Department of Veterans Affairs

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	Date of examination:

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 completed questionnaires. **It is intended that this questionnaire will be completed by the Veteran's healthcare provider.**

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

☐ Veteran/Claimant

☐ Third party (please list name(s) of organization(s) or individual(s))

☐ 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

Note: These are condition(s) for which an evaluation has been requested on the exam request form (Internal VA) or for which the Veteran has requested medical evidence be provided for submission to VA.

1A. List the claimed condition(s) that pertain to this questionnaire:

Note: These are the diagnoses determined during this current evaluation of the claimed condition(s) listed above. If there is no diagnosis, if the diagnosis is different from a previous diagnosis for this condition, or if there is a diagnosis of a complication due to the claimed condition(s), explain your findings and reasons in the Remarks section. Date of diagnosis can be the date of the evaluation if the clinician is making the initial diagnosis or an approximate date determined through record review or reported history.

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 since such loss is not considered disabling. This is intended for loss of teeth due to service-related trauma.

1B. Select diagnoses associated with the claimed condition(s) (check all that apply):

☐ The Veteran does not have a current diagnosis associated with any claimed condition(s) listed above. Explain your findings and reasons in the remarks section.

☐	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:
☐	Mandible, nonunion of, confirmed by diagnostic imaging studies	ICD code:		Date of diagnosis:
☐	Mandible, malunion of	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 the Veteran has a TMD condition and additional oral and dental conditions, complete this questionnaire and also complete the TMD 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 the TMD questionnaire)	ICD code:		Date of diagnosis:
☐	Soft tissue injury of the mouth, other than tongue or lips	ICD code:		Date of diagnosis:
☐	Lips, injuries of	ICD code:		Date of diagnosis:
☐	Tongue, loss of whole or part	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 oral and dental conditions (specify)			
	Other diagnosis #1	ICD code:		Date of diagnosis:
	Other diagnosis #2	ICD code:		Date of diagnosis:
	Other diagnosis #3	ICD code:		Date of diagnosis:

1C. If there are additional diagnoses that pertain to oral and dental conditions, list using above format:

SECTION II - MEDICAL HISTORY

2A. Describe the history (including onset and course) of the Veteran's oral and/or dental condition(s) (brief summary):

SECTION III - MANDIBLE, INCLUDING ANATOMICAL LOSS OR BONY INJURY

3A. 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, indicate if unilateral or bilateral, and indicate severity.

◯ Unilateral ◯ Bilateral

☐ Loss of less than one-half of the mandible including the ramus, not involving the temporomandibular articulation

☐ Loss of less than one-half of the mandible including the ramus, involving the temporomandibular articulation

☐ Complete loss of the mandible between angles

☐ Loss of one-half or more of mandible including the ramus, without loss of temporomandibular articulation

☐ Loss of one-half or more of mandible including the ramus, involving loss of temporomandibular articulation

☐ Other (describe): _____

3B. If the Veteran has lost any part of the mandible, is the loss replaceable by prosthesis? ◯ Yes ◯ No ◯ Not Applicable

3C. Has the Veteran lost either condyle (condyloid process) of the mandible? ◯ Yes ◯ No

If yes, indicate side: ◯ Right ◯ Left ◯ Both

3D. Has the Veteran lost either coronoid process of the mandible? ◯ Yes ◯ No

If yes, indicate side: ◯ Right ◯ Left ◯ Both

3E. 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 open bite ◯ anterior ◯ posterior

☐ Malunion, displacement, causing severe open bite ◯ anterior ◯ posterior

☐ 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.

SECTION IV - MAXILLA, INCLUDING ANATOMICAL LOSS OR BONY INJURY

4A. Has the Veteran lost any part of the maxilla? (Not due to endentulous atrophy or periodontal disease)

◯ Yes ◯ No If yes, indicate severity:

◯ Loss of less than 25% ◯ Loss of 25% - 50% ◯ Loss of more than half

4B. If the Veteran has lost any part of the maxilla, is the loss replaceable by prosthesis? ◯ Yes ◯ No ◯ Not applicable

4C. 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

4D. If the Veteran has lost any part of the hard palate, is the loss replaceable by prosthesis? ◯ Yes ◯ No ◯ Not Applicable

4E. 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 open bite ◯ anterior ◯ posterior

☐ Malunion, displacement, causing moderate open bite ◯ anterior ◯ posterior

☐ Malunion, displacement, causing severe open bite ◯ anterior ◯ posterior

☐ 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 V - TEETH, INCLUDING ANATOMICAL LOSS OR BONY INJURY LEADING TO LOSS OF ANY TEETH

5A. Is the loss of teeth due to loss of substance of body of maxilla or mandible without loss of continuity? ◯ Yes ◯ No

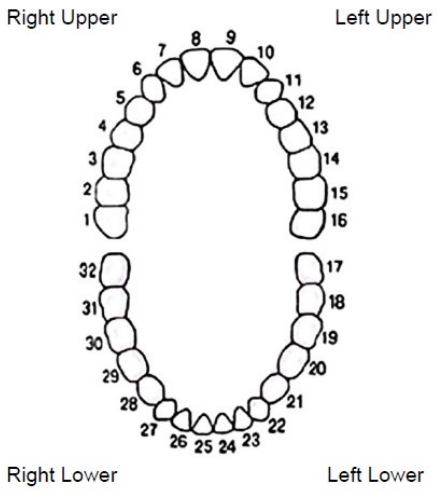
5B. Is the loss of teeth due to trauma or disease (such as osteomyelitis)? ◯ Yes ◯ No

If yes, describe:

5C. Can the masticatory surfaces be restored by suitable prosthesis? ◯ Yes ◯ No

If yes, describe. If no, explain why not.

