OMB Approved No. 2900-0781 Respondent Burden: 15 Minutes Expiration Date: 09/30/2019

Department of Veterans Affairs	ORAL AND DENTAL CONDITIONS INCLUDING MOUTH, LIPS AND TONGUE (OTHER THAN TEMPOROMANDIBULAR JOINT CONDITIONS) DISABILITY BENEFITS QUESTIONNAIRE					
IMPORTANT - THE DEPARTMENT OF VETERANS AFFAIRS (VA) <i>WI</i> PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM. PLEA BEFORE COMPLETING FORM.						
NAME OF PATIENT/VETERAN (First, Middle Initial, Last)						
NOTE TO PHYSICIAN - Your patient is applying to the U.S. Department of V provide on this questionnaire as part of their evaluation in processing the veteran private health care providers.						
	I - DIAGNOSIS					
 1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGN <i>claiming or for which an exam has been requested</i>) YES NO (<i>If "Yes," complete Item 1B</i>) 	OSED WITH AN ORAL OR DENTAL CO	ONDITION? (This is the condition the veteran is				
NOTE : These are the diagnosis determined during this current evaluation of the from a previous diagnosis for this condition, or if there is a diagnosis of a complisection. Date of diagnosis can be the date of the evaluation if the clinician is mak	cation due to the claimed condition, ex	xplain your findings and reasons in the "Remarks'				
reported history. 1B. 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 JOINT DISORDER (TMJD) (If checked, complete the VA Form 21-0960M-15, Temporomandibular Joint Conditions Disability Benefits Questionnaire in lieu of this questionnaire if that is the veteran's only condition. If the veteran has a TMJD condition AND additional oral or dental conditions, complete this questionnaire and ALSO complete VA Form 21-0960M-15) 	ICD Code:	Date of diagnosis:				
LIMITATION OF MOTION OF THE TEMPOROMANDIBULAR JOINT DUE TO CAUSES OTHER THAN TMJD (If checked, complete this questionnaire and ALSO complete VAF Form 21-0960M-15, Temporomandibular Joint 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 BISPHOSPHONATE- RELATED 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:				
1C. IF ADDITIONAL DIAGNOSES THAT PERTAIN TO ORAL OR DENTAL CONDI	TIONS, LIST USING ABOVE FORMAT					
NOTE: This questionnaire is appropriate for bone loss due to trauma or disease disease, edentuious atrophy since such loss is not considered disabling. This is in	such as osteomyelitis and <i>not</i> to the lost tended for loss of teeth due to service-	ss of the alveolar process as a result of periodonta related trauma.				
SECTION II - MED	ICAL RECORD REVIEW					
2. INDICATE MEDICAL RECORDS REVIEWED IN PREPARATION OF THIS REPO	DRT:					
SECTION III - MEDICAL HISTORY 3A. MEDICAL/DENTAL HISTORY (including onset and course) OF THE VETERAN'S ORAL AND/OR DENTAL CONDITION:						

