# SMHU_Black**ORAL HEALTH SERVICE**

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ONTARIO WORKS – DENTURE COVERAGE

(Please answer all questions. Incomplete forms will be returned.)

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ontario Works ❑ or ODSP ❑

To help Ontario Works determine whether ODSP/Ontario Works client is eligible for coverage for dentures, we require the following information:

Is this an initial appliance? [Upper ❑Yes ❑No] [Lower ❑Yes ❑No]

If yes, provide the dates of the relevant extractions. If no, provide reasons for replacement and year of construction of denture(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indicate if any of the missing teeth in the upper and/or lower arch have been previously replaced with a prosthetic appliance. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Circle the numbers for the missing teeth |  | Circle the numbers for the teeth to be extracted |
| 18 17 16 15 14 13 12 11 21 22 23 24 25 26 27 28 |  | 18 17 16 15 14 13 12 11 21 22 23 24 25 26 27 28 |
| 48 47 46 45 44 43 42 41 31 32 33 34 35 36 37 38 |  | 48 47 46 45 44 43 42 41 31 32 33 34 35 36 37 38 |

Signature of denture provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For Partial Dentures, please indicate when the patient last had a complete examination by a dentist:

 ❑ 1 year ❑ 2 years ❑ 3 years ❑ 4 years ❑ 5 years ❑ 5+ years ago

Indicate abutment teeth for the denture(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have all restorative, periodontal and endodontic work been completed? ❑ Yes ❑ No

Are all remaining teeth restoratively, periodontally, endodontically sound? ❑ Yes ❑ No

If no, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s oral hygiene is: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Signature of DDS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_