Post Office MEDiPOS Medical Scheme

Putting your wellbeing first

APPLICATION FORM

REQUEST FOR ORTHODONTIC TREATMENT

Please do not include any study models at this stage. In the event that these should be required by us, we will request so specifically and return them to you after two weeks. Please include sketches of the arches and cephalometric tracings.

INFORMATION OF MEMBER/PATIENT

Name of member

Membership number

Name of patient

ID number or date of birth

Telephone number | Cell phone

Email address

INFORMATION OF DENTAL PRACTITIONER

Name of practitioner

Practice number

Telephone number | Fax

Email address

PROPOSED TREATMENT

Tariff code	Tariff amount

Intended duration of treatment

Initial primary tariff

Sequential monthly tariff

PROPOSED TREATMENT (CONTINUED)

Any foreseen extra costs (e.g. orthognatic surgery, etc.)

Cephalometric analysis (please include a copy of the tracing)

Any other relevant information (diastemas, rotated teeth, missing teeth, etc.)

IMPORTANT: Please indicate if the laboratory account will be claimed separately by the dental laboratory.

☐ Yes ☐ No If no, please include the laboratory quotation.

HISTORY OF PREVIOUS ORTHODONTIC TREATMENT

Please use mm degrees of identifying tooth numbering, where applicable, during the presentation of the following information, to assist with the motivation for this treatment.

Angle classification	
Overjet (mm)	
Overbite (mm)	

Space analysis (indicate the amount in mm)

☐ Crowding __________ mm

☐ Excess space __________ mm

Membership no. | | | | | | | | | | | | | |

Practice no. | | | | | | | | | | | | |

PROPOSED TREATMENT (CONTINUED)

LIST YOUR TREATMENT PLAN IN ORDER OF SEQUENCE

1.
2.
3.
4.
5.

Signature of dental practitioner

D	D	M	M	Y	Y	Y	Y

Date

PATIENT CONSENT

1. I hereby confirm that the information provided in this application is true and correct.
2. I acknowledge that Medscheme MEDiPOS Business Unit is the administrator of the programme and that any dental treatment provided, taking into consideration my oral health status and general health, will be the sole responsibility of my dental practitioners, in consultation with myself. Medscheme MEDiPOS Business Unit and the Scheme and/or employer will accordingly not be held liable for any claims by me or my dependants arising from the implementation of the programme.
3. I hereby give my consent to Medscheme MEDiPOS Business Unit, including their agents and dental staff, to obtain my special personal information (i.e. health and biometric) from my healthcare providers (dentists, dental specialists, pharmacists, pathologists, medical practitioners and radiologists) to assess my medical risk and enrol me on the programme and to use such information to my benefit. I understand and agree that special personal information relevant to my current state of health can be disclosed to third parties for the purpose of scientific, epidemiological and/or financial analysis without disclosure of my identity.
4. I understand that no information regarding my case will be made available to my employer/s or any other person not directly involved in my care.
5. I give my consent to Medscheme MEDiPOS Business Unit to electronically store, access, process and retain my special personal information for the purposes set out in this document as may otherwise be required to administer the programme.
6. While Medscheme MEDiPOS Business Unit undertakes to take all reasonable precautions to uphold the confidentiality of information disclosed to it, I am aware that the Scheme and/or employer and practitioner (where necessary) shall also gain access to the same information. I shall therefore not hold Medscheme MEDiPOS Business Unit liable for any claims by me or my dependants arising from any unauthorised disclosure of my special personal information to other parties.
7. I shall be entitled to terminate my participation in the programme at any time with immediate effect on notice to the Scheme, but understand that all benefits that I enjoyed under the programme shall immediately cease and the Scheme shall not be obliged to reinstate such benefits at any time thereafter. I understand that the consequences of such a decision will rest with me alone.
8. I understand that telephone calls will be recorded for internal clinical quality assurance purposes and will not be shared outside of the programme.
9. I understand and acknowledge that 'consent', for the purposes of this document, means my informed consent, in other words:
   - 9.1 I have read and understood the contents of this document.
   - 9.2 I understand and acknowledge the nature and purpose for which the personal medical information that will be made available to and disclosed, used, processed and retained by the Scheme and my healthcare providers, as set out in this consent.
   - 9.3 I have the legal capacity to give my informed consent, in other words, I am over the age of 18 and am able to fully understand and make decisions about my healthcare.

Patient's signature
(or signature of parent/guardian if patient is under the age of 18)

D	D	M	M	Y	Y	Y	Y

Date

Membership no.

Practice no.

01/20

Return address: MEDiPOS Dental Management Programme, PO Box 921, Westville, 3629
Tel 0860 100 078 **Fax** 0865 608 087 **Email** dental@medipos.co.za