5D. 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

SECTION VI - INJURY OF MOUTH, LIPS, TONGUE AND DISFIGURING SCARS TO THE MOUTH OR LIPS

6A. Does the Veteran have any scars or other disfigurement to the mouth or lips?

◯ Yes ◯ No If yes, also complete the appropriate dermatological questionnaire.

6B. Does the Veteran have a soft tissue injury of the mouth, other than the tongue or lips, that results in impairment of mastication? ◯ Yes ◯ No

If yes, describe:

6C. Does the Veteran have partial or complete loss of the tongue? ◯ Yes ◯ No If yes, select one of the following:

◯ Asymptomatic

◯ Intact oral nutritional intake with permanently impaired swallowing function without prescribed dietary modification.

◯ Intact oral nutritional intake with permanently impaired swallowing function that requires prescribed dietary modification.

◯ Absent oral nutritional intake.

6D. Does the Veteran have complete or incomplete aphonia due to loss of whole or part of the tongue? ◯ Yes ◯ No

If yes, also complete the aphonia questions on the appropriate Ear, Nose, and Throat questionnaire.

SECTION VII - OSTEOMYELITIS/OSTEORADIONECROSIS/OSTEONECROSIS OF THE JAW

7A. 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 the Osteomyelitis questionnaire.

7B. Does the Veteran now have or has he or she ever been diagnosed with osteonecrosis of the jaw? ◯ Yes ◯ No

If yes, describe

SECTION VIII - TUMORS AND NEOPLASMS

8A. Does the Veteran currently have, or has had, a benign or malignant neoplasm or metastases related to any condition in the diagnosis section?

◯ Yes ◯ No If yes, complete the following section.

8B. Is the neoplasm:

◯ Benign

◯ Malignant (if malignant complete the following):

◯ Active ◯ In remission

◯ Primary ◯ Secondary (metastatic) (if secondary, indicate the primary site, if known): _____

8C. Has the Veteran completed treatment or is the Veteran currently undergoing treatment for a benign or malignant neoplasm or metastases?

◯ Yes ◯ No; watchful waiting

If yes, indicate type of treatment the Veteran is currently undergoing or has completed (check all that apply):

☐ Treatment completed

☐ Surgery

If checked, describe: _____

Date(s) of surgery: _____

☐ Radiation therapy

Date of most recent treatment: _____ Date of completion of treatment or anticipated date of completion: _____

☐ Antineoplastic chemotherapy

Date of most recent treatment: _____ Date of completion of treatment or anticipated date of completion: _____

☐ Other therapeutic procedure

If checked, describe procedure: _____

Date of most recent procedure: _____

☐ Other therapeutic treatment

If checked, describe treatment: _____

Date of completion of treatment or anticipated date of completion: _____

8D. Does the Veteran currently have any residuals 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 residuals or complications (brief summary), and also complete the appropriate questionnaire:

8E. If there are additional benign or malignant neoplasms or metastases related to any of the diagnoses in the diagnosis section, describe using the above format:

SECTION IX - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

9A. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to any conditions listed in the diagnosis section above?

◯ Yes ◯ No If yes, describe (brief summary)

9B. Does the Veteran have any scars or other disfigurement (of the skin) related to any conditions or to the treatment of any conditions listed in the diagnosis section other than those identified in Section VI?

◯ Yes ◯ No If yes, also complete the appropriate dermatological questionnaire.

SECTION X - 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.

10A. Have clinically relevant diagnostic imaging studies or other diagnostic procedures been performed or reviewed in conjunction with this examination?

◯ Yes ◯ No If yes, check all that apply.

☐	Panographic/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, specify:	Date:		Results:

10B. Are there any other clinically relevant diagnostic test findings or results related to the claimed condition(s) and/or diagnosis(es), that were reviewed in conjunction with this examination?

◯ Yes ◯ No

If yes, provide type of test or procedure, date and result (brief summary):

10C. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed conditions:

SECTION XI - FUNCTIONAL IMPACT

Note: Provide the impact of only the diagnosed condition(s), without consideration of the impact of other medical conditions or factors, such as age.

11A. Regardless of the Veteran's current employment status, do the conditions listed in the diagnosis section impact his/her ability to perform any type of occupational task?

◯ Yes ◯ No

If yes, describe the functional impact of each condition, providing one or more examples:

SECTION XII - REMARKS

12A. Remarks (if any – please identify the section to which the remark pertains when appropriate).

SECTION XIII - EXAMINER'S CERTIFICATION AND SIGNATURE

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

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.

13A. Examiner's signature:	13B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):
13C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):	13D. Date Signed:
13E. Examiner's phone/fax numbers:	13F. National Provider Identifier (NPI) number: / 13G. Medical license number and state:
13H. Examiner's address:	