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**DENTAL FORM**

**Date Treatment Provided:** \_\_\_\_\_  
 (Separate form for each date)

**Patient Name;** \_\_\_\_\_

**Membership Number;** \_\_\_\_\_  
 (Registered Number)

**Dentists Certification** – I certify that I provided the dental treatment as set out by me in the panel and dental chart below and applied a fee in respect of the treatment provided.

**Details of Treatment:**

<b>No of Fillings;</b> _____	<b>Total Cost</b> € _____	<b>No of Extractions;</b> _____	<b>Total Cost</b> € _____
<b>No of Crowns;</b> _____	€ _____	<b>Bridgework;</b> _____	€ _____
<b>No of X-rays;</b> _____	€ _____	<b>Scale/Polish/Clean</b> _____	€ _____
<b>Other Treatment – Specify;</b> _____			€ _____
_____			€ _____

**Total Cost for all treatment provided;** € \_\_\_\_\_

**CHART MUST BE COMPLETED.**

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

**Dentist's Signature;** \_\_\_\_\_ **Date** \_\_\_\_\_

**Patient/Member Certification** – I certify that on this date I received the dental treatment as set out in detail by my dentist in the panel above.

**Member/Patient Signature;** \_\_\_\_\_ **Date** \_\_\_\_\_

(This form is not a receipt - a separate receipt on dentists headed paper to accompany this form and the Members Claim Form when submitting claim to the Society)