GLOBALITY HEALTH
premium health insurance worldwide

Dental Report Form

Insured's details	Dentist's details
Name	Name of dentist
Date of birth	Name AND address of practice or clinic

Dental chart and details of planned treatment

Please complete the dental chart using the abbreviations listed below.

I																	I
II																	II
EU	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	EU
US	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	US
								Tooth									
EU	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	EU
US	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	US
I																	I
II																	II

Line I
Current dental record with details of existing treatments

Line II
Details of planned treatments

Abbreviations

F	Filling	I	Implant
R	Repair	K	Crown
E	Tooth substitution	PIN	Post and core
f	Tooth absent	SK	Pivot crown
)(	Gap closure	B	Span or bridge
H	Apparatus or attachment	U	Relining
T	Telescopic crown	P	Removable denture
C	Cavity		

If dentures or complex dental treatment is planned, please attach the latest x-ray, intra-oral photos and a cost estimate.

Periodontal Screening Index

Sextant Score

Date (dd/mm/yyyy)

Is periodontal treatment needed?	☐ Yes ☐ No

If yes, we kindly ask you to attach a detailed periodontal status report, x-rays, intra-oral photos and a cost estimate.

- When was the periodontal disease diagnosed for the first time?
- Has periodontal disease been diagnosed or treated in the past?
  If yes, when?

Orthodontic treatment

Is orthodontic treatment needed?	☐ Yes ☐ No

If yes, we kindly ask you to provide details of the malocclusion below (with measurements where required). Please also provide us with the latest x-rays, intra-oral photos, photos of the plaster models (if available) and a cost estimate.

- Protrusion/overjet of upper/lower front teeth (in mm): _____ mm
- Reversal overjet interfering with normal functions (in mm): _____ mm
- Open bite (in mm): _____ mm
- Deep bite (in mm): _____ mm
- Cross bite (teeth numbers): _____
- Displacement of contact points (teeth numbers & in mm): _____
- Missing teeth requiring gap closures (teeth numbers): _____
- Details of any cranio-facial anomalies, such as cleft lip and palate: _____

_____

If you prefer to provide details of the malocclusion in a separate report, please ensure that it includes the above information and is signed and stamped.

- When was the malocclusion diagnosed for the first time?
- Has the malocclusion been diagnosed or treated in the past? If yes, when?

Additional remarks

I hereby declare that all information supplied is true and correct and the treatments detailed have been/will be completed.

Official dentist's stamp

_____
Dentist's signature

_____
Date (dd/mm/yyyy)