatment, which I have requested and authorized. I understand that no other Dentist is responsible for my dental treatment.

I hereby authorize any of the doctors or dental auxiliaries to proceed with and perform the dental restorations and treatments explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosed circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees collection fees, or court costs that may be incurred to satisfy this obligation.

Signature of Patient or Guardian _____ Date _____

INFORMED CONSENT FOR DENTAL TREATMENT

CROWNS – CAPS

BENEFITS:
- Make you look nicer (cosmetic)
- To Repair a tooth which is badly broken
- To Prevent a tooth from fracturing
- To restore a tooth which has broken
- To eliminate a space where food is being trapped
- To hold a false tooth in place as part of a bridge
- To make a solid structure to attach partial denture
- To splint loose teeth together to strengthen them
- The tooth can no longer be filled

POSSIBLE COMPLICATIONS:
- Porcelain portion of crown may fracture
- Crown may come off and need to be reconnected
- Tooth may abscess and require further treatment (may not show up until later)

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING
- Tooth will probably fracture
- Tooth may need to be extracted
- May need a root canal in addition to the crown
- May need bridgework or denture

ALTERNATIVES
- Extraction
- Temporary crown
- Steel crown

BRIDGEWORK

BENEFITS:
- Make you look nicer
- To replace missing teeth
- Missing teeth are not removable
- Some of the same advantages as crowns
- Can improve chewing efficiency

POSSIBLE COMPLICATIONS:
- Same as crowns

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING
- Teeth will drift and lean over
- May loose back teeth due to shifting
- Periodontal problems (Gun disease)
- Can reduce chewing efficiency

ALTERNATIVES:
- Partials
- Temporary partials
- No teeth in the spaces

PARTIALS (REMOVABLE BRIDGEWORK)

BENEFITS:
- Cost

POSSIBLE COMPLICATIONS:
- Can wear on teeth
- Can rock or stress teeth – may loosen own natural teeth
- Metal clasps a sometimes visible
- Decay can occur under clasps
- Usually some amount of movement from the partial

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING
- Same as under Bridgework

ALTERNATIVES:
- Bridgework
- Temporary Partial
- Keep spaces without teeth placement

ROOT CANAL

BENEFITS:
- Eliminate decay
- Relieve Pain
- Save the tooth

POSSIBLE COMPLICATIONS
- Undiagnosable root fracture means failure and extraction
- Undiagnosable auxiliary canal means failure and extraction

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING
- Extraction of tooth

ALTERNATIVES
- Extraction
- Bridgework

FILLINGS

BENEFITS:
- Eliminate decay
- Relieve pain
- Fill in a hole or space in tooth
- Cover eroded area
- Protect a sensitive surface

POSSIBLE COMPLICATIONS:
- Tooth may abscess from the filling
- May fracture the tooth
- Tooth will be sensitive to temperature changes
- Toxicity from silver fillings is alleged by some
- Filling may fall out

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING
- May loose tooth
- Tooth may fracture
- Decay will get worse
- May result in need for root canal

ALTERNATIVES:
- Temporary filling

GUM SURGERY (Gingivectomy)

BENEFITS:
- Eliminate infection
- Reduce food pockets around teeth
- Eliminate foul odors
- Reduce overgrown tissue
- Can eliminate Tartar effectively

POSSIBLE COMPLICATIONS:
- May need to be replaced after a time
- Some after-pain
- Might lose teeth if they don't respond to treatment

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING
- Will lose tooth sooner
- May not get rid of infection

ALTERNATIVES:
- More frequent appointments for scaling

EXTRACTIONS

BENEFITS:
- Last resort for non-salvageable tooth
- Eliminate pain
- Remove teeth that are out of position

POSSIBLE COMPLICATIONS:
- Fractured particles may remain
- Irritation to nerves may cause temporary or permanent numbness
- Part or all of the tooth may be lodged in sinus, requiring more surgery
- Bad infections may take a long time to clear up
- Jaw may be stiff and difficult to open for a time
- If jawbone is very weak it may fracture

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
- Spread of infection
- Swelling
- Pain

ALTERNATIVES:
- None

CLEANING – SCALING

BENEFITS:
- Look nicer
- Clean mouth
- Eliminate odors
- Prevent odors
- Prevents Gum Disease
- Some portions may be performed by auxiliary personnel

POSSIBLE COMPLICATIONS:
- Sensitive teeth
- Feeling of spaces between teeth
- Filling may be loosened (Normal if filling was ready to fall out)
- Sensitive gums

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
- Stains on teeth
- Odors
- Gum Disease
- Will lose teeth sooner

ALTERNATIVES:
- None

X-RAYS

BENEFITS:
- More complete diagnosis
- Can find hidden problems
- Can make a determination of treatment
- X-Rays are taken by qualified personnel

POSSIBLE COMPLICATIONS:
- Exposure to X-Ray radiation (minimal)
- X-ray pictures remain property if this office

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
- Cannot perform dental services

ALTERNATIVES:
- None

BONDED FACINGS

BENEFITS:
- Esthetics – they look really nice
- Cover crooked teeth
- Close spaces and gaps
- Cover discolored teeth

POSSIBLE COMPLICATIONS:
- Edges can stain after a time and need to be freshened up (additional fee)
- Breakage can occur, resulting in need for remake
- Difficult to remove

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING
- None (other than appearance)

ALTERNATIVES:
- Crowns

LOCAL ANESTHETICS

BENEFITS:
- Avoid pain during treatment and procedures

POSSIBLE COMPLICATIONS:
- Prolonged numbness may extend beyond normal
- Nerve damage
- Bruising (hematoma)
- In rare instances, possible consequences may include all of those applicable. General Anesthesia, including allergic reactions up to and including death

