

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
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Teeth with fillings

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
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Periodontally compromised teeth

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
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Crowns, bridges

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

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

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

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
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Crown fracture, no pulp damage

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
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Crown fracture, pulp damage

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

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

Insured person

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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 .

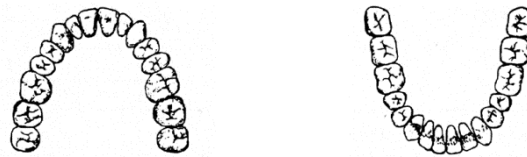
7 Proposals for definitive treatment

(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 *

Table with 8 columns: Tooth no., Tariff no., Treatment type, Tariff points, Tooth no., Tariff no., Treatment type, Tariff points. Includes rows for 'carried over', 'Total tariff points', and '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.