PATIENT/VETERAN'S SOCIAL SECURITY NO.							
SECTION III - MEDICAL HISTORY (Continued)							
3B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF THE VETERAN'S ORAL AND/OR DENTAL CONDITION?							
YES NO If "Yes," list only those medications required for the veteran's oral and/or dental condition)							
SECTION IV - DENTAL AND ORAL CONDITIONS							
4. DOES THE VETERAN HAVE ANY OF THE FOLLOWING DENTAL OR ORAL CONDITIONS?							
$ \begin{array}{ c c c c } \hline YES & NO & (If "No," proceed to Section V) \\ & (If "Yes," check all that apply) \end{array} $							
(I) Tes, check all that apply) Mandible (anatomical loss or bony injury) (If checked, complete Part A below.)							
Maxilla (anatomical loss or bony injury) (If checked, complete Part B below.)							
Teeth (anatomical loss or bony injury leading to loss of any teeth) (If checked, complete Part C below.)							
Mouth, lips, tongue and disfiguring scars to the mouth or lips (anatomical loss or injury) (If checked, complete Part D below.)							
Osteomyelitis/osteoradionecrosis/bisphposphonate-related osteonecrosis of the jaw (If checked, complete Part E below.)							
Tumors or neoplasms (If checked, complete Part F below.)							
Other dental or oral conditions, pertinent physical findings or scars due to dental or oral conditions (<i>If checked, complete Part G below.</i>)							
PART A - MANDIBLE, INCLUDING ANATOMICAL LOSS OR BONY INJURY (NOT DUE TO EDENTULOUS ATROPHY OR PERIODONTAL DISEASE) 1. HAS THE VETERAN LOST ANY PART OF THE MANDIBLE OR MANDIBULAR RAMUS (not due to edentulous atrophy or periodontal disease)?							
\square YES \square NO (If "Yes," indicate severity (check all that apply))							
Loss of approximately 1/2 of the mandible, not involving the temporomandibular articulation							
Loss of approximately 1/2 of the mandible, involving the temporomandibular articulation							
Complete loss of the mandible between angles							
Loss of less than 1/2 the substance of mandibular ramus, not involving loss of continuity (If checked, indicate side):							
Loss of whole or part of mandibular ramus, without loss of temporomandibular articulation (<i>If checked, indicate side</i>):							
Loss of whole or part of mandibular ramus, involving loss of temporomandibular articulation (<i>If checked, indicate side</i>):							
Other (describe): 2. HAS THE VETERAN LOST EITHER CONDYLOID (condyloid process) OF THE MANDIBLE?							
YES NO (If "Yes," indicate side): Right Left Both							
3. HAS THE VETERAN LOST EITHER CORONOID PROCESS OF THE MANDIBLE?							
YES NO (If "Yes," indicate side): Right Left Both							
4. HAS THE VETERAN HAD AN INJURY RESULTING IN MALUNION OR NONUNION OF THE MANDIBLE?							
YES NO (If "Yes," indicate severity):							
Malunion with slight displacement							
Malunion with moderate displacement							
Malunion with severe displacement							
Nonunion, moderate							
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.							
PART B - MAXILLA, INCLUDING ANATOMICAL LOSS OR BONY INJURY (NOT DUE TO ENDENTULOUS ATROPHY OR PERIODONTAL DISEASE)							
1. 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 to 50%							
Loss of more than 50%							
2. IF THE VETERAN HAS LOST ANY PART OF THE MAXILLA, IS THE LOSS REPLACEABLE BY PROSTHESIS?							
3. HAS THE VETERAN LOST ANY PART OF THE HARD PALATE?							
YES NO (If "Yes," indicate severity)							
Loss of less than 50%							
4. IF THE VETERAN HAS LOST ANY PART OF THE HARD PALATE, IS THE LOSS REPLACEABLE BY PROSTHESIS?							
5. HAS THE VETERAN HAD AN INJURY RESULTING IN MALUNION OR NONUNION OF THE MAXILLA?							
\square YES \square NO (If "Yes," indicate severity)							
Malunion or nonunion with slight displacement Malunion or nonunion with moderate displacement							
Malunion or nonunion with severe displacement							

PATIENT/VETERAN'S SOCIAL SECURITY NO.						
SECTION IV - DENTAL AND ORAL CONDITIONS (Continued)						
PART C - 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)						
1. IS THE LOSS OF TEETH DUE TO LOSS OF SUBSTANCE OF BODY OF MAXILLA OR MANDIBLE WITHOUT LOSS OF CONTINUITY?						
YES NO						
2. IS THE LOSS OF TEETH DUE TO TRAUMA OR DISEASE (SUCH AS OSTEOMYELITIS?)						
YES NO (If "Yes," describe):						
3. CAN THE MASTICATORY SURFACES BE RESTORED BY SUITABLE PROSTHESIS?						
YES NO (If "Yes," describe):						
4. INDICATE THE EXTENT OF LOSS OF TEETH (Check all that apply): Upper Teeth						
No missing teeth All right posterior missing Other, describe:						
All posterior teeth missing bilaterally All right anterior missing						
All anterior teeth missing bilaterally						
All upper teeth missing						
No missing teeth All right posterior missing Other, describe:						
All posterior teeth missing bilaterally All right anterior missing All anterior teeth missing bilaterally All left posterior missing						
All lower teeth missing						
5. LIST MISSING TEETH BY NUMBER:						
PART D - MOUTH, LIPS, TONGUE AND DISFIGURING SCARS TO THE MOUTH OR LIPS (ANATOMICAL LOSS OR INJURY)						
1. DOES THE VETERAN HAVE ANY DISFIGURING SCARS TO THE MOUTH OR LIPS?						
YES NO (If "Yes," ALSO complete VA Form 21-0960F-1, Scars/Disfigurement Disability Benefits Questionnaire)						
2. DOES THE VETERAN HAVE A MOUTH INJURY THAT RESULTS IN IMPAIRMENT OF MASTICATION?						
YES NO (If "Yes," describe):						
3. 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						
4. 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 (<i>If checked, describe</i>):						
PART E - OSTEOMYELITIS/OSTEORADIONECROSIS/BISPHOSPHONATE-RELATED OSTEONECROSIS OF THE JAW 1. 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)						
2. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH BISPHOSPHONATE-RELATED OSTEONECROSIS OF THE JAW?						
YES NO (If "Yes," describe):						
PART F - TUMORS AND NEOPLASMS						
1. DOES THE VETERAN HAVE A BENIGN OR MALIGNANT NEOPLASM OR METASTASES RELATED TO ANY OF THE DIAGNOSES CHECKED IN SECTION I, DIAGNOSIS?						
YES NO (If "Yes," complete the following section)						
2. IS THE NEOPLASM?						
BENIGN MALIGNANT						

