



Non-Insured Health Benefits Completion of Active Orthodontic Treatment Form

Provider Information

Name _____ Provider Number: _____

Mailing Address: _____

Client Information

Name _____ Client ID Number: _____

Mailing Address: _____ Date of Birth: _____
(YYYY/MM/DD)

Date active orthodontic treatment started (YYYY/MM/DD):

Date active orthodontic treatment completed (YYYY/MM/DD):

Was the original orthodontic treatment plan changed: YES NO
If yes, please explain: _____

Were the objectives of the orthodontic treatment plan accomplished? YES NO
If no, please explain: _____

Were retainers inserted? YES NO
If no, please explain: _____

What is the projected duration of retention phase of orthodontic treatment?

Does the client require any additional dental services (restorative, periodontal etc.)? YES NO
If yes, please explain: _____

I confirm that the above information is complete and accurate.
X
Provider Signature _____ Date (YYYY/MM/DD) _____