



J.J. STANIS
& COMPANY, INC.

J.J. STANIS AND COMPANY, INC
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Orthodontic Worksheet

Return completed form by Mail, E-mail: claims1@jjstanisco.com, or Fax

Section I: Patient Information

Patient Name: _____
Responsible Party: _____

Date of Birth: _____
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.		
Will there be additional charges if treatment time is longer than estimated?	Yes	No
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