REGISTRATION FORM FOR THE DENTAL CARE PROGRAM & PRE-AUTHORISATION FOR DENTAL PROCEDURES

This form should be completed if benefits are requested for:
(Please tick where applicable)

- ☐ More than four fillings
- ☐ Endodontic treatment and re-treatment
- ☐ Crowns and bridges
- ☐ Dentures
- ☐ Orthodontic treatment
- ☐ Periodontal procedures
- ☐ Oral and maxillo facial surgery
- ☐ Dental procedures under General Anesthetic

Please return the completed form to us via:
Fax on 086 615 6696, **or**
E-mail at shs2auth1@shsdent.co.za **or**
Post to P O Box 3095 Paarl 7620.

MEMBER & PATIENT INFORMATION	
MEMBERSHIP NUMBER	
NAME & SURNAME OF MAIN MEMBER	
NAME & SURNAME OF PATIENT	
DEPENDANT CODE	
DATE OF BIRTH OF PATIENT	
SCHEME	
OPTION	
TELEPHONE NUMBERS	
FAX NUMBER	
E-MAIL ADDRESS	

DENTAL PROVIDER INFORMATION	
NAME OF PROVIDER	
PRACTICE NUMBER	
TELEPHONE NUMBERS	
FAX NUMBER	
E-MAIL ADDRESS	
POSTAL ADDRESS	

©Supplementary Health Services

CURRENT FULL MOUTH CHARTING - *DURING ORAL EXAMINATION*

Please indicate the symbol on the current charting of any of the following: missing teeth, all types of restorations including inlays/onlays, crowns and bridges, impacted teeth, caries etc. by indicating one or more of the symbols of charting in the empty block corresponding to the relevant tooth number.

SYMBOLS OF CHARTING	
DESCRIPTION	**SYMBOL**
Missing tooth	X
Carious tooth	Indicate surfaces e.g. MO.
Restored (resin)	RRE (Indicate surfaces)
Restored (amalgam)	RA (Indicate surfaces)
Restored but defective	RD (Indicate surfaces) or
Pulpotomy	PUL
Root canal	RC
Root canal defective	RCD
Inlay/Onlay	I **or** O
Crowned	C
Crowned but defective	CD
Unerupted	UE
Unerupted but impacted	UI
Bridge abutment	AB
Bridge pontic	PB
Fracture	FR
Residual Root	RR
Implant	IM
Dentures - Full Upper & Lower	DFF
Dentures - Full Upper	DFU
Dentures - Full Lower	DFL
Denture-Partial Upper	DPU
Denture-Partial Lower	DPL

DECIDUOUS DENTITION

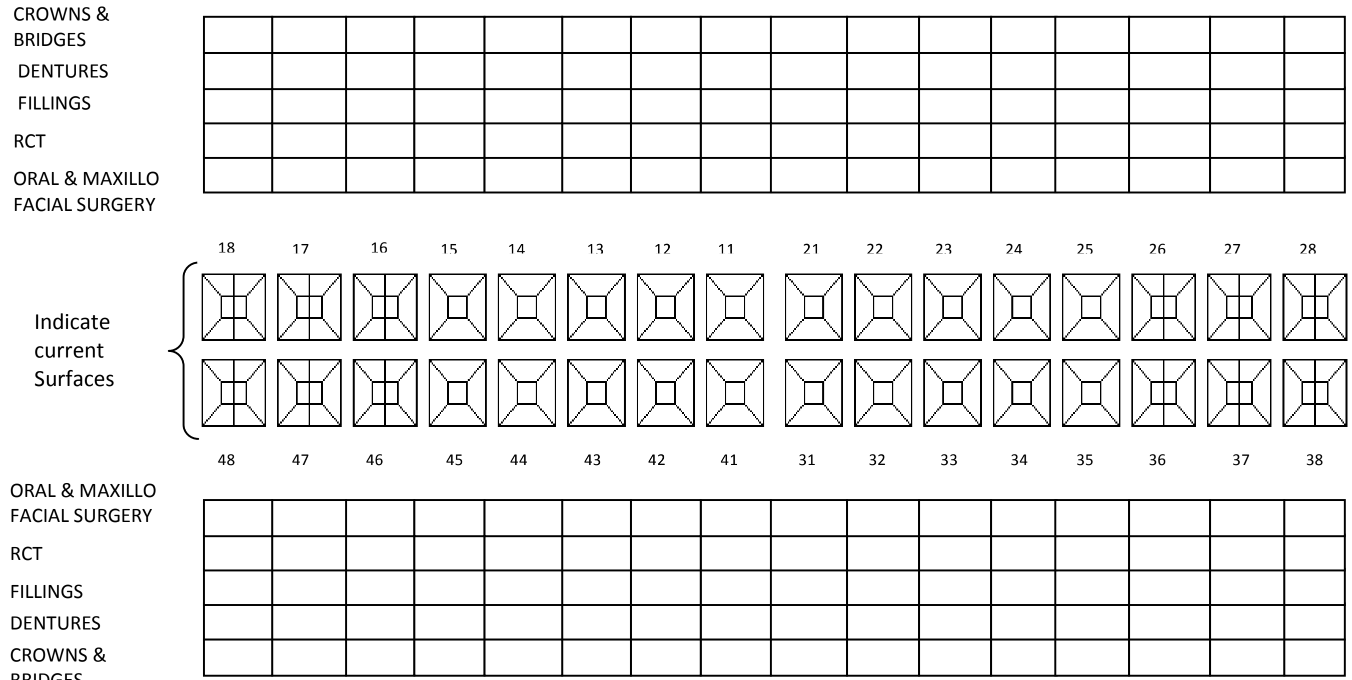
	55	54	53	52	51	61	62	63	64	65
FILLINGS										
PULPOTOMY										
EXTRACTIONS										

