Cigna Dental
Comprehensive Treatment Plan

Patient Name	Member ID #	Patient Charge Schedule	Date

Dental Office Name	Dental Office Number	Number of Visits

Procedure Category/Description	Tooth Numbers/Area	Estimated Patient Responsibility	Initial for Acceptance
SIMPLE RESTORATIVE Amalgam (silver) Fillings Composite (white) Fillings			
ENDODONTICS Anterior Root Canal Therapy Bicuspid Root Canal Therapy Molar Root Canal Therapy			
PERIODONTICS Full Mouth Debridement Scaling and Root Planing Perio Maintenance Osseous Surgery Night Guard			
ORAL SURGERY Extraction, Simple Extraction, Surgical Extraction, Impacted Alveoplasty General Anesthesia			
PROSTHETICS Crowns (caps) Bridges (fixed) Partial Denture (removable) Full Denture Immediate Denture			
OTHER			
ESTIMATED TOTAL PATIENT RESPONSIBILITY			

My dentist has discussed the proposed treatment plan with me. He/She has explained any alternative procedures and any inherent risks, including consequences of partial or no treatment. I understand that the fees listed are estimated based on my current coverage and may be different from fees listed on the Patient Charge Schedule if my plan includes an alternate benefit provision or if I have selected any optional services. Additional charges, such as office visit fees, may apply. My payment responsibilities may change if my Patient Charge Schedule or plan changes. All fees will correspond to the Patient Charge Schedule and plan in effect on the date each procedure is initiated.

Patient Signature	Date

General Dentist Signature	Date

594086 Rev. 02/2012