



ORAL AND DENTAL CONDITIONS INCLUDING MOUTH, LIPS AND TONGUE
(OTHER THAN TEMPOROMANDIBULAR DISORDER CONDITIONS)
DISABILITY BENEFITS QUESTIONNAIRE

NAME OF PATIENT/VETERAN:

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER:

IMPORTANT - THE DEPARTMENT OF VETERANS AFFAIRS (VA) **WILL NOT PAY OR REIMBURSE** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM.

Note - The Veteran is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim. VA may obtain additional medical information, including an examination, if necessary, to complete VA's review of the veteran's application. VA reserves the right to confirm the authenticity of ALL Questionnaires completed by providers. **It is intended that this questionnaire will be completed by the Veteran's provider.**

Are you completing this Disability Benefits Questionnaire at the request of:

Veteran/Claimant

Other, please describe:

Are you a VA Healthcare provider? Yes No

Is the Veteran regularly seen as a patient in your clinic? Yes No

Was the Veteran examined in person? Yes No

If no, how was the examination conducted?

EVIDENCE REVIEW

Evidence reviewed:

No records were reviewed

Records reviewed

Please identify the evidence reviewed (e.g. service treatment records, VA treatment records, private treatment records) and the date range.

SECTION I - DIAGNOSIS

1. DIAGNOSIS

DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH AN ORAL OR DENTAL CONDITION? (This is the condition the veteran is claiming or for which an exam has been requested)

YES NO

IF YES, SELECT THE VETERAN'S CONDITION (check all that apply)

- LOSS OF ANY PORTION OF MANDIBLE (for reasons other than periodontal disease or edentulous atrophy) ICD Code: _____ Date of diagnosis: _____
- LOSS OF ANY PORTION OF MAXILLA (for reasons other than periodontal disease or edentulous atrophy) ICD Code: _____ Date of diagnosis: _____
- MALUNION OR NONUNION OF MANDIBLE ICD Code: _____ Date of diagnosis: _____
- MALUNION OR NONUNION OF MAXILLA ICD Code: _____ Date of diagnosis: _____
- LOSS OF TEETH (for reasons other than periodontal disease, or other routine dental maladies: this is intended for loss of teeth due to service-related trauma) ICD Code: _____ Date of diagnosis: _____
- TEMPOROMANDIBULAR DISORDER (TMD) (If checked, complete the Temporomandibular Disorder Conditions Disability Benefits Questionnaire in lieu of this questionnaire if that is the veteran's only condition. If the veteran has a TMD condition AND additional oral or dental conditions, complete this questionnaire and ALSO complete the Temporomandibular Disorder Conditions Disability Benefits Questionnaire. ICD Code: _____ Date of diagnosis: _____
- LIMITATION OF MOTION OF THE TEMPOROMANDIBULAR JOINT DUE TO CAUSES OTHER THAN TMD (If checked, complete this questionnaire and ALSO complete Temporomandibular Disorder Conditions Disability Benefits Questionnaire) ICD Code: _____ Date of diagnosis: _____
- ANATOMICAL LOSS OR INJURY OF THE MOUTH, LIPS OR TONGUE ICD Code: _____ Date of diagnosis: _____
- OSTEOMYELITIS, OSTEORADIONECROSIS OR OSTEONECROSIS OF THE JAW ICD Code: _____ Date of diagnosis: _____
- ORAL NEOPLASM (If checked, specify): _____ ICD Code: _____ Date of diagnosis: _____
- PERIODONTAL DISEASE (If this is the ONLY diagnosis checked, proceed to the signature section at the end of this form (for VA purposes this disease is not considered disabling) ICD Code: _____ Date of diagnosis: _____
- OTHER (specify):
Other diagnosis #1 _____ ICD Code: _____ Date of diagnosis: _____
Other diagnosis #2 _____ ICD Code: _____ Date of diagnosis: _____

IF ADDITIONAL DIAGNOSES THAT PERTAIN TO ORAL OR DENTAL CONDITIONS, LIST USING ABOVE FORMAT:

NOTE: This questionnaire is appropriate for bone loss due to trauma or disease such as osteomyelitis and **not** to the loss of the alveolar process as a result of periodontal disease, edentulous atrophy since such loss is not considered disabling. This is intended for loss of teeth due to service-related trauma.

