WSIB ONTARIO CSPAAT
200 Front Street West
Toronto ON
M5V 3J1

Telephone: (416) 344-1000 Fax: (416) 344-4684
For toll free calling, check
your local telephone directory.

Dental Report

Claim No.	Desk	Alloc. No.

Worker's Name

Social Insurance Number

Injury

Date of Injury dd-mmm-yyyy

To Enquire, Contact

( )

For toll free number, check local directory

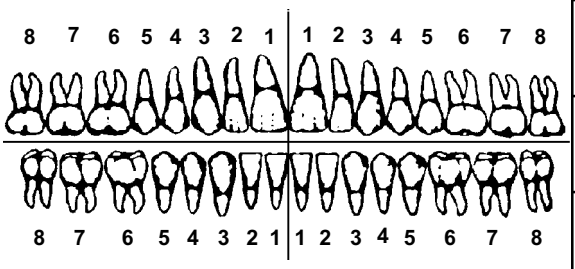
Date of First Treatment dd-mmm-yyyy --

-- **Important information about completing this form is on the next page. Please read the instructions carefully.**

Pre Accident History

Appraise and describe the condition of the teeth before the accident.

Patient's Right — Patient's Left



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.

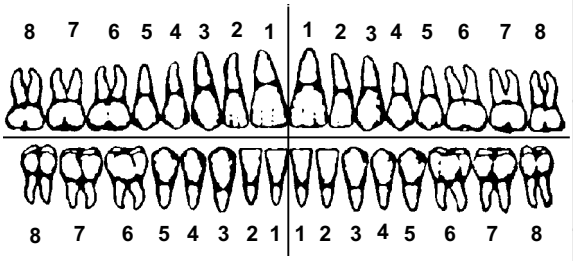
Indicate evidence of periodontal disease present. Indicate location and severity if applicable.

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

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

Accident History

Describe injuries to the teeth and mouth as a result of the accident.



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

Claim Number

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)

TOTAL >

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 ( ) Telephone No.

Postal Address

Date dd-mmm-yyyy

City or Town

Postal Code

Dentist's Signature

Please print form & sign before returning to the WSIB

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

print

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.

...home