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Orthodontic Treatment Plan Form

Member's details (member or practitioner to complete)

Membership number: Level of cover:

Patient surname: Patient first name:

Address:

Practitioner's details (practitioner to complete)

Practitioner's name:

Address:

☐ Complete treatment case **OR** ☐ Minor treatment case

Date treatment commenced: / / Date first seen: / /

Date appliance fitted: / /

Anticipated duration of active treatment:

Estimated cost of treatment:

Description of service (including dental item numbers):

Payments made:

Date	Amount	Dental item

I declare that the information I have provided is true and correct and understand that it may be used by Peoplecare for auditing purposes.

Signed: **Full name:**

Provider number: **Date:** / /