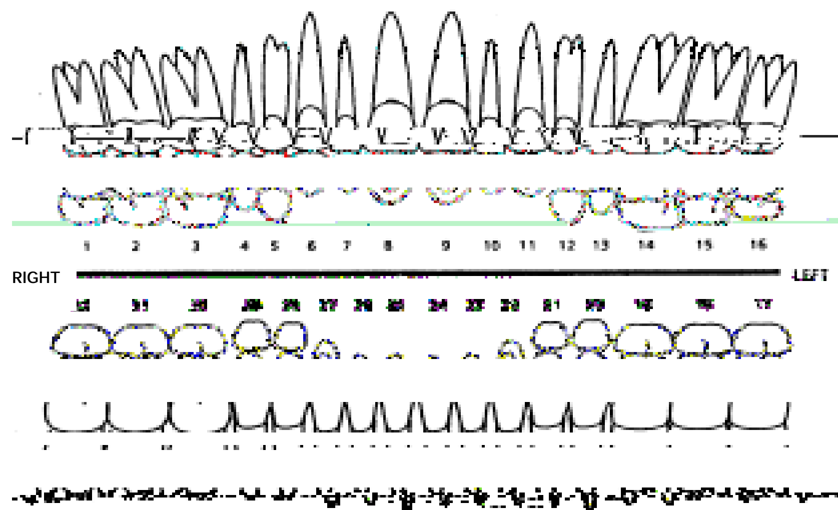
DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB) REPORT OF DENTAL EXAMINATION	*Form Approved* *OMB No. 0704-0396* *Expires Aug 31, 2003*

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.



		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

YES NO *(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

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.)*

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