SECTION II - MEDICAL /DENTAL HISTORY

DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S ORAL AND/OR DENTAL CONDITION:

SECTION III - DENTAL AND ORAL CONDITIONS

DOES THE VETERAN HAVE ANY OF THE FOLLOWING DENTAL OR ORAL CONDITIONS?

- YES NO (If "No," proceed to Section IV) (If "Yes," check all that apply)
- Mandible (anatomical loss or bony injury) (If checked, complete #1 below.)
 - Maxilla (anatomical loss or bony injury) (If checked, complete #2 below.)
 - Teeth (anatomical loss or bony injury leading to loss of any teeth) (If checked, complete #3 below.)
 - Mouth, lips, tongue and disfiguring scars to the mouth or lips (anatomical loss or injury) (If checked, complete #4 below.)
 - Osteomyelitis/osteoradionecrosis/osteonecrosis of the jaw (If checked, complete #5 below.)
 - Tumors or neoplasms (If checked, complete #6 below.)
 - Other dental or oral conditions, pertinent physical findings or scars due to dental or oral conditions (If checked, complete #7 below.)

1. MANDIBLE, INCLUDING ANATOMICAL LOSS OR BONY INJURY (NOT DUE TO EDENTULOUS ATROPHY OR PERIODONTAL DISEASE)

1A. HAS THE VETERAN LOST ANY PART OF THE MANDIBLE TO INCLUDE THE RAMUS (not due to edentulous atrophy or periodontal disease)?

- YES NO
- If "Yes," is the loss unilateral or bilateral: Unilateral Bilateral
- If "Yes," indicate severity (check all that apply):
- Loss of less than 1/2 of the mandible including the ramus, not involving the temporomandibular articulation
 - Loss of less than 1/2 of the mandible including the ramus, involving the temporomandibular articulation
 - Complete loss of the mandible between angles
 - Loss of half or more of mandible including the ramus, without loss of temporomandibular articulation
 - Loss of half or more of mandible including the ramus, involving loss of temporomandibular articulation
 - Other (describe): _____

1B. IF THE VETERAN HAS LOST ANY PART OF THE MANDIBLE, IS THE LOSS REPLACEABLE BY PROSTHESIS?

- YES NO NOT APPLICABLE

1C. HAS THE VETERAN LOST EITHER CONDYLE (condyloid process) OF THE MANDIBLE?

- YES NO (If "Yes," indicate side): Right Left Both

1D. HAS THE VETERAN LOST EITHER CORONOID PROCESS OF THE MANDIBLE?

- YES NO (If "Yes," indicate side): Right Left Both

1E. HAS THE VETERAN HAD AN INJURY RESULTING IN MALUNION OR NONUNION OF THE MANDIBLE?

- YES NO (If "Yes," indicate severity):
- Malunion, displacement, causing only mild or no anterior or posterior open bite
 - Malunion, displacement, causing moderate anterior or posterior open bite
 - Malunion, displacement, causing severe anterior or posterior open bite
 - Nonunion, confirmed by diagnostic imaging, moderate without false motion
 - Nonunion, confirmed by diagnostic imaging, severe with false motion
 - Other (describe): _____

NOTE - The assessment of the severity of malunion or nonunion of the mandible is dependent upon degree of motion and relative loss of masticatory function.

2. MAXILLA, INCLUDING ANATOMICAL LOSS OR BONY INJURY (NOT DUE TO EDENTULOUS ATROPHY OR PERIODONTAL DISEASE)

2A. HAS THE VETERAN LOST ANY PART OF THE MAXILLA? (Not due to edentulous atrophy or periodontal disease)

- YES NO (If "Yes," indicate severity)
- Loss of less than 25% Loss of 25% - 50% Loss of more than half

2B. IF THE VETERAN HAS LOST ANY PART OF THE MAXILLA, IS THE LOSS REPLACEABLE BY PROSTHESIS?

- YES NO NOT APPLICABLE

2C. HAS THE VETERAN LOST ANY PART OF THE HARD PALATE?

- YES NO (If "Yes," indicate severity)
- Loss of less than half Loss of half or more

2D. IF THE VETERAN HAS LOST ANY PART OF THE HARD PALATE, IS THE LOSS REPLACEABLE BY PROSTHESIS?

