**Head Office: 693 McPhillips Street, Winnipeg, Manitoba R2X 2H6 (204) 774-7774 Fax: (204) 633-1143**
246 Portage Avenue, Winnipeg, Manitoba R3C 0B1 (204) 779-7779 Fax: (204) 594-5768
249 ½ Henderson Hwy, Winnipeg, Manitoba R2L 1M3 (204) 775-7775 Fax: (204) 667-6229
1531 Pembina Hwy, Winnipeg, Manitoba R3T 2E5 (204) 221-2221
1128 Richards St, Vancouver, BC V6B 3E6 (604) 566-7666 Fax: (604) 566-7660
**Email: info@greenwoodsdental.com(Winnipeg), info@greenwoodsdentalbc.com(Vancouver)**

# Standard Dental Claim Form (Orthodontics)

## INSURANCE

Employer's Name:_____ Insured's Name (If Not Patient)_____ POLICY

Or Group Number_____ Account Number _____Certificate Number_____

Name Of Insurer/s _____TREATMENT THE RESULT OF ACCIDENT?__YES__NO

## DENTIST

Name _____

Address _____

_____TEL NO. _____

I hereby certify that the services listed have been performed _____planned _____

_____ _____
Dentist Signature Date

## PATIENT

Name _____

Address _____

_____TEL NO. _____

Patient's Birthdate __Male __Single
____Mo _____Day _____Yr. __Female __Married

Relationship to Insured _____

## PROPOSED PLAN OF TREATMENT AND FINANCIAL ARRANGEMENTS FOR OTHODONTIC BENEFITS

Description of Malocclusion, Classification, Irregularities, Habits, Overbite, Overjet, open Bite, Impactions, Supernumerary Teeth, Missing Teeth, Closed Bite.

_____
_____
_____
_____

## PLAN OF TREATMENT

_____
_____
_____
_____

## DESCRIPTION OF APPLIANCES

Comprehensive Orthodontics_____

Date of commencement of treatment _____Month _____Year _____
Estimated time-active treatment _____ _____Months
Estimates time-retention _____ _____Months
Estimated time-other procedures _____ _____Months