The Helsana Group comprises Helsana Insurance Company Ltd,
Helsana Supplementary Insurance Ltd and Helsana Accidents Ltd.

Helsana

Tooth damage: Findings /cost estimate

This form must be completed by your dentist.

Insured person

Last name, first name

Insurance no.

Date of accident

Helsana Group
Service Centre
Dental Group
P.O. Box, 8081 Zurich

1 Date of first assessment

Accident details

2 Dental summary as at the date of the report (cross out missing teeth)

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

3 ☐ **Condition of all teeth before tooth damage**

☐ **Condition of all teeth before the date of the report** (if prior condition is unknown)

☐ **Endodontically treated teeth**

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

☐ **Teeth damaged, not treated**

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

☐ **Teeth with fillings**

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

☐ **Periodontally compromised teeth**

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

☐ **Crowns, bridges**

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

☐ **Prostheses**

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

☐ **Type of orthodontic appliance**

4 Accident-related findings (cross out)

For deciduous teeth, please use dental quadrants 5–8.

a) Teeth

☐ **Total luxation**

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

☐ **Luxation**

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

☐ **Subluxation**

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

☐ **Contusion**

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

☐ **Crown fracture, no pulp damage**

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

☐ **Crown fracture, pulp damage**

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

☐ **Root fracture**

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

Continued overleaf

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Insured person Last name, first name

Insurance no.

4 b) Jawbone or soft tissue

c) Damaged dental prosthesis/ orthodontic appliances (please provide precise details on the nature of the work and/or appliances and the extent of the damage)

5 Immediate measures

a) Diagnostic measures with description of findings (X-ray, vitality test, movement of neighbouring teeth and antagonists)

b) Therapeutic measures

6 Proposals for initial treatment – expected progress from here

☐ Observation needed for at least years.

☐ Orthodontic treatment required/more difficult after accident. Referral to SSO orthodontic surgeon reserved.

☐ Definitive treatment can only be planned after an observation period of .

7 Proposals for definitive treatment
(if possible at the time of this report)

8 Tooth replacement chart
(to be completed by the dentist)

Right **Upper jaw** Left Right **Lower jaw** Left

9 Cost estimate Please mark amounts for emergency treatment already carried out with *

Tooth no.	Tariff no.	Treatment type	Tariff points	Tooth no.	Tariff no.	Treatment type	Tariff points
				carried over			
						Total tariff points	
				x CHF tariff points		= CHF	
				plus laboratory costs			

Place and date Stamp and signature

Please enclose any X-rays with this form (providing name and tooth numbers). The duplicate is for the dentist's use.

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