PATIENT'S NAME, MEDICAL CARD NO. VALID TO

Name: CoinciDental Test

Medical Card Number: 123456789

Valid To:

DENTIST'S NAME & PANEL NO.

Dr Robert Spence

12345

PATIENT'S P.P.S.N.

Declaration by Patient

I certify that the treatment detailed hereon has been received by me.

Commencement Date: 30 10 15

Completion Date:

I agree toattend an Examining Dentist if requested.

Patient's Signature

Declaration by Dentist

I certify
(a) the treatment detailed hereon has been completed
(b) clininical necessity as may be outlined below and claim the appropriate fees.

Dentist's Signature

Date:

Clinical Necessity

Form No. D3451121

GENERAL MEDICAL SERVICES
DENTAL TREATMENT SERVICES SCHEME

A1 Oral Examination ☑ Yes ☐ No

1	8	F	F	F	F	F	2	F		1	2	O	F	O	F	F	F	2
4	F	F	6	F	F	3	2	1		F	2	O	F	F	O	F	F	3

CODES O - Decayed F - Filled _ - Missing

A2 Prophylaxis

Date: CODES

0 - Healthy
1 - Bleeding
2 - Calculus

A3 A Amalgam Restoration

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

No. of Fees 1

A3 C Composite Restoration (Anterior teeth only)

1	3	2	1		1	2	3	2
4	3	2	1		1	2	3	3

No. of Fees 1

A4 Exodontics

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

No. of Fees

A5 Surgical Extraction

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

No. of Fees

Please state No. of 15 minute units (Max 3 per tooth)

A6 Miscellaneous

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

No. of Fees

A7 1st Stage Endodontic Treatment

1	3	2	1		1	2	3	2
4	3	2	1		1	2	3	3

No. of Fees

A8 Denture Repairs

	No. of Repairs		No. of Repairs
Cracks, fissures and fractures		Replacement of teeth	
Replacement of Band or wire		Extension of Plate	

B1/B2 2nd Stage Endo/Apicectomy/Amputation of Roots

1	3	2	1		1	2	3	2
4	3	2	1		1	2	3	3

Dentist's Estimate

H.B. Approved Amount

H.B. Official's Signature

CODES:
E- Endodontic
A- Apicectomy

B3 Protracted Periodontal Treatment

Please complete the C.P.I.T.N. Chart using the appropriate codes

UPPER RIGHT UPPER UPPER LEFT

LOWER RIGHT LOWER LOWER LEFT

Dentist's Estimate

H.B. Approved Amount

H.B. Official's Signature

CODES: 3-Pocket 4-5mm
4-Pocket>6mm
No. of visits

B4 Extra Oral Radiographs

☐ One Film ☐ Two+ Films ☐ Panoramic

B5 Prosthetics

Full Denture (12+ Teeth)	UPPER	LOWER	H.B. Approved Amount
Partial Denture (1-11 Teeth)	UPPER	LOWER	H.B. Official's Signature
Reline	UPPER	LOWER	

For Official Use Only

Approval is granted to carry out the treatment(s) detailed hereon. ☐ Below the Line

H.B. Official's Signature:

Date of Approval:

Health Board Official Stamp

	€
A1	33.00
A2	0
A3A	50.06
A3C	51.88
A4	0
A5	0
A6	0
A7	0
A8	0
B1	0
B2	0
B3	0
B4	0
B5	0