

First Report (C-055)

DENTAL REPORT

Progress Report (C-887)

Box 2415, Edmonton
Alberta T5J 2S5
Fax (780) 427-5863
1-800-661-1993

**Authorization for dental services (excluding emergency treatment)
must be obtained before proceeding with treatment.
Worker cannot be charged directly.**

**Please submit treatment plan preauthorization,
(on standard dental claim form).**

Please print or type

Patient's Surname		First Name	Initial	WCB Claim Number	
Address Street		City/Town		Province	
Postal Code	Telephone Number	Date of Accident (YYYY/MM/DD)		Is the patient working? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employer's Name			Telephone Number		
Address Street		City/Town		Province	Postal Code
Who provided first dental treatment? Doctor:		Date (YYYY/MM/DD)	The worker attended my office on: (YYYY/MM/DD)		
History of injury:					
Describe dental injury resulting from accident, include damage to any prostheses: (in point form)					
Describe emergency treatment carried out:					
Describe further treatment required as a result of injury:					
Evidence of relevant pre-existing conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:					
Any complicating factors affecting recovery? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:					
Dental X-Rays taken? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, by Doctor:		Date of X-Rays (YYYY/MM/DD)	
Referral to Specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, to Doctor:		Specialty Type:	
Name and Address to whom fee is payable: (please print)			Provider's Signature:		
			Print Name:		
WCB Billing Number.		Date (YYYY/MM/DD)	Telephone Number		