- YES NO NOT APPLICABLE

2E. HAS THE VETERAN HAD AN INJURY RESULTING IN MALUNION OR NONUNION OF THE MAXILLA?

- YES NO (If "Yes," indicate severity)
- Malunion, displacement, causing only mild or no anterior or posterior open bite
 - Malunion, displacement, causing moderate anterior or posterior open bite
 - Malunion, displacement, causing severe anterior or posterior open bite
 - Nonunion, confirmed by diagnostic imaging, moderate without false motion
 - Nonunion, confirmed by diagnostic imaging, severe with false motion
 - Other (describe): _____

NOTE - For VA compensation purposes, the severity of maxillary nonunion is dependent upon the degree of abnormal mobility of maxilla fragments following treatment (i.e., presence or absence of false motion), and maxillary nonunion must be confirmed by diagnostic imaging studies.

SECTION III - DENTAL AND ORAL CONDITIONS (Continued)

3. TEETH, INCLUDING ANATOMICAL LOSS OR BONY INJURY LEADING TO LOSS OF ANY TEETH (OTHER THAN THAT DUE TO THE LOSS OF THE ALVEOLAR PROCESS AS A RESULT OF PERIODONTAL DISEASE)

3A. IS THE LOSS OF TEETH DUE TO LOSS OF SUBSTANCE OF BODY OF MAXILLA OR MANDIBLE WITHOUT LOSS OF CONTINUITY?

YES NO

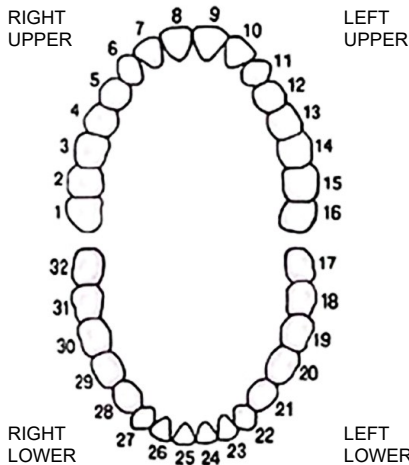
3B. IS THE LOSS OF TEETH DUE TO TRAUMA OR DISEASE (SUCH AS OSTEOMYELITIS?)

YES NO (If "Yes," describe):

3C. CAN THE MASTICATORY SURFACES BE RESTORED BY SUITABLE PROSTHESIS?

YES NO (If "Yes," describe):

3D. LIST MISSING TEETH BY NUMBER:



RIGHT UPPER: 1 2 3 4 5 6 7 8

LEFT UPPER: 9 10 11 12 13 14 15 16

LEFT LOWER: 17 18 19 20 21 22 23 24

RIGHT LOWER: 25 26 27 28 29 30 31 32

4. MOUTH, LIPS, TONGUE AND DISFIGURING SCARS TO THE MOUTH OR LIPS (ANATOMICAL LOSS OR INJURY)

4A. DOES THE VETERAN HAVE ANY DISFIGURING SCARS TO THE MOUTH OR LIPS?

YES NO (If "Yes," ALSO complete the Scars/Disfigurement Disability Benefits Questionnaire)

4B. DOES THE VETERAN HAVE A MOUTH INJURY THAT RESULTS IN IMPAIRMENT OF MASTICATION?

YES NO (If "Yes," describe):

4C. DOES THE VETERAN HAVE PARTIAL OR COMPLETE LOSS OF THE TONGUE?

YES NO (If "Yes," indicate severity)

Loss of less than 1/2 of tongue

Loss of 1/2 or more of tongue

4D. DOES THE VETERAN HAVE A SPEECH IMPAIRMENT CAUSED BY PARTIAL OR COMPLETE LOSS OF THE TONGUE, OR BY ANY OTHER TONGUE CONDITION?

YES NO (If "Yes," indicate severity)

Marked speech impairment (If checked, describe): _____

Inability to communicate by speech (If checked, describe): _____

5. OSTEOMYELITIS/OSTEORADIONECROSIS/OSTEONECROSIS OF THE JAW

5A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH OSTEOMYELITIS OR OSTEORADIONECROSIS OF THE MANDIBLE?

