Saskatchewan Workers' Compensation Board
200-1881 Scarth Street
Regina SK S4P 4L1
www.wcbsask.com
Phone: 306.787.4370
Toll free: 1.800.667.7590
Fax: 306.787.4311
Toll free fax: 1.888.844.7773

Click on any field to start editing.

M7

Reset Form

Approved by the College of Dental Surgeons of Saskatchewan

The College of Dental Surgeons of Saskatchewan

Emergency dental treatment will be paid for at reasonable rate. Authorization for the remaining dental services must be obtained before proceeding with treatment.

Dentist's Initial Report

WCB claim number:

Firm number	Rate code	Injury date (MM/DD/YYYY)	Provincial Health Number	Date of birth (MM/DD/YYYY)

Clinic number: Provider number:

Worker's name, address, postal code

1. Worker's history of injury including symptoms:

Employer's name, address, postal code

2. Who rendered first treatment?

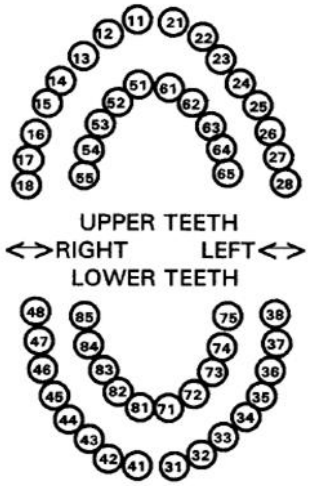
3. Date of your first treatment: (MM/DD/YYYY)

4. How did the injury occur?

5. Describe damage resulting from accident. If damage is to dentures, please describe:

6. Please mark chart as follows, using symbols as designated:
A. Teeth damaged by accident E. Teeth to be extracted M. Teeth missing prior to accident

7. Describe any oral condition that may be present with opinion as to whether or not due to accident:



8. Describe in detail your treatment plan to restore, as nearly as possible, the masticatory function to pre-injury state:

9. Describe estimate below and itemize charges, using the College of Dental Surgeons of Saskatchewan Fee Schedule:

$			
Approximate lab fee $ **TOTAL $**			

Please print or stamp
Doctor:

Dentist's signature

Please print & sign form before mailing/faxing.

Payee code

Address:

Phone: Date: (MM/DD/YYYY)

When writing to the WCB, please print name and claim or firm number.