

Request for orthodontic treatment

Name of member:.....

Name of patient:.....

Date of birth:.....

Scheme name:.....

Membership no:.....

Name and practice no. (service provider):.....

Codes of intended treatment:

Code	Tariff

Intended duration of treatment:.....

Initial primary tariff:.....

Sequential monthly tariff:.....

Any foreseen extra costs (e.g. orthognatic surgery, etc.)

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.....

History of previous orthodontic treatment:

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.....

Please use mm degrees of identifying tooth numbering, where applicable, during the presentation of the following information, in aid of the motivation for this treatment.

Angle classification:.....

Overjet (mm):.....

Overbite (mm):.....

Space analysis: (indicate the amount in mm)

Crowding: excess space:

mm:..... mm:.....

Cephalometric analysis: (please include a copy of the tracing)

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.....

Any other relevant information: (diastemas, rotated teeth, missing teeth, etc.)

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.....

List your treatment plan in order of sequence:

- 1.....
- 2.....
- 3.....
- 4.....
- 5.....

Signature of service provider:..... Signature of main member:.....

Date:..... Date:.....

Please do not include any study models at this stage at all. In the event that these should be required by us, we will request so specifically and return them to you after two weeks.

Please include sketches of the arches and Cephalometric-tracings.

PLEASE RETURN COMPLETED FORM TO:

Afrox Medical Aid Society
PO Box 31391
Braamfontein
2017
Tel: (011) 381 2022
Fax: (011) 381 2399
E-mail: afrox@mhg.co.za