North Dakota Workforce Safety & Insurance

PRIOR DENTAL QUESTIONNAIRE

CLAIMS DIVISION
SFN 61053 (03/2024)

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SECTION 1 – *Injured employee's information*

Claim number	Injured employee's (First name)	(Last name)

Body part(s)/tooth number(s)

SECTION 2 – *Dental health factors*

Do you brush your teeth?
☐ Yes ☐ No If yes, how often

Do you floss your teeth?
☐ Yes ☐ No If yes, how often

Are you currently taking prescribed or over-the-counter medications, supplements, or drugs?
☐ Yes ☐ 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.)
☐ Yes ☐ No If yes, describe the condition and treatment

Do you have diabetes?
☐ Yes ☐ No If yes, for how long?

Do you, or have you been told that you grind your teeth?
☐ Yes ☐ No If yes, for how long?

Do you drink caffeinated or sugary drinks?
☐ Yes ☐ 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.)
☐ Yes ☐ No If yes, list type

How often per day

How long months years

I stopped using tobacco or nicotine products months years ago

When did you become aware your condition was related to your work?

SECTION 3 – *Prior dental history*

Before this injury, have you received or been told you need treatment to the claimed teeth?
☐ Yes ☐ 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)
☐ Gingivitis ☐ Gum disease ☐ 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

C96t

Claim number	Injured employee's (First name)	(Last name)

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 lasts for 1 year after the date signed unless I enter a different expiration date here _____.

I understand that this authorization may be revoked at any time in writing. Revocation of this authorization will not apply to any information released prior to receipt of my written revocation of this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.

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 employees, 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.

Injured employee's signature	**Date**