Workers' Compensation Board
Alberta

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

C884
DENTURIST REPORT

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

Please print or type

WCB Claim Number

Personal Health Number

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

Date of Birth *(Year / Month / Day)*

Address *Street*

Postal Code

Telephone Number ( )

Date of Accident *(Year / Month / Day)*

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 *(Year / Month / Day)*

The worker attended my office on: *(Year / Month / Day)*

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 *(Year / Month / Day)*

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 *(Year / Month / Day)*

Telephone Number ( )

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

*** Please submit treatment plan preauthorization.**