DENTAL HEALTH SUMMARY *(To be completed by dental provider)*
(This Form is subject to the Privacy Act of 1974 – USE BLANKET PAS – DD FORM 2005))

PRINCIPAL PURPOSE: An assessment by a dentist is needed to determine your dental health as part of the family member relocation clearance for travel.
If you are enrolled in the TRICARE Dental Plan, your **civilian dentist completes this form.**
If you are not enrolled in the TRICARE Dental Plan, your **military dental treatment facility** completes this form.

1a. PATIENT NAME (Last, First, Middle Initial)	**b. SPONSOR SSN**	**c. FAMILY MEMBER PREFIX**

2. DENTAL EXAMINATION RESULTS

Dear Doctor,

The individual you are examining is a family member of an active duty member of the United States Armed Forces. This family member needs your assessment of his/her dental health for a pending duty assignment. Please mark (X) **the block** that best describes the condition of the family member, using as a suggested minimum a clinical examination with mirror and probe, and bitewing radiographs. This form is meant to determine the oral fitness for prolonged assignment without ready access to dental care of the family member, it is not intended to address the member's 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 pathologic lesions and lesions requiring biopsy or awaiting biopsy report.
  - [ ] (b) Caries/Restorations: Dental caries or fractures with moderate or advanced extension into dentin; baby bottle tooth decay/early childhood caries; defective restorations or temporary restorations that patients cannot maintain for 12 months.
  - [ ] (c) Missing Teeth: Edentulous areas requiring immediate prosthodontic treatment for adequate mastication, communications, or acceptable esthetics.
  - [ ] (d) Periodontal Conditions: Acute gingivitis or pericoronitis, active moderate to advanced periodontitis, periodontal abscess, progressive mucogingival conditions, 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: Temporamandibular disorders or myofascial pain dysfunction requiring active treatment.
- [ ] (4) Patient is undergoing active orthodontics treatment

3. If you selected Block (3) or (4) above, please circle the condition(s) you identified in this patient if they appear above, or briefly describe the condition(s) and recommended treatment (s) below:

4. Were x-rays consulted?		YES		NO	If yes, date x-ray was taken (YYYYMMDD)

5a. **DENTAL PROVIDER NAME**	b. **SIGNATURE**	c. **DATE (YYYYMMDD)**