

DENTAL CARE SUBSEQUENT TO AN ACCIDENT

TO BE COMPLETED BY THE MEMBER

Date of the accident: | YY | MM | DD | Location of the accident: _____
How did the accident occur?

If the claim is the result of a work injury or a motor vehicle accident please note that the claim must first be submitted to your provincial automobile insurance (if applicable in your province) or occupational health and safety plan before being forwarded to your insurer.

TO BE COMPLETED BY THE DENTIST

Preoperative X-rays are required for the study of dental care made necessary as the result of an accident. They will be returned to the attending dentist as soon as possible.

Is it an accidental injury to a healthy and natural tooth? Yes No
Diagnosis and clinical description prior to the accident: _____

CLAIM FOR A DENTURE, VENEER APPLICATION, CROWN OR INLAY

Please include a copy of the bill from the commercial lab with your claim.

REMOVABLE DENTURE

Is this the first time such a denture has been inserted? Yes No
If it is, indicate the date on which the teeth replaced by the denture were extracted and the teeth numbers:

If it is a replacement, by the same type of denture, please indicate:

- A. The date of previous insertion: | YY | MM | DD |
- B. What material was the old denture made of? _____
- C. The reason of the replacement: _____

FIXED BRIDGES — Please send us the appropriate X-rays taken prior to the treatment and X-rays showing the left and right sides.

If it is the first time a fixed bridge was inserted, indicate:
A. The date the extracted teeth were replaced: _____

B. The date of the previous insertion if the partial denture was replaced by a fixed bridge: | YY | MM | DD |
What material was the old denture made of? _____

C. List the missing teeth: _____

If it is to replace a fixed bridge, indicate:
A. The date of the previous insertion: | YY | MM | DD |
What material was it made of? _____

B. The reason of the replacement: _____

CROWNS, VENEER APPLICATIONS, INLAYS — Please send the appropriate X-rays for the treated tooth taken before the treatment.

Is it the first insertion? Yes No
If it is a replacement, indicate:
A. The date of previous insertion: | YY | MM | DD |
B. The reason of the replacement: _____

C. Add any details pertaining to the claim: _____

Signature of dentist _____ Date _____