

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

*Form Approved  
OMB No. 0704-0396  
Expires Aug 31, 2003*

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.

<b>1. NAME OF APPLICANT</b> <i>(Last, First, Middle Initial)</i>	<b>2. SSN OF APPLICANT</b>
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**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:

<p><b>3. INDICATE ON THE CHART BELOW, RESTORABLE, NON-RESTORABLE, MISSING TEETH, TEETH REPLACED, SPACES CLOSED AND ANY DEFECTS OR ABNORMALITIES.</b> <i>(Do not chart restorations.)</i></p>	<p><b>4. TYPED OR PRINTED NAME OF EXAMINING DENTIST</b></p> <hr/> <table border="1" style="width:100%"> <tr> <td style="width:70%;"><b>5. SIGNATURE OF EXAMINING DENTIST</b></td> <td style="width:30%;"><b>6. DATE SIGNED</b></td> </tr> </table> <hr/> <p><b>7. EXAMINING FACILITY</b></p> <p>NAME</p> <hr/> <p>ADDRESS</p> <hr/> <p><b>NOTE:</b> If examinee has a questionable occlusal relationship, forward diagnostic casts to: DODMERB/DB 8034 Edgerton Drive, Suite 132 USAF Academy CO 80840-2200</p>	<b>5. SIGNATURE OF EXAMINING DENTIST</b>	<b>6. DATE SIGNED</b>
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**8. GENERAL** *(X Yes or No for each question.)*

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

**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.)*

<input type="checkbox"/>	<input type="checkbox"/>	HAS THE EXAMINEE EVER HAD A CYST OR TUMOR REMOVED FROM THE MOUTH OR JAWS? <i>(If so, describe.)</i>
<input type="checkbox"/>	<input type="checkbox"/>	HISTORY OF ABNORMAL BLEEDING OF THE ORAL TISSUES <i>(Describe)</i>
<input type="checkbox"/>	<input type="checkbox"/>	ORAL ULCERATIONS, SOFT TISSUE LESIONS, ETC. <i>(Describe)</i>
<input type="checkbox"/>	<input type="checkbox"/>	HISTORY OF CLEFT LIP
<input type="checkbox"/>	<input type="checkbox"/>	HISTORY OF CLEFT PALATE
<input type="checkbox"/>	<input type="checkbox"/>	IF YES, IS THERE AN ORO-NASAL OR ORO-ANTRAL FISTULA PRESENT?
<input type="checkbox"/>	<input type="checkbox"/>	HISTORY OF TMJ DISEASE OR PAIN <i>(Describe)</i>

*(Continued on reverse side)*

