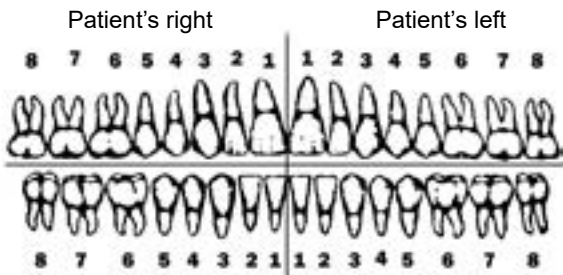


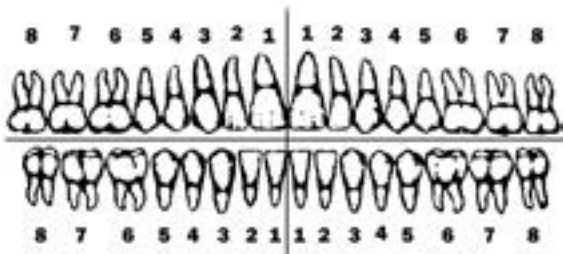
Visit wsib.ca/submit to submit this form and supporting documents.

Desk	Alloc. no.
Worker's name	
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 back.
Please carefully read the instructions listed on the back.**

Pre-accident history	
<p>Appraise and describe the condition of the teeth <u>before</u> the accident.</p> <p style="text-align: center;">Patient's right Patient's left</p> 	<p>Indicate any teeth missing before the accident.</p> <hr/> <p>Indicate any fixed bridgework present. Specify abutment teeth and type of abutment attached.</p> <hr/> <p>Indicate any teeth with crowns.</p> <hr/> <p>Indicate and describe any removable dental appliance being worn at time of accident.</p> <hr/> <p>Indicate evidence of periodontal disease present. Indicate location and severity if applicable.</p> <hr/> <p>Indicate and describe any diseased or damaged teeth, or TMJ involvement prior to this accident.</p>

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

Accident history	
<p>Describe injuries to the teeth and mouth <u>as a result</u> of the accident.</p> 	<p>Indicate teeth damaged or missing as a result of this accident.</p> <hr/> <p>Indicate extent and location of fracture where present and comment.</p> <hr/> <p>If teeth were artificial did you see fractured bridge or dentures. Describe extent of damage in detail.</p> <hr/> <p>Give details of any other oral injury.</p>

Email accessibility@wsib.on.ca if you need a different format or accommodation. Disponible en français.

