wsib cspaat ONTARIO
Workplace Safety & Insurance Board
Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

200 Front Street West
Toronto ON M5V 3J1

Telephone:
416-344-1000
or 1-800-387-0750

Fax to:
416-344-4684
or 1-888-313-7373

Dental Report

Claim No.	Desk	Alloc. No.
Worker's Name		
Injury		
Date of Injury		
To Enquire, Contact For toll free number, check local directory		

Date of First Treatment

Important information about completing this form is on the back.
Please carefully read the instructions listed on the back.

Pre Accident History

Appraise and describe the condition of the teeth <u>before</u> the accident.

Patient's Right | Patient's Left

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

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

Indicate any teeth missing before the accident.

Indicate any fixed bridgework present. Specify abutment teeth and type of abutment attached.

Indicate any teeth with crowns.

Indicate and describe any removable dental appliance being worn at time of accident.

Indicate evidence of periodontal disease present. Indicate location and severity if applicable.

Indicate and describe any diseased or damaged teeth, or TMJ involvement prior to this accident.

Accident History

Forward radiographic films of diagnostic quality of injured areas along with your comments.

Describe injuries to the teeth and mouth <u>as a result of</u> the accident.

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

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

Indicate teeth damaged or missing as a result of this accident.

Indicate extent and location of fracture where present and comment.

If teeth were artificial did you see fractured bridge or dentures. Describe extent of damage in detail.

Give details of any other oral injury.

PRE-DETERMINATION

Date of Service dd	mm	yy	Procedure Codes (ODA)					Initial Tooth Code	Tooth Surface	Dentist's Fee		Laboratory Charge		Total Charges	
										$		$		$	

Additional Comments: (use additional sheet if necessary)

Do you wish WSIB dental consultant to phone?

☐ yes

Mounted x-rays enclosed: ☐ yes ☐ no (if not enclosed give reasons)

(If duplicate x-rays are submitted, please identify (R) or (L). Bite wing x-rays are not acceptable.)

Dentist's Name (please print) ☐ Specialist | Area code | Phone No.

Postal Address | Date

City or Town | Postal Code | Dentist's Signature

Please Note: Read the following instructions carefully before completing this form.

1. **Complete this form in detail and return it to your local Workplace Safety and Insurance Board (WSIB) office.**
2. **Please PRINT legibly in black ink or type your comments/recommendations.**
3. **Attach pre-treatment x-rays.**
4. **Prior authorization must be obtained from the WSIB for all treatment except for x-rays and emergency services.**
5. **If the patient has entitlement for dental treatment, emergency services will be paid.**
6. **Describe in detail all emergency treatment rendered by you to date. Include ODA procedure code(s), tooth number, tooth surfaces and fees.**
7. **Copies of laboratory invoices should accompany all billings.**
8. **Dental services are paid in accordance to fees approved by the WSIB. The patient or any other insurer is NOT responsible for any balance over and above these fees.**
9. **A fractured incisor is a common accidental injury. In case of a vital tooth, it is requested that if necessary a provisional crown be placed to permit the tooth to recover from traumatic shock. The final crown restoration to be delayed for 3 months from date of accident.**