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DEPARTMENT OF DEFENSE ACTIVE DUTY/RESERVE/GUARD/CIVILIAN FORCES DENTAL EXAMINATION

OMB No. 0720-0022
OMB approval expires
December 31, 2019

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ORGANIZATION.

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, Under Secretary of Defense for Personnel and Readiness; 10 U.S.C. 1074f, Medical Tracking System for Members Deployed Overseas; DoDD 1404.10, DoD Civilian Expeditionary Workforce; DoDI 6025.19, Individual Medical Readiness; and E.O. 9397 (SSN), as amended.

PURPOSE: To collect information necessary to determine your readiness to participate in a deployment with the U.S. Armed Forces.

ROUTINE USE(S): Your information may be shared with other Federal and State agencies and civilian health care providers, as necessary, to provide medical care and treatment and to guide possible referrals. The DoD Blanket Routine Uses may apply to this system. The complete list of DoD Blanket Routine Uses can be found online at: **http://dpcld.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx**. The Military Services individual system of records notices may have additional routine uses. They can be found at the individual links listed below. Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations. The applicable system of records notices and links to the full text are listed below.

Army: A0040-66b DASG, Health Care and Medical Treatment Record System, http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-view/Article/569974/a0040-66b-dasg/

Navy: N06150-2, Health Care Record System, http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article -view/Article/570394/n06150-2/

Air Force: F044 AF SG E, Medical Record System, http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide SORN-Article-View/Article/569877/f044-f-sg-e/

DISCLOSURE: Voluntary. However, failure to provide the information requested may result in delays in assessing your dental health needs for military service and/or for possible deployment.

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/Civilian 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. **determine fitness for prolonged duty without ready access to dental care and is not intended to comprehensive dental needs.**

	(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 **do not** 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 **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 pathologiclesions 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 indicate the condition(s) you identified in this patient if they appear above, or briefly describe the condition(s) below:

(5) Were X-rays consulted?		**IF YES, DATE X-RAY WAS TAKEN** *(YYYYMMDD)*
6. DENTIST'S NAME *(Last, First, Middle Initial)*		**7. DENTIST'S TELEPHONE NUMBER** *(Include Area Code)*
9. DENTIST'S SIGNATURE'S LICENSE NUMBER		**10. DATE OF EXAMINATION** *(YYYYMMDD)*