CONNECTICUT DENTAL HEALTH PARTNERSHIP
the dental plan for HUSKY Health

Understanding and Undergoing Orthodontic Treatment

(Keep Original in Client Chart)

Client Name: _____ Medicaid ID #: _____

Treating Provider Name: _____ NPI #: _____

Name of Provider Group: _____

Address of Provider Group: _____

City, State, Zip Code: _____

An orthodontic treatment plan has been established for **Client Name:** _____ by Dr. _____. In order for the treatment plan to work, I know that I must keep the following good oral hygiene practices.

Patient Initials ↓

_____ **Brush my teeth** at least twice a day or as told by the Doctor's office.

_____ **Floss my teeth** at least once a day or as told by the Doctor's office.

_____ **Rinse my mouth** after each meal or snack or as told by the Doctor's office.

_____ **Avoid sugar** containing foods and drinks including soda, candy, gum, etc. or as told by the Doctor's Office.

_____ **Get six-month cleanings** from my primary care dentist.

_____ If I need to cancel an appointment, I must give the office as much notice as possible. I know that I must set up another appointment.

_____ I know that missing appointments during my orthodontic treatment may harm my teeth.

_____ I know that the orthodontic treatment involves many appointments set by the Doctor's Office. I understand that failing to follow the appointment schedule may result in having my treatment stopped.

_____ I know that HUSKY Health only covers Comprehensive Orthodontic treatment for children.

- Under the age of twenty-one.
- With permanent dentition.
- As a one-time covered benefit.

_____ I know that if my orthodontic treatment is stopped before completion due to poor oral hygiene or lack of cooperation, I will not be eligible to resume orthodontic treatment while under my Medicaid insurance at a later date for any reason.

Doctor Signature: _____ Date: _____

Client Signature: _____ Date: _____

Client Representative Signature: _____ Date: _____

Representative's relationship to Client: _____ Date: _____

Witnessed by (Name): _____ Date: _____

Signature: _____ Title: _____