# SMHU_Black**ORAL HEALTH SERVICE**

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ORAL HEALTH SERVICE

ONTARIO WORKS – ENDODONTIC 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 multiple endodontic services, we require the following information:

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

Circle the tooth numbers of missing teeth or teeth to be extracted, in both arches:

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

Are the teeth that require endodontic treatment restorable, conservatively (one to three surface fillings)? ❑ Yes ❑ No

Does the patient have any other teeth in the maxilla and/or mandible (not listed in the predetermination) that require restorative, periodontal or endodontic treatments?

❑ Yes ❑ No

If yes, provide the tooth numbers and codes for the treatments:

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

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