CONSEQUENCES OF NOT HAVING WORK DONE OR POSTPONING:
- Mild to severe pain during and after treatment

ALTERNATIVES:
- Willingness to accept pain during treatment

Name of Patient _____

I have read the above statements and have received a copy of them if requested, and recognize their importance in helping me make decisions. My initials indicate that I have read and understand this consent document. I recognize that failures can occur for all kinds of reasons and that complications can occur in any procedure. I also understand that, where decay has occurred, or a tooth has fractured or abscessed, that these same forces are still working on the tooth even after it has been restored therefore, decay or fracture can still occur as the restored tooth is not better than what nature has given in the first place. If for any reason a conflict or disagreement should arise I will present such conflict or disagreement to my attending dentist in order to resolve the problem. If we are unable to agree on a solution, then I agree to take the problem to a reconciliation/mediation board such as the dental society and agree to accept their resolution in lieu of pursuing remedies by way of litigation. I also understand that this agreement is binding on my heirs and all other family members. I now give my consent to the attending dentist to render to me dental treatment that we have agreed is necessary for myself. I also agree to reimburse the attending dentist for all services rendered to me and I am aware that the payment for these services is due at the time they are rendered.

Signature _____ Date _____

MODERN SMILES

COSMETIC DENTISTRY

10545 Victory Blvd
North Hollywood CA 91606

(818) 763-9353
www.modernsmiles.com

HIPAA INFORMATION and CONSENT FORM

The Health Insurance Portability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your protected health information (PHI). Their restrictions do not include normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as it is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically included the sharing of information with other health care providers, laboratories, health insurance payers as it is necessary and appropriate for your care. Patient files may be stored in open racks and will not contain any coding which identifies a patient's condition of information with is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examinations room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents of information.

2. It is the policy of this office to remind patients of their appointments. We may do this be telephone, email, U.S. mail, or by any means convenient for the practice and/or requested by you. We may send you other communication informing you of changes to office policy and new technology that you might find valuable of informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in the performance of their duties.

5. You agree to bring any concern or complaints regarding privacy to the attention of the office manager of the doctor.

6. Your confidential information will not be used for the purpose of marketing of advertising of product, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning you PHI. However, we are not obligated to alter internal policies to conform to the request.

I, _____ Date_____

do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA information for and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Modern Smiles

10545 Victory Blvd.
North Hollywood, CA 91606
(818)763-9353

Thank you for choosing us as your dental health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we require that you read and sign prior to your first appointment.

All patients must complete our "Patient Information Form" before seeing the doctor.

PAYMENT IS DUE AT THE TIME OF SERVICE:
For non-insurance patients, full payment is due at the time of service. We accept cash, checks, and Visa/MasterCard/American Express and Discover. We do offer an easy payment plan through Care Credit upon credit approval.

ADULT PATIENTS:
Adult patients are responsible for payment at the time of service.

MINOR PATIENTS:
The adult accompanying a minor and the parents (or guardian) is responsible for payment. For unaccompanied minors, treatment will be denied unless charges have been pre-authorized to an approved Visa/MasterCard/American Express/Discover, cash or check.

INSURANCE:
If you have insurance, all estimated co-payments are due at the time of service. As a courtesy to our patients, we will call your insurance before any major treatment is performed and get your estimated co-payment amount.

Although we do verify your insurance over the phone, please understand that this is just an estimate. Your insurance decides to cover procedures at their discretion once they review the claim form. They may pay slightly more than our estimate or they may pay slightly less. Once your insurance pays, if there is a balance left over, the Patient/Parent/Guardian is responsible for that balance.

We encourage all of our patients to touch base with their insurance before any treatment and educate themselves on their insurance.

MISSED APPOINTMENTS:
x_____ **Appointments must be cancelled with at least 48hrs business day notice.** If less then 48hrs business day notice, our policy is to charge a minimum of **$75.00**. This fee will increase if the missed appointment is a lengthy appointment. We do understand that emergencies come up in life. But please help us serve our patients better by honoring this missed appointment policy.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy (above). I understand and agree to this Financial Policy.

X_____ _____
Signature-Patient or Responsible Party Date

MODERN SMILES CONSENT FOR DENTAL PHOTOGRAPHY

I, _____ (Patient), authorize

Dr. Kasra Tajik and Dr. Shahira Saad, to take photographs and/or videos of my face, jaws, and teeth, before, during and after treatment.

I consent to allow photographs to be used for the following:

- Dental Records
- Dental Research
- Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books
- Patient education
- Marketing materials, including website and social media

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

☐ Check here if you do not want your full face shot used for any of the above purposes

Signature (Patient) _____

Date _____

COVID-19 Pandemic Emergency Dental Treatment Consent Form

I,_____ knowingly and willingly consent to having dental treatment completed during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. Given the current limits in virus testing, it is impossible to determine who has it and who does not have COVID-19.

Dental procedures create water spray (aerosols), which is one way the disease can be spread. The ultra-fine nature of the spray can linger in the air for several minutes to hours, which can transmit the COVID-19 virus.

- I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office. _____(Initial)

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

- Fever
- Shortness of breath
- Cough
- Stomach upset
- Sore throat

_____ (Initial)

I understand that air travel significantly increases the risk of contracting and transmitting the COVID-19 virus. The CDC recommends social distancing of at least 6 feet for a period of 14 days around anyone who has traveled by air, and this distance is not possible with dentistry. _____ (Initial)

- I verify that I have not traveled outside the United States during the past 14 days to countries that have been affected by COVID-19._____ (Initial)

- I verify that I have not traveled within the United States by commercial airline, bus, or train within the past 14 days._____ (Initial)

Name _____Date_____

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

Primary Insurance

Person Responsible for Account _____
Last Name *First Name* *Initial*

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Please complete both sides.