Workers' Compensation Board Alberta

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

☐ **First Report (C-055)**

☐ **Progress Report (C-887)**

DENTAL REPORT

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

Please print or type

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

WCB Claim Number

Personal Health Number

Patient's *Surname* | *First Name* | *Initial*

Date of Birth (YYYY/MM/DD)

Address *Street* | *City/Town* | *Province*

Postal Code | Telephone Number ( ) | Date of Accident (YYYY/MM/DD) | Is the patient working? ☐ Yes ☐ 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? ☐ Yes ☐ No If yes, please describe:

Any complicating factors affecting recovery? ☐ Yes ☐ No If yes, please describe:

Dental X-Rays taken? ☐ Yes ☐ No If yes, by Doctor: Date of X-Rays (YYYY/MM/DD)

Referral to Specialist? ☐ Yes ☐ 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 ( )

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.

REV APR 2006

Des: Date of Service