

Orthodontic Treatment Form

This form is to be completed and signed by the dentist/orthodontist providing the service and submitted with your first orthodontic claim.

Member details

Member name	Membership number
<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Address	Postcode
<input type="text"/>	<input type="text"/>

Patient details

Patient name	Date of birth
<input type="text"/>	<input type="text"/>

Provider details

Provider name	Provider number
<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Address	Postcode
<input type="text"/>	<input type="text"/>

Details of treatment

Complete treatment case	<input type="checkbox"/> Fixed appliance/s	<input type="checkbox"/> Removable appliance/s
Minor treatment case	<input type="checkbox"/> Fixed appliance/s	<input type="checkbox"/> Removable appliance/s

Description of service

Treatment to commence	Expected duration of treatment	Estimated cost of treatment
<input type="text"/>	<input type="text"/>	<input type="text"/> \$

Costs of treatment

Code	Fee	Notes
Case notes	\$	
Initial payment	\$	
Progress payment	\$	
Other payment plan	\$	
Total fee:	\$	

Provider signature	Date signed
<input type="text"/>	<input type="text"/>