PATIENT/VETERAN'S SOCIAL SECURITY NO.								
SECTION IV - DENTAL AND ORAL CONDITIONS (Continued)								
PART F - TUMORS AND NEOPLASMS (Continued)								
3. HAS THE VETERAN COMPLETED TREATMENT OR IS THE VETERAN CURRENTLY UNDERGOING TREATMENT FOR A BENIGN OR MALIGNANT NEOPLASM SECTION? YES NO; WATCHFUL WAITING (If "Yes," indicate type of treatment the veteran is currently undergoing or has completed (check all that apply)): Treatment completed; currently in watchful waiting status 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 completion of treatment or anticipated date of completion: Other therapeutic procedure Date of completion of treatment or anticipated date of completion:								
If checked, describe procedure:								
5. 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: PART G - OTHER PERTINENT PHYSICAL FINDINGS, SCARS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS								
 1. 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? YES NO IF "YES," ARE ANY OF THESE SCARS PAINFUL AND/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? YES NO IF "YES," ALSO COMPLETE VA FORM 21-0960F-1, SCARS/DISFIGUREMENT DISABILITY BENEFITS QUESTIONNAIRE (DBQ). IF "NO," PROVIDE LOCATION AND MEASUREMENTS OF SCAR IN CENTIMETERS. 								
LOCATION: MEASUREMENTS: Length cm X width cm. NOTE: An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar. If there are multiple scars, enter additional locations and measurements in the "Remarks" section. It is not necessary to also complete a Scars/Disfigurement DBQ.								
2. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS? YES NO (If "Yes," describe (brief summary):								
SECTION V - 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.								
SA. HAVE IMAGING STUDIES OR PROCEDURES BEEN PERFORMED? YES NO (If "Yes," check all that apply): Panographic/intraoral imaging to demonstrate loss of teeth, mandible or maxilla Other: Date: Results:								
SB. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS? YES NO (If "Yes," provide type of test or procedure, date and results (brief summary)):								

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PATIENT/VETERAN'S SOCIAL SECURITY NO.	SEC	TION VI -	- FUN	ICTIONAL IMPACT			
6. DOES THE VETERAN'S ORAL OR DENTAL CONE							
YES NO (If "Yes," describe impact of	feach of the ve	teran's ora	l or d	ental condition(s), provi	ding one or more example.	s):	
		SECTIC	ON VI	I - REMARKS			
7. REMARKS (<i>lf any</i>)							
				ERTIFICATION AND			
CERTIFICATION - To the best of my knowl	edge, the info	ormation of	conta	ined herein is accurat	e, complete and current		
8A. PHYSICIAN'S SIGNATURE		8B. PHYSI	CIAN'	S PRINTED NAME		8C. DATE SIGNED	
8D. PHYSICIAN'S PHONE/FAX NUMBERS	8E. NATIONA	L PROVID	ER ID	ENTIFIER (NPI) NUMBE	R 8F. PHYSICIAN'S ADDI	RESS	
		1.1%					
NOTE - VA may request additional medical information	ition, including	g additional	l exan	ninations, if necessary to	complete VA's review of	the veteran's application.	
IMPORTANT - Physician please fax the com	pleted form to	o:					
(VA Regional Office FAX No.)							
NOTE - A list of VA Regional Office FAX Numbers can be found at <u>www.benefits.va.gov/disabilityexams</u> or obtained by calling 1-800-827-1000.							
1.012 Theorem Chief The Theorem Control Fund and the Theorem Control Control of Control							
PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 28. Code of Federal Pagulations 1576 for participations (i.e. given by a foregraphic terms of the privacy act of 1974).							
or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and							
delivery of VA benefits, verification of identity and Pension, Education and Vocational Rehabilitation and							
your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account							
information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is							
considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.							
RESPONDENT BURDEN: We need this information to determine entitlement to benefits (38 U.S.C. 501). Title 38, United States Code, allows us to ask for this							
information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete the form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not							
sponsor a collection of information unless a valid Ol displayed. Valid OMB control numbers can be locate	MB control nur ed on the OMB	nber 1s disj 8 Internet P	played Page a	d. You are not required t t www.reginfo.gov/pub	to respond to a collection o lic/do/PRAMain. If desire	of information if this number is not ed, you can call 1-800-827-1000 to	
get information on where to send comments or suggestions about this form.							