Aevitae
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This form must be used to apply for dental care in special cases. This form must be completed by the dentist performing the treatment. We are unable to accept forms that are not fully completed or are unsigned.

Application for Special Dental Care

1 Insured person (patient)

Policy number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Surname and initial(s):

Steet name / house number:

Postal code / town/city: ___ ___ ___ ___ ___ ___

Who referred the insured person to the centre? ○ Dentist ○ Dental surgeon ○ Orthodontist

2 Treating Dentist

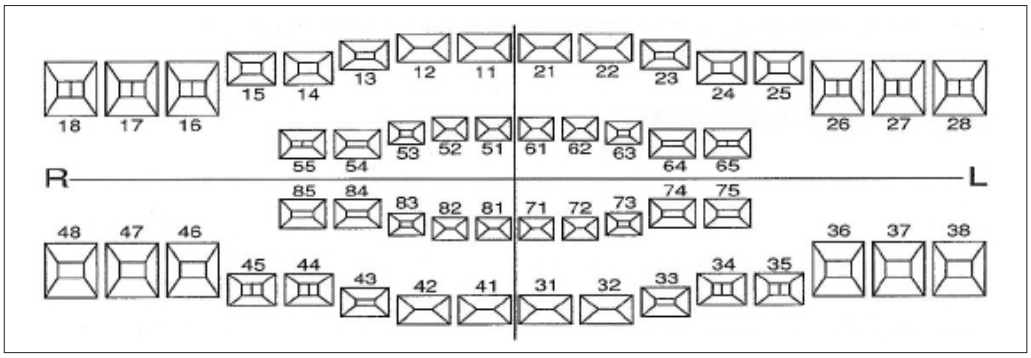
Name:

Town/city:

Attached to the centre:

Phone number of centre:

3 Initial status



Notes:

YOU ARE REQUESTED TO COMPLETE THE DENTAL CHART AS FOLLOWS:

Cavities
by means of a circle on the area affected

Restorations
by shading in the areas concerned

Missing elements
with a horizontal line through the element concerned

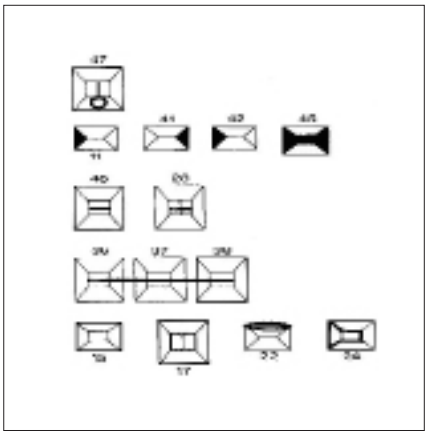
Cast restorations
indicatie individually by outlining the ares

Plate denture
indicate the elements replaced with a P

Frame denture
indicate the elements replaced with an F

Full denture
indicate separately under the dental chart

Endodontically treated elements
indicate with a line through the number concerned



4 Information about the dental abnormality

A The abnormality consists of ○ Multiple agenesis ○ Cheilo- and/or gnatho- and/or palatoschisis
○ Craniomandibular dysfunction ○ Oro-maxillofacial defect
○ Dento-alveolar defect

Where is the abnormality located:

B Only to be completed in case of craniomandibular dysfunction

What therapy has been implemented so far:

By whom?

With what result?

5 Treatment Plan

Treatment Plan:

Is jaw orthopaedics pre- or post-treatment necessary? ○ Yes ○ No
Is dental surgical treatment necessary? ○ Yes ○ No

For what part of the treatment plan stated above is treatment in the centre indicated?

6 Budget

Estimated number of treatment hours: X € = €
Estimated technical costs: €
Total €

7 Signature of treating dentist

Date: __ __ - __ __ - __ __ __ __ Dentist's signature/name stamp:

8 Declaration by the insured person

I consent to the treatment proposed and give permission to dental advisor to collect further information.

Date: __ __ - __ __ - __ __ __ __ Your signature:

Please enclose the X-rays and mark the envelope with 'DO NOT PERFORATE/NIET PERFOREREN'.