YES NO (If "Yes," ALSO complete VA Form 21-0960M-11, Osteomyelitis Disability Benefits Questionnaire)

5B. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH OSTEONECROSIS OF THE JAW?

YES NO (If "Yes," describe):

SECTION III - DENTAL AND ORAL CONDITIONS (Continued)

6. TUMORS AND NEOPLASMS

6A. DOES THE VETERAN HAVE A BENIGN OR MALIGNANT NEOPLASM OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN THE DIAGNOSIS SECTION?

YES NO (If "Yes," complete the following section)

6B. IS THE NEOPLASM?

BENIGN MALIGNANT

(If malignant, indicate status of disease)

ACTIVE

- Surgery, describe: _____
- Antineoplastic chemotherapy _____
- Radiation therapy _____
- Other, describe: _____

Anticipated date of final treatment (surgical, antineoplastic, chemotherapy, or other): _____

REMISSION

- Surgery, describe: _____
- Antineoplastic chemotherapy _____
- Radiation therapy _____
- Other, describe: _____

Anticipated date of final treatment (surgical, antineoplastic, chemotherapy, or other): _____

6C. DOES THE VETERAN CURRENTLY HAVE ANY RESIDUAL CONDITIONS OR COMPLICATIONS DUE TO THE NEOPLASM (*including metastases*) OR ITS TREATMENT, OTHER THAN THOSE ALREADY DOCUMENTED IN THE REPORT ABOVE?

YES NO (If "Yes," list residual conditions and complications (brief summary)):

6D. IF THERE ARE ADDITIONAL BENIGN OR MALIGNANT NEOPLASMS OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN SECTION I, DIAGNOSIS, DESCRIBE USING THE ABOVE FORMAT:

7. OTHER PERTINENT PHYSICAL FINDINGS, SCARS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS

7A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO THE CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

YES NO

IF YES, DESCRIBE (brief summary):

7B. DOES THE VETERAN HAVE ANY SCARS (surgical or otherwise) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

YES NO

IF YES, ARE ANY OF THESE SCARS PAINFUL OR UNSTABLE; HAVE A TOTAL AREA EQUAL TO OR GREATER THAN 39 SQUARE CM (6 square inches); OR ARE LOCATED ON THE HEAD, FACE OR NECK? (An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar.)

YES NO

IF YES, ALSO COMPLETE VA FORM 21-0960F-1, SCARS/DISFIGUREMENT.

IF NO, PROVIDE LOCATION AND MEASUREMENTS OF SCAR IN CENTIMETERS.

LOCATION: _____ MEASUREMENTS: length _____ cm X width _____ cm.

NOTE: If there are multiple scars, enter additional locations and measurements in Comment section below. It is not necessary to also complete a Scars DBQ.

7C. COMMENTS, IF ANY:

SECTION IV - DIAGNOSTIC TESTING

NOTE - If diagnostic test results are in the medical record and reflect the veteran's current oral or dental condition, repeat testing is not required.

A. HAVE IMAGING STUDIES OR PROCEDURES BEEN PERFORMED?

YES NO (If "Yes," check all that apply):

- Panorographic/intraoral imaging to demonstrate loss of teeth, mandible or maxilla Date: _____ Results: _____
- X-ray Date: _____ Results: _____
- CT scan Date: _____ Results: _____
- MRI Date: _____ Results: _____
- PET scan Date: _____ Results: _____
- Radionuclide bone scanning Date: _____ Results: _____
- Ultrasonography Date: _____ Results: _____
- Other: _____ Date: _____ Results: _____

SECTION V - FUNCTIONAL IMPACT

1. FUNCTIONAL IMPACT

DOES THE VETERAN'S ORAL OR DENTAL CONDITION IMPACT HIS OR HER ABILITY TO WORK?

YES NO (If "Yes," describe impact of each of the Veteran's oral or dental condition(s), providing one or more examples):

2. REMARKS (If any)

SECTION VI - EXAMINER'S CERTIFICATION AND SIGNATURE

CERTIFICATION - To the best of my knowledge, the information contained herein is accurate, complete and current.

6A. Examiner's signature:

6B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

6C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

6D. Date Signed:

6E. Examiner's phone/fax numbers:

6F. National Provider Identifier (NPI) number:

6G. Medical license number and state:

6H. Examiner's address: