Health Canada Santé Canada

Non-Insured Health Benefits
Completion of Active Orthodontic Treatment Form

Provider Information

Name: _____ Provider Number: _____

Mailing Address: _____

Client Information

Name: _____ Client ID Number: _____

Mailing Address: _____ Date of Birth: _____
(Day/Month/Year)

Date active orthodontic treatment started (Day/Month/Year):

Date active orthodontic treatment completed (Day/Month/Year):

Was the original orthodontic treatment plan changed: ☐ YES ☐ NO

If yes, please explain: _____

Were the objectives of the orthodontic treatment plan accomplished? ☐ YES ☐ NO

If no, please explain: _____

Were retainers inserted? ☐ YES ☐ NO

If no, please explain: _____

Projected duration of retention phase of orthodontic treatment?

Does the client require any additional dental services (restorative, periodontal etc.)? ☐ YES ☐ NO

If yes, please explain: _____

I confirm that the above information is complete and accurate.

x

Provider signature Date (Day/Month/Year)

Canada