



**PRIOR DENTAL
QUESTIONNAIRE**
CLAIMS DIVISION
SFN 61053 (01/2018)

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SECTION 1 – Worker’s information				
Claim number		Worker’s (First name)	(Last name)	
Body part(s)/tooth number(s)				
SECTION 2 – Dental health factors				
Do you brush your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how often				
Do you floss your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how often				
Are you currently taking prescribed or over-the-counter medications, supplements, or drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list the medication(s) or drug(s) and for how long?				
Do you have an autoimmune condition(s)? (e.g. Lupus, Multiple Sclerosis, HIV/AIDS, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe the condition and treatment				
Do you have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for how long?				
Do you, or have you been told that you grind your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for how long?				
Do you drink caffeinated or sugary drinks? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how often and for how long?				
Do you use, or have you used tobacco or nicotine products? (e.g. cigarettes, smokeless tobacco, e-cigarettes, vaping, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list type How often _____ per day How long _____ months _____ years I stopped using tobacco or nicotine products _____ months _____ years ago				
SECTION 3 – Prior dental history				
Before this injury, have you received or been told you need treatment to the claimed teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe the condition and treatment. Complete the additional information requested below beginning with the most recent treatment.				
Medical/dental provider	Year	City	State	Telephone number
Before this injury, have you received or been told you need treatment for the following conditions? (Select all that apply) <input type="checkbox"/> Gingivitis <input type="checkbox"/> Gum disease <input type="checkbox"/> Any other gum condition (Please list) If selected, complete the additional information requested below beginning with the most recent treatment.				
Medical/dental provider	Year	City	State	Telephone number

Form is continued on next page. Submit all pages to WSI.

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PRIOR DENTAL QUESTIONNAIRE (cont'd)

SFN 61053 (01/2018)

Claim number	Worker's (First name)	(Last name)
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Before this injury, have you received or been told you need any of the following treatments? (Select all that apply)

Crowns Root canal Bridge Treatment for loose teeth Other (Please list)

If selected, complete the additional information requested below beginning with the most recent treatment.

Medical/dental provider	Year	City	State	Telephone number

Before this injury have you received routine dental care? (e.g. cleanings, x-rays, etc.)

Yes No

If yes, complete the additional information requested below, beginning with the most recent treatment.

Medical/dental provider	Year	City	State	Telephone number

SECTION 4 – Release of information**Release of information**

I understand and agree that North Dakota law determines all my rights and obligations to and from WSI. I authorize any medical provider or facility, any insurance company, including workers' compensation relating to work injuries, any law enforcement or military agency, any government benefit agency including the Social Security Administration, and any educational agency or institution to release to WSI, its agents and attorneys, any and all information or records, including all prior records as well as those pertaining to mental health, alcohol, or drug abuse, and HIV/AIDS/AIDS-related illness. I authorize healthcare providers to respond to WSI regarding my injury, including request for conclusions and opinions not otherwise contained within existing medical records.

In addition, I authorize any education agency or institution to release to WSI any and all "educational records" as defined by 20 U.S.S 21 Sec. 1232g. This authorization continues while I have any claim open or pending before WSI. WSI is exempt from HIPAA regulations. I authorize WSI to release any information or records about my claim to third parties or their insurers for the purpose of resolving claims against third parties. I authorize the release of any medical information related to my claim to my employer.

Fraud Warning

Any person claiming benefits or compensation from WSI who files a false claim, or makes a false statement, or fails to notify WSI as to the receipt of income or an increase in income from employment, in connection with any claim or application for worker's compensation benefits will forfeit any future benefits and may be guilty of a felony which is punishable by imprisonment, substantial fines, or both. These criminal penalties are applicable to all persons dealing with WSI, including injured workers, employers, medical providers, and attorneys.

Signature

By signing this form, I acknowledge that I have read and understand the release of information and fraud warning. I understand that falsifying this claim or making a false statement regarding this claim may be a felony, punishable by substantial fines and imprisonment. I authorize the release of information and agree that statements in this form are true and accurate.

Worker's signature	Date
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