Indicate current Surfaces

	85	84	83	82	81	71	72	73	74	75
EXTRACTIONS										
PULPOTOMY										
FILLINGS										

CURRENT FULL MOUTH CHARTING (Continued)

PERMANENT DENTITION



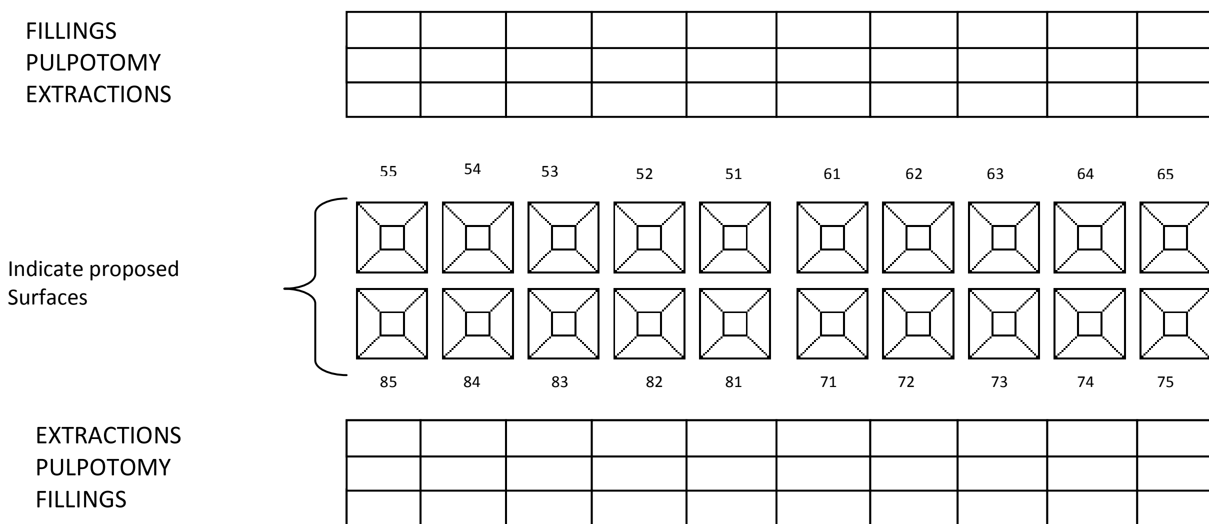
PROPOSED TREATMENT

Please indicate the symbol on the proposed treatment charting of any of the following: missing teeth, all types of restorations including inlays/onlays, crowns and bridges, impacted teeth, caries etc. by indicating one or more of the symbols of charting in the empty block corresponding to the relevant tooth number.

Please note: Where indicated by ★ Radiographs will be required for purpose of benefit allocation.

In other instances radiographs may be requested.

DECIDUOUS DENTITION



PROPOSED TREATMENT (Continued)

PERMANENT DENTITION

	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
★CROWNS & BRIDGES																
DENTURES																
FILLINGS																
★RCT																
★ORAL & MAXILLO FACIAL SURGERY																

Indicate proposed Surfaces

	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38
★ORAL & MAXILLO FACIAL SURGERY																
★RCT																
FILLINGS																
DENTURES																
★CROWNS & BRIDGES																

CLINICAL DESCRIPTION	TARIFF CODE	ICD 10 CODES	TOOTH ID	FEE QUOTED
			TOTAL COST	

DENTAL LABORATORY **Please specify** **(*8099 not sufficient)*** **DESCRIPTION**	**TARIFF CODE**	**ICD 10 CODES**	**TOOTH ID**	**FEE QUOTED**
			TOTAL COST	

PROPOSED TREATMENT (Continued)

1. If the treatment is part of multiple phases or if planned over more than the current calendar year, please provide details.
2. How many theatre admissions are proposed for the total treatment plan?
3. What is the estimated theatre time for each admission?
4. What is prognosis of the intended procedures?
5. Any additional information /motivation:

TREATMENT NEEDS SUMMARY

BASIC ORAL HEALTH EXTRACTIONS	
MAJOR SURGICAL PROCEDURES	
PERIODONTAL MANAGEMENT	
RESTORATIVE DENTISTRY	
ORTHODONTIC TREATMENT	
PROSTHODONTIC REHABILITIVE	
ORAL AND MAXILLO FACIAL SURGERY	

SIGNATURE OF PROVIDER ______________________ DATE ______________________

SIGNATURE OF MEMBER ______________________ DATE ______________________