

**DEPARTMENT OF DEFENSE  
ACTIVE DUTY/RESERVE FORCES DENTAL EXAMINATION**

*Form Approved  
OMB No. 0720-0022  
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The public reporting burden for this collection of information is estimated to average 3 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0720-0022), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

**PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS.**

**PRIVACY ACT STATEMENT**

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

**ROUTINE USE(S):** None.

**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.

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

<b>1. SERVICE MEMBER'S NAME</b> ( <i>Last, First, Middle Initial</i> )	<b>2. SOCIAL SECURITY NUMBER</b>	<b>3. BRANCH OF SERVICE</b>
<b>4. UNIT OF ASSIGNMENT</b>	<b>5. UNIT ADDRESS</b>	

**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 is not intended to address the member's comprehensive dental needs.**

<input type="checkbox"/>	(1) Patient has good oral health and is not expected to require dental treatment or reevaluation for 12 months.
<input type="checkbox"/>	(2) Patient has some oral conditions, but you <b>do not</b> 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).
<input type="checkbox"/>	(3) Patient has oral conditions that you <b>do</b> expect to result in dental emergencies within 12 months if not treated. Examples of such conditions are: ( <i>X the applicable block or specify in the space provided</i> )
<input type="checkbox"/>	(a) <b>Infections:</b> Acute oral infections, pulpal or periapical pathology, chronic oral infections, or other pathologic lesions and lesions requiring biopsy or awaiting biopsy report.
<input type="checkbox"/>	(b) <b>Caries/Restorations:</b> Dental caries or fractures with moderate or advanced extension into dentin; defective restorations or temporary restorations that patients cannot maintain for 12 months.
<input type="checkbox"/>	(c) <b>Missing Teeth:</b> Edentulous areas requiring immediate prosthodontic treatment for adequate mastication, communication, or acceptable esthetics.
<input type="checkbox"/>	(d) <b>Periodontal Conditions:</b> 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.
<input type="checkbox"/>	(e) <b>Oral Surgery:</b> Unerupted, partially erupted, or malposed teeth with historical, clinical, or radiographic signs or symptoms of pathosis that are recommended for removal.
<input type="checkbox"/>	(f) <b>Other:</b> 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?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	IF YES, DATE X-RAY WAS TAKEN (YYYYMMDD)
<b>7. DENTIST'S NAME</b> ( <i>Last, First, Middle Initial</i> )		<b>8. DENTIST'S ADDRESS</b> ( <i>Street, City, State, 9-digit ZIP Code</i> )	
<b>9. DENTIST'S TELEPHONE NUMBER</b> ( <i>Include Area Code</i> )			
<b>10. DENTIST'S SIGNATURE/STATE LICENSE NUMBER</b>			<b>11. DATE OF EXAMINATION</b> (YYYYMMDD)