DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF DENTAL EXAMINATION

Form Approved
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The public reporting burden for this collection of information is estimated to average 20 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 (0704-0396), 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

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS. RETURN COMPLETED FORM TO DODMERB/DR, 8034 EDGERTON DRIVE, SUITE 132, USAF ACADEMY CO 80840-2200.

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, USC 133, 3012, 5031, 8013, and Executive Order 9397.

PRINCIPAL PURPOSE: To determine medical acceptability or update a medical file as part of the application process to a United States Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Program, or the Uniformed Services University of the Health Sciences (USUHS).

ROUTINE USES: This information may be disclosed to the Coast Guard Academy and Merchant Marine Academy for applications to their Academies.

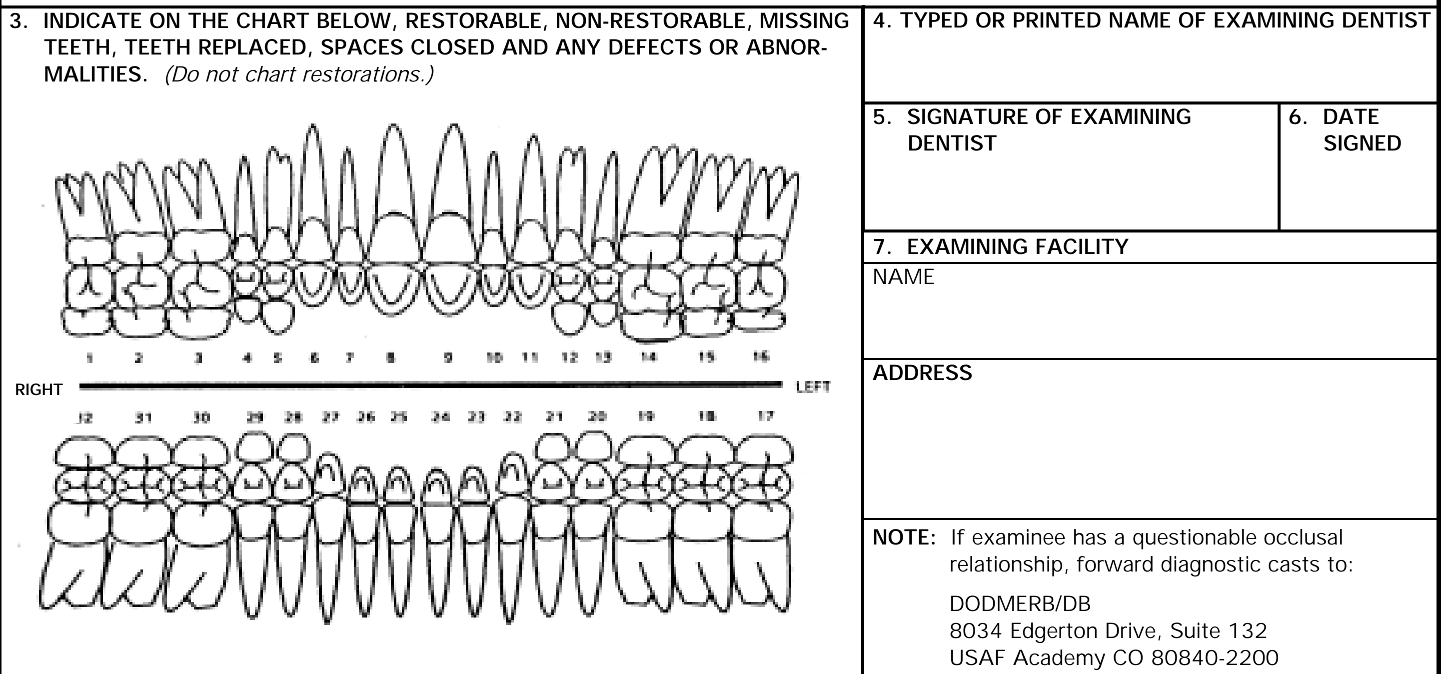
DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy. Use of the Social Security Number (SSN) is used for positive identification of records.

1. NAME OF APPLICANT *(Last, First, Middle Initial)*	2. SSN OF APPLICANT

INSTRUCTIONS

To be completed at scheduled Examining Center by the Examining Dentist. Panoramic and bitewing radiographs must accompany this examination and be identified by name and SSN. Expedite completed Dental Examination with completed Medical Examination to:

3. INDICATE ON THE CHART BELOW, RESTORABLE, NON-RESTORABLE, MISSING TEETH, TEETH REPLACED, SPACES CLOSED AND ANY DEFECTS OR ABNORMALITIES. *(Do not chart restorations.)*



4. TYPED OR PRINTED NAME OF EXAMINING DENTIST

5. SIGNATURE OF EXAMINING DENTIST	6. DATE SIGNED

7. EXAMINING FACILITY

NAME

ADDRESS

NOTE: If examinee has a questionable occlusal relationship, forward diagnostic casts to:

DODMERB/DB
8034 Edgerton Drive, Suite 132
USAF Academy CO 80840-2200

8. GENERAL *(X Yes or No for each question.)*

YES	NO	
		DENTAL CARIES *(Indicate on chart, do not chart incipiencies.)*
		MISSING TEETH, OTHER THAN THIRD MOLARS *(Indicate on chart by marking "X" through the roots.)*
		NON-RESTORABLE TEETH *(Indicate on chart by drawing two vertical lines through tooth.)*
		UNERUPTED TEETH *(Draw circle around the tooth on the chart and indicate position by an arrow.)*
		DEVELOPMENTAL DISTURBANCES IN TEETH *(Significant enamel hypoplasias, amelogenesis imperfecta, dentinogenesis imperfecta, etc.)*
		STAINED TEETH *(Intrinsic, unsightly)*

9. HISTORY OF ORAL DISEASE, TUMOR OR ANY OTHER ABNORMALITY OF THE ORAL CAVITY *(X Yes or No for each question. If additional space is needed, use "REMARKS" section.)*

YES	NO	
		HAS THE EXAMINEE EVER HAD A CYST OR TUMOR REMOVED FROM THE MOUTH OR JAWS? *(If so, describe.)*
		HISTORY OF ABNORMAL BLEEDING OF THE ORAL TISSUES *(Describe)*
		ORAL ULCERATIONS, SOFT TISSUE LESIONS, ETC. *(Describe)*
		HISTORY OF CLEFT LIP
		HISTORY OF CLEFT PALATE
		IF YES, IS THERE AN ORO-NASAL OR ORO-ANTRAL FISTULA PRESENT?
		HISTORY OF TMJ DISEASE OR PAIN *(Describe)*

(Continued on reverse side)

10. OCCLUSAL RELATIONSHIP

(X Yes or No for each question. If additional space is needed, use the "REMARKS" section.)

YES	NO	
		ANTERIOR VERTICAL OPEN BITE GREATER THAN 1 mm
		ANTERIOR OVERBITE IN EXCESS OF 4 mm
		ANTERIOR HORIZONTAL OVERJET IN EXCESS OF 4 mm
		SOFT TISSUE IMPINGEMENT OF THE LOWER ANTERIOR TEETH INTO THE HARD PALATE, OR THE UPPER ANTERIOR TEETH INTO THE LOWER LABIAL GINGIVAE
		ANTERIOR CROSSBITE *(Describe)*
		MANDIBULAR PROGNATHISM
		POSTERIOR OPEN BITE *(Bilateral involving more than one tooth)*
		POSTERIOR CROSSBITE *(Entire quadrant)*
		UNSIGHTLY CROWDING OF THE ANTERIOR TEETH
		MULTIPLE CONGENITALLY MISSING TEETH
		MIDLINE DEVIATION
		ARE DENTAL STUDY CASTS BEING FORWARDED?

11. ORTHODONTICS *(X Yes or No for each question.)*

YES	NO	
		PAST HISTORY OF ORTHODONTIC TREATMENT *(Date completed)*
		PRESENTLY UNDERGOING ACTIVE ORTHODONTIC TREATMENT *(Specify fixed or removable.) (Is orthodontic surgery required? If Yes, describe.)*
		WEARING RETAINER APPLIANCES

12. PROSTHODONTICS *(X Yes or No for each question. If additional space is needed, use the "REMARKS" section.)*

YES	NO	
		MISSING TEETH *(Prosthesis required. Describe.)*
		MISSING TEETH REPLACED BY AN UNSERVICEABLE PROSTHESIS *(Describe)*
		ARE THERE LESS THAN EIGHT, SERVICEABLE, NATURAL TEETH IN EACH ARCH?

13. PERIODONTAL STATUS *(X Yes or No for each question.)*

YES	NO	
		MODERATE TO HEAVY CALCULUS *(Supra and/or sub-gingival)*
		ACUTE NECROTIZING ULCERATIVE GINGIVITIS
		LOCAL OR GENERALIZED PERIODONTITIS *(With associated bone loss)*
		LOCALIZED JUVENILE PERIODONTITIS
		PERICORONITIS

PERIODONTAL SCREENING

14. PANOGRAPHIC RADIOGRAPH EXAMINATION *(X Yes or No for each question. If additional space is needed, use the "REMARKS" section.)*

YES	NO	
		ABNORMAL RADIOLUCENT/RADIOPAQUE AREA *(Describe)*
		IMPACTED TEETH WITH PATHOLOGY *(Describe)*
		IMPACTED TEETH OTHER THAN THIRD MOLARS *(Describe)*
		OTHER RADIOGRAPHIC ABNORMALITIES *(Describe)*

15. OTHER ABNORMAL CONDITIONS OF THE ORAL CAVITY NOT PREVIOUSLY MENTIONED *(X Yes or No.)*

YES	NO

16. REMARKS *(Indicate item of reference. Use additional sheet if necessary.)*

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