

ORTHODONTIC TREATMENT FORM

Part A: Member details

Member name:

Membership number:

Residential address:

Postcode:

Part B: Patient details

Patient name:

Date of birth (DD/MM/YYYY):

Part C: Provider details

Provider name:

Provider number:

Address:

Postcode:

Part D: Details of treatment

Complete treatment case: ☐ Fixed appliance/s ☐ Removable appliance/s

Minor treatment case: ☐ Fixed appliance/s ☐ Removable appliance/s

Description of service:

Treatment to commence (DD/MM/YYYY):

Expected duration of treatment:

Estimated cost of treatment: \$

Part E: Costs of treatment

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

Part F: Provider signature

Provider signature:

Date signed: