DEPARTMENT OF DEFENSE
ACTIVE DUTY/RESERVE FORCES DENTAL EXAMINATION

OMB No. 0720-0022
OMB approval expires
Jul 31, 2009

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION.

PRIVACY ACT STATEMENT

AUTHORITY: Public Law 105-85, Sec. 765; DoD Directive 6490.2; E.O. 9397.

PRINCIPAL PURPOSE(S): An assessment by a dentist of the state of your dental health for the next 12 months is needed to determine your fitness for prolonged duty without ready access to dental care.

ROUTINE USE(S): None.

DISCLOSURE: Voluntary; however, failure to provide the information may result in delays in assessing your dental health needs for military service.

1. SERVICE MEMBER'S NAME *(Last, First, Middle Initial)*	2. SOCIAL SECURITY NUMBER	3. BRANCH OF SERVICE

4. UNIT OF ASSIGNMENT	5. UNIT ADDRESS

6. EXAMINATION RESULTS

Dear Doctor,

The individual you are examining is an Active Duty/Guard/Reserve member of the United States Armed Forces. This member needs your assessment of his/her dental health for worldwide duty. **Please mark (X) the block** that best describes the condition of the member, using as a suggested minimum a clinical examination with mirror and probe, and bitewing radiographs. **This form is meant to determine fitness for prolonged duty without ready access to dental care and <u>is not intended to address the member's comprehensive dental needs</u>.**

	(1) Patient has good oral health and is not expected to require dental treatment or reevaluation for 12 months.
	(2) Patient has some oral conditions, but you **<u>do not</u>** expect these conditions to result in dental emergencies within 12 months if not treated (i.e., requires prophylaxis, asymptomatic caries with minimal extension into dentin, edentulous areas not requiring immediate prosthetic treatment).
	(3) Patient has oral conditions that you **<u>do</u>** expect to result in dental emergencies within 12 months if not treated. Examples of such conditions are: *(X the applicable block or specify in the space provided)*
	(a) **Infections:** Acute oral infections, pulpal or periapical pathology, chronic oral infections, or other pathologic lesions and lesions requiring biopsy or awaiting biopsy report.
	(b) **Caries/Restorations:** Dental caries or fractures with moderate or advanced extension into dentin; defective restorations or temporary restorations that patients cannot maintain for 12 months.
	(c) **Missing Teeth:** Edentulous areas requiring immediate prosthodontic treatment for adequate mastication, communication, or acceptable esthetics.
	(d) **Periodontal Conditions:** Acute gingivitis or pericoronitis, active moderate to advanced periodontitis, periodontal abscess, progressive mucogingival condition, moderate to heavy subgingival calculus, or periodontal manifestations of systemic disease or hormonal disturbances.
	(e) **Oral Surgery:** Unerupted, partially erupted, or malposed teeth with historical, clinical, or radiographic signs or symptoms of pathosis that are recommended for removal.
	(f) **Other:** Temporomandibular disorders or myofascial pain dysfunction requiring active treatment.

(4) If you selected Block (3) above, please circle the condition(s) you identified in this patient if they appear above, or briefly describe the condition(s) below:

(5) Were X-rays consulted?		YES		NO	IF YES, DATE X-RAY WAS TAKEN *(YYYYMMDD)*

7. DENTIST'S NAME *(Last, First, Middle Initial)*	8. DENTIST'S ADDRESS *(Street, City, State, 9-digit ZIP Code)*
9. DENTIST'S TELEPHONE NUMBER *(Include Area Code)*	

10. DENTIST'S SIGNATURE/STATE LICENSE NUMBER	11. DATE OF EXAMINATION *(YYYYMMDD)*