J.J. STANIS AND COMPANY, INC.

377 Oak Street Suite 406 Garden City, NY 11530
Phone 516 • 465 • 3900 Fax 516 • 465 • 3920

ORTHODONTIC WORKSHEET

Return by Fax To:
J.J. Stanis and Company, Inc.
Fax: (516) 465-3920
Questions? Call J.J. Stanis and Company at (877) 470-3715 or (516) 465-3900

Section I: Patient Information

Patient Name: _____ Date of Birth:_____
Responsible Party:_____ Diagnosis: _____

Section II: Financial Information

(1) The total cost of treatment is expected to be: $_____
(2) The Primary Insurance Carrier is expected to pay: $_____
(3) The Secondary Insurance Carrier is expected to pay: $_____
(4) "Out-of-Pocket" expenses to responsible party: $_____
(5) Date Treatment Began or is Expected to Begin: _____/_____/_____

Section III: Expenses

Amount Charged or Percentage of Total Treatment	Procedures:	Has this procedure been performed? If "YES", list Date of Service.
	for Pre-treatment (X-rays, molds, spacers)	YES NO
	for Application of the Appliances	YES NO
	for Ongoing Treatment	YES NO
	for Removal of Appliances	YES NO
	for Post-treatment (retainers, positioners, etc.)	YES NO
	for Other Expenses (please explain on separate sheet)	YES NO
	TOTAL (this should equal 100% or the amount listed as the Total Cost of Treatment)	

Section IV: Other Information

Estimated Treatment time is _____ months

We offer a _____ discount if all fees are paid in advance.

	Yes	No
Will there be additional charges if treatment time is longer than estimated?		
If the total fee is paid in advance and treatment must stop due to Extenuating circumstances (i.e.: transfer, disability, death) will a refund be made?	Yes	No

Section V: Service Provider Information and Signature

The information provided above may be used as a planning tool, and is not a contract for services. The above estimates are reasonable for client use in benefit planning and documentation. I understand that I may be asked for additional information and documentation as services are rendered.

Provider Name: _____ Phone Number: _____

Provider Address: _____ Fax Number: _____

_____ Contact Person: _____

_____ _____
Signature Date