



DEPARTMENT OF THE NAVY  
BUREAU OF MEDICINE AND SURGERY  
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IN REPLY REFER TO  
BUMEDINST 6620.4  
BUMED M3/5  
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BUMED INSTRUCTION 6620.4

From: Chief, Bureau of Medicine and Surgery  
To: Ships and Stations Having Dental Personnel

Subj: INSTRUCTIONS FOR COMPLETING NAVMED 6620/2, EMERGENCY DENTAL TREATMENT RECORD

Encl: (1) Instructions for Completing NAVMED 6620/2

1. Purpose. To issue guidance for the completion of NAVMED 6620/2, Emergency Dental Treatment Record.
2. Scope. This instruction applies to dental health care providers in all Navy medical treatment facilities (MTFs) and dental treatment facilities (DTFs) ashore and afloat.
3. Background. Emergency dental treatment is often administered in environments where a complete patient dental treatment record is either inaccessible or unavailable such as during deployments or after hours. In these instances, NAVMED 6620/2, Emergency Dental Treatment Record provides a concise and reliable means of documenting the essential information required for patient care—health information, patient consent, diagnosis, and treatment procedures—that can later be incorporated into the full dental record to ensure continuity of care.
4. Procedure. This instruction outlines the proper use of NAVMED 6620/2. Place the NAVMED 6620/2, Emergency Dental Treatment Record chronologically in the treatment notes section of the dental record with page 2 facing up once the full patient dental record is located or created. When the Emergency Dental Treatment Record is used for the treatment of non-beneficiaries or in humanitarian care for those without military dental treatment records, a copy of NAVMED 6620/2 may be provided to the patient for inclusion in their private records. The original NAVMED 6620/2 should be archived in the MTF or DTF for the legally prescribed duration of time.
5. Form. NAVMED 6620/2 (10-2010), Emergency Dental Treatment Record is available for order at <https://navalforms.daps.dla.mil/web/public/home> using stock number 0105-LF-127-8000. This form is not authorized for local reproduction.

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**INSTRUCTIONS FOR COMPLETING  
NAVMED 6620/2, EMERGENCY DENTAL TREATMENT RECORD**

1. General Comments:

a. NAVMED 6620/2 is an adjunct to the complete dental treatment record and is not intended to replace it. All entries will be printed in black ink except as noted.

b. NAVMED 6620/2 is only authorized for use when it is impractical or impossible to access or create a complete dental treatment record: afterhours, on deployments, or when a patient presents without a record and it is not readily obtainable. Outside of these circumstances, routine use during normal working hours is not authorized.

c. When authorized as defined above, all providers of dental treatment may complete NAVMED 6620/2 following release of this instruction. Once the permanent dental record is located or created, NAVMED 6620/2 will be placed chronologically in the treatment notes section with page 2 facing up and become a permanent part of the full record.

d. NAVMED 6620/2 is a specialty form. It is ordered using stock number 0105-LF-127-8000 from Naval Forms Online at: <https://navalforms.daps.dla.mil/web/public/home>. This form is not authorized for local reproduction.

2. Instructions for completing the front of NAVMED 6620/2

a. Date, Time Arrived, Name, SSN, Rate, Rank, DOB, Sex, Sponsor Information, Service, and Status - All sections are self-explanatory and should be filled out completely.

b. Chief Complaint - A concise statement in the patient's own words detailing their chief complaint.

c. Pain level - Recorded on a scale from 1 to 10. The patient should be instructed to use a score of 10 for the worst pain imaginable and a score of 0 for the absence of any pain (normal).

d. Health Questionnaire

(1) All sections must be answered.

(2) Summarize relevant findings in the Doctor's summary section.

(3) List allergies in red ink (if available).

(4) Include dosage and frequency with medications. If possible verify in the Composite Health Care System (CHCS).

(5) Review the health questionnaire with the patient and ensure that both patient and doctor sign and date.

e. Privacy Act Statement - patient must read the statement in its entirety and sign. Parent or guardian must sign for patients under the age of 18 years.

3. Instructions for completing the back of NAVMED 6620/2

a. Check the appropriate box next to After-hours or Sick-call.

b. Check the appropriate box next to Record Unavailable or No Record/Lost Record.

Note: If you are unable to check at least two boxes in this section NAVMED 6620/2 should not be used and a complete patient dental record must be created instead.

c. Date, Tooth Number - self-explanatory and should be filled out completely.

d. Medical Alert - Include any allergies or medical conditions that may affect dental treatment in red ink (if available).

e. S - This should be the same concise statement in the patient's own words from the Chief Complaint section of page 1.

f. O - All of these boxes must be checked prior to performing any treatment verifying that proper patient time out procedures have been followed.

g. Clinical findings

(1) Accurate vital signs are required for all emergency treatment.

(2) Clearly document all relevant findings for the patient's chief complaint in this section including onset and duration of symptoms, defective restorations, and pathology.

h. Radiographic Findings - List any radiographs taken and the interpretation of them.

i. A - Assessment of the cause or source of the patient's chief complaint based on your evaluation.

j. P - Detail the planned procedures required to address the patient's chief complaint.

k. Tx - Check the box confirming that you have explained the required treatment to the patient (or guardian) in the presence of at least one member of staff and that the patient consents to having this treatment performed. List all procedures performed including materials used, dosage, and amounts of anesthesia or other medications administered. Make note of any unusual occurrences during the course of patient treatment.

l. Rx: List any medications prescribed to the patient including dosage, frequency, and amount dispensed.

m. Current status chart

(1) Ink entries for all procedures performed at this appointment.

(2) Pencil entries for treatment required at the next visit.