

DENTAL ACCIDENT REPORT FORM

TO BE COMPLETED BY SUBSCRIBER

SUBSCRIBER		PATIENT		
SURNAME	GIVEN NAME	NAME		
ADDRESS		GREEN SHIELD I.D. #		
CITY/PROV/CODE		RELATIONSHIP TO SUBSCRIBER		
PHONE NO. ()		LOCATION OF ACCIDENT		
DATE OF ACCIDENT _____ / _____ / _____ Year Month Day		Date of Admission	Date of Discharge	
If taken to hospital, name of the hospital and address of attending physician.				
		Year	Month	Day
		Year	Month	Day

Describe briefly how the accident occurred, and extent of injury. _____

Please provide the name and address of any other insurance involved. _____

Name(s) and address(es) of witness(es) (1) _____
(2) _____

I authorize the release of any information or records requested in respect of this claim to the insurer/plan administrator and certify that the information given is true, correct and complete to the best of my knowledge. _____
Subscriber's Signature _____ Year Month Day

DENTIST'S REPORT - PLEASE INCLUDE RADIOGRAPHS - RADIOGRAPHS WILL BE DUPLICATED AND RETURNED TO DENTIST. IF RADIOGRAPHS ARE NOT AVAILABLE, PLEASE PROVIDE A BRIEF RADIOLOGICAL REPORT OR EXPERTISE STATEMENT REGARDING TRAUMATIZED TOOTH (TEETH).

DENTIST	DATE OF INITIAL VISIT PERTAINING TO ACCIDENT
	Year Month Day
NAME	DESCRIPTION OF DAMAGE
ADDRESS	
CITY/PROV/CODE	
PHONE NO. ()	IDENT. NO.

PRESENT TREATMENT INDICATED

TOOTH CODE	PROCEDURE CODE OR ADEQUATE DESCRIPTION	EST. COST INCLUDING LAB CHARGES

Please note any future potential problems and treatment. _____

Dentist's Signature _____ Year Month Day

BY SIGNING THIS CLAIM FORM AND/OR SUBMITTING ACTUAL RECEIPTS, I AGREE THAT THE INFORMATION PROVIDED IS COMPLETE AND ACCURATE, TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE GREEN SHIELD CANADA TO EXCHANGE INFORMATION WITH OTHER PARTIES AS REQUIRED AND ONLY WHEN THE INFORMATION IS NEEDED TO ADMINISTER THIS BENEFIT CLAIM AND/OR TO CONFIRM THE ACCURACY OF THIS INFORMATION.

The cost, if any, of obtaining this information is at the expense of the Patient/Subscriber.