OMB No. 0990-0324; OMB Approval Expires 05/31/2020

Department of Health and Human Services
Public Health Service Commissioned Corps

REPORT OF DENTAL EXAMINATION OF APPLICANTS TO THE PUBLIC HEALTH SERVICE COMMISSIONED CORPS

(See Privacy Act Statement for Form PHS-6355)

NAME *(Last, First, Middle)* *(Please type or print)*	SOCIAL SECURITY NUMBER

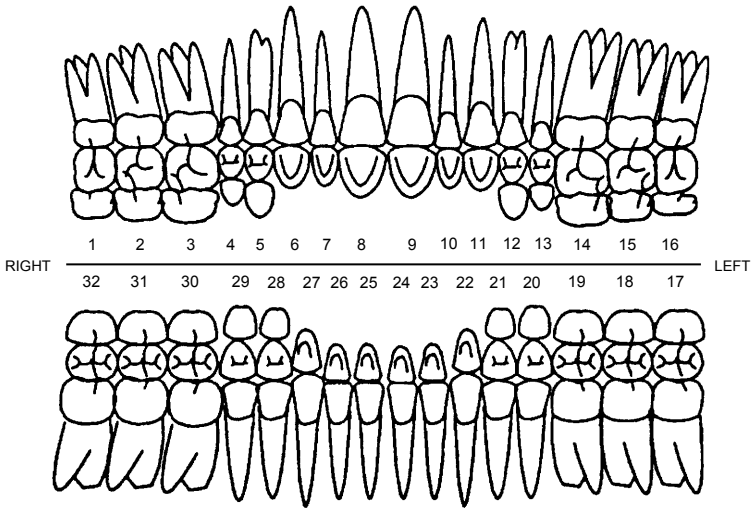
INSTRUCTIONS TO APPLICANT

Present this form to your examining dentist for completion. Failure by you or your examiner to comply completely will delay medical clearance, which is required prior to call to active duty. You may be able to obtain a dental examination at dental examination sections of military medical facilities. **If done privately, it must be done at your own expense.**

INSTRUCTIONS TO EXAMINING DENTIST

A complete examination is required in order that *all* questions listed below can be completed. If there are a number of "Yes" responses to questions listed below, or if otherwise clinically indicated, bitewing and panoramic (or diagnostic quality full mouth) radiographs should be performed. If examinee has a questionable occlusal relationship, forward diagnostic casts to the address at the end of this form.

(1) Indicate on the chart below restorable teeth with an "R," non-restorable teeth with an "N," missing teeth with an "X," teeth replaced by a fixed or removable prosthetics by a "continuous line," and any other defects or abnormalities. Do not chart restorations.



(2) GENERAL *(Check Yes or No for each question)*

Yes	No	
☐	☐	a. DENTAL CARIES *(Indicate on chart, do not chart incipiencies)*
☐	☐	b. MISSING TEETH, OTHER THAN THIRD MOLARS *(Indicate on chart by marking "X" through the roots)*
☐	☐	c. NON-RESTORABLE TEETH *(Indicate on chart by marking "N" through tooth)*
☐	☐	d. UNERUPTED TEETH (*Indicate by marking "U" in the position on the tooth)*
☐	☐	e. DEVELOPMENTAL DISTURBANCES IN TEETH *(Significant enamel hypoplasias, amelogenesis imperfecta, dentinogenesis imperfecta, etc.)*
☐	☐	f. STAINED TEETH *(Instrisic) (unsightly)*

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

Yes	No	
☐	☐	a. HAS THE EXAMINEE EVER HAD A CYST OR TUMOR REMOVED FROM THE MOUTH OR JAWS *(If so, describe)*
☐	☐	b. HISTORY OF ABNORMAL BLEEDING OF THE ORAL TISSUES *(Describe)*
☐	☐	c. ORAL ULCERATIONS, SOFT TISSUE LESIONS, ETC. *(Describe)*
☐	☐	d. HISTORY OF CLEFT LIP
☐	☐	e. HISTORY OF CLEFT PALATE
☐	☐	(1) If yes, is there an oro-nasal or oro-antral fistula present?
☐	☐	f. HISTORY OF TMJ DISEASE OR PAIN *(Describe)*

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(4) OCCLUSAL RELATIONSHIP *(Check Yes or No for each question) (If additional space is needed, use "REMARKS" section)*

Yes	No	
☐	☐	a. ANTERIOR VERTICAL OPEN BITE GREATER THAN 1mm.
☐	☐	b. ANTERIOR OVERBITE IN EXCESS OF 4mm.
☐	☐	c. ANTERIOR HORIZONTAL OVERJET IN EXCESS OF 4 mm.
☐	☐	d. SOFT TISSUE IMPINGEