Department of Veterans Affairs

INTERNAL VETERANS AFFAIRS USE
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

NOTE TO EXAMINER - The Veteran/Claimant 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.

IS THIS QUESTIONNAIRE BEING COMPLETED IN CONJUNCTION WITH A VA21-2507, C&P EXAMINATION REQUEST?

☐ YES ☐ NO

How was the examination completed? (check all that apply)

☐ In-person examination
☐ Records reviewed
☐ Examination via approved video telehealth
☐ Other, please specify in comments box:

Comments:

ACCEPTABLE CLINICAL EVIDENCE (ACE)

INDICATE METHOD USED TO OBTAIN MEDICAL INFORMATION TO COMPLETE THIS DOCUMENT:

☐ Review of available records (without in-person or video telehealth examination) using the Acceptable Clinical Evidence (ACE) process because the existing medical evidence provided sufficient information on which to prepare the questionnaire and such an examination will likely provide no additional relevant evidence.

☐ Review of available records in conjunction with an interview with the Veteran (without in-person or telehealth examination) using the ACE process because the existing medical evidence supplemented with an interview provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.

EVIDENCE REVIEW

EVIDENCE REVIEWED *(check all that apply):*

☐ Not requested
☐ VA claims file (hard copy paper C-file)
☐ VA e-folder (VBMS or Virtual VA)
☐ CPRS
☐ Other (please identify other evidence reviewed):

☐ No records were reviewed

EVIDENCE COMMENTS:

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 ENDENTULOUS ATROPHY OR PERIODONTAL DISEASE)

2A. 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

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

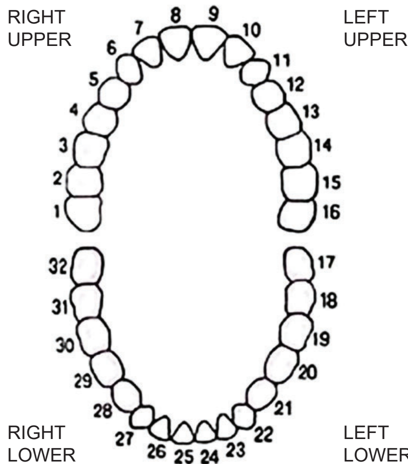
3B. IS THE LOSS OF TEETH DUE TO TRAUMA OR DISEASE (SUCH AS OSTEOMYELITIS?)

☐ 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):*

☐ 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: ________ 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 - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

6A. PHYSICIAN'S SIGNATURE	6B. PRINTED NAME	6C. DATE SIGNED

6D. PHYSICIAN'S PHONE/FAX NUMBERS	6E. MEDICAL LICENSE NUMBER & STATE	6F. 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.