WCB Workers Compensation Board of Manitoba

Phone 204-954-4321
(Toll free 1-855-954-4321)
333 Broadway, Winnipeg R3C 4W3
wcb.mb.ca

Dentist Report

Claim Number	35

Dentist Information

Dentist Name		
Dentist Address		
City	Province	Postal Code

Worker Information

Worker's Name		Worker's Address
City		Province
Postal Code	Date of Birth (DD/MM/YYYY)	Phone Number

Injury Details

Date of Injury	Area(s) of Injury

Check Report Type That Applies 1. Initial 2. Change in treatment 3. WCB re-treatment	Examination Date (dd/mm/yyyy)

Dental Charting

1. For Initial Report: draw in ALL previous dental treatment & pre-existing missing teeth, caries & chipped teeth.
2. For Change in Treatment: draw in change of treatment.
3. For WCB re-treatment: draw in Treatment failure due to WCB-related dental treatment.

P= Primary Tooth as applicable

RIGHT

18 17 16 15 14 13 12 11 21 22 23 24 25 26 27 28

48 47 46 45 44 43 42 41 31 32 33 34 35 36 37 38

4. Oral Hygiene
Pre-Accident Good Fair Neglected Unknown
Active Periodontal Disease Yes No Unknown
If yes, provide a copy of periodontal charting.
Smoker **Non-Smoker** If smoker, average per day: _____

5. Diagnosis: (Dentist Only)
Please indicate condition resulting from the workplace accident.
Does the injury relate to:
A. Tooth structure only
B. Previously restored portion of the tooth (eg. filling, crown, bridge, denture, implant) only.
C. Both A and B

6. Mechanism Of Injury
How did the dental injury occur as a result of the workplace accident?
Report all damage, paying attention to extent and surface location.

7. TMJ
Not Applicable Applicable
Jaw Opening: _______________(mm) between free edges of the upper and lower incisors
Protrusion: _________________
Laterotrusion: Right ______ (mm) Left ______ (mm)
Prior TMJ Treatment: Yes Date: ___________ Type:____________________ No

8. Enclosures
Radiographs conventional/digital Most current Post
Trimmed Casts Most current Post
Photographs conventional/digital Most current Post
If referring to denturist: Oral Health Certificate is required for complete dentures. Yes
Prescription for partial dentures is required. Yes

When submitting your correspondence ensure tooth numbers, dates, worker's name, and dentist name are labeled on all enclosures.

Fax this form - in Winnipeg: 204-954-4999 | toll free: 1-877-872-3804

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Treatment Provided to Date:

Date Service Performed	Tooth Number	Procedure Code	M.D.A. Fee Recommended Fee Guide	Please Separate: L = Lab Charges E = Expense Fees	Potential Future Treatment (Will require pre-approval)	Prognosis 2-3 Years 4-6 Years 8-10 Years > 10 Years
			$			
			$			
			$			
			$			
			$			

*Forward Copies Of Itemized Dental Lab Charges And Expense Fees

Proposed Future Treatment:

Proposed Date of Future Treatment	Tooth Number	Procedure Code	M.D.A. Fee Recommended Fee Guide	Please Separate: L = Lab Charges E = Expense Fees	Potential Future Treatment (Will require pre-approval)	Prognosis 2-3 Years 4-6 Years 8-10 Years > 10 Years
			$			
			$			
			$			
			$			
			$			

*Forward Copies Of Itemized Dental Lab Charges And Expense Fees

Regular maintenance of dental health and rehabilitation is the worker's responsibility and lack thereof is not eligible for WCB dental benefits.

Declaration:

To be completed by the Dentist.

I, (print surname and first name) ______________________________, hereby certify

a) That the dental injuries specified in this report result from a workplace injury or are consistent therewith.

b) That the proposed treatment is solely to restore the damage sustained in the workplace incident or re-treatment failure.

c) That the type of treatment is consistent with the patient's pre-accident status and standard of dental care.

d) That I am providing services within my scope of practice and training.

Stamp or type name and address of dentist or group:	**Signature of Dentist**	
	Date (dd/mm/yyyy)	Telephone Number

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