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

OMB NO. 0704-0307
OMB approval expires
JUN 30, 2009



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

## PRIVACY ACT STATEMENT

**AUTHORITY:** Public Law 108-136, Sec. 704; DoD Directive 6490.2E; 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<br>1) (ICD) |
|---|---|---|
| 4. UNIT OF ASSIGNMENT<br>MSU TOLEDO, OHIO | 5. UNIT ADDRESS<br>MSU TOLEDO, 420 MADISON AVE, SUITE 700, TOLEDO, OHIO 43604 | |

**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 concerns/problems for dental needs.**

| | |
|---|---|
| | (1) Patient has good oral health and is not expected to require dental treatment or evaluation for 12 months. |
| | (2) Patient has some oral conditions, but you **do not** expect these conditions to result in dental emergencies within 12 months, if not treated (i.e., requires prophylaxis, amalgam/composite caries with minimal extension into dentin, edentulous areas not requiring immediate prosthetics treatment). |
| | (3) Patient has oral conditions that you **do** 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 periodontitis, active moderate to advanced periodontitis, periodontal abscess, progressive histologic/oral condition, moderate to heavy subgingival calculus, or periodontal manifestations of systemic disease or hormonal disturbances. |
| | (e) **Oral Surgery:** Other (specify), partially unerupted, or malposed teeth with histological, 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 conducted? | | 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) |