OMB Approved No. 2900-0781
Respondent Burden: 15 Minutes
Expiration Date: XX/XX/XXXX

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) ***WILL NOT PAY*** OR ***REIMBURSE*** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

NOTE TO PHYSICIAN - Your patient 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 reserves the right to confirm the authenticity of ALL DBQs completed by private health care providers.

SECTION I - DIAGNOSIS

1A. 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," complete Item 1B)*

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

SECTION II - MEDICAL RECORD REVIEW

2. INDICATE MEDICAL RECORDS REVIEWED IN PREPARATION OF THIS REPORT:

☐ C-FILE (VA ONLY)

☐ OTHER, DESCRIBE: _____

SECTION III - MEDICAL HISTORY

3. MEDICAL/DENTAL HISTORY *(including onset and course)* OF 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?

☐ YES ☐ NO *(If "No," proceed to Section V)*
(If "Yes," 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 *(If checked, complete Part G below.)*

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)*?

☐ YES ☐ 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):* ☐ Right ☐ Left ☐ Both
- ☐ Loss of whole or part of mandibular ramus, without loss of temporomandibular articulation *(If checked, indicate side):* ☐ Right ☐ Left ☐ Both
- ☐ Loss of whole or part of mandibular ramus, involving loss of temporomandibular articulation *(If checked, indicate side):* ☐ Right ☐ Left ☐ Both
- ☐ 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
- ☐ Nonunion, severe
- ☐ 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?

☐ YES ☐ NO ☐ NOT APPLICABLE

3. HAS THE VETERAN LOST ANY PART OF THE HARD PALATE?

☐ YES ☐ NO *(If "Yes," indicate severity)*

- ☐ Loss of less than 50%
- ☐ Loss of 50% or more

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

☐ YES ☐ NO ☐ NOT APPLICABLE

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

☐ YES ☐ NO *(If "Yes," indicate severity)*

- ☐ Malunion or nonunion with slight displacement
- ☐ Malunion or nonunion with moderate displacement
- ☐ Malunion or nonunion with severe displacement

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 posterior teeth missing bilaterally
☐ All anterior teeth missing bilaterally
☐ All upper teeth missing
☐ All right posterior missing
☐ All right anterior missing
☐ All left posterior missing
☐ All left anterior missing
☐ Other, describe: _____

Lower Teeth

☐ No missing teeth
☐ All posterior teeth missing bilaterally
☐ All anterior teeth missing bilaterally
☐ All lower teeth missing
☐ All right posterior missing
☐ All right anterior missing
☐ All left posterior missing
☐ All left anterior missing
☐ Other, describe: _____

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 *(If checked, describe):* _____

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

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 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: _____

4. 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)):*

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 SECTION I, DIAGNOSIS?

☐ YES ☐ NO

(If "Yes," are any of the scars painful and/or unstable, or is the total area of all related scars greater than or equal to 39 square cm (6 square inches))?

☐ YES ☐ NO *(If "Yes," ALSO complete VA Form 21-0960F-1, Scars/Disfigurement Disability Benefits Questionnaire)*

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.

5A. 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 Date: _____ Results: _____

☐ Other: _____ Date: _____ Results: _____

5B. 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)):*

SECTION VI - FUNCTIONAL IMPACT

6. 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):*

SECTION VII - REMARKS

7. REMARKS *(If any)*

SECTION VIII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

8A. PHYSICIAN'S SIGNATURE	8B. PHYSICIAN'S PRINTED NAME	8C. DATE SIGNED

8D. PHYSICIAN'S PHONE AND FAX NUMBERS	8E. PHYSICIAN'S MEDICAL LICENSE NUMBER	8F. PHYSICIAN'S ADDRESS

NOTE - VA may request additional medical information, including additional examinations, if necessary to complete VA's review of the veteran's application.

IMPORTANT - Physician please fax the completed form to: _____

(VA Regional Office FAX No.)

NOTE - A list of VA Regional Office FAX Numbers can be found at **www.benefits.va.gov/disabilityexams** or obtained by calling 1-800-827-1000.

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 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 status, and personnel administration) as identified in the VA system of records, 58/VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. VA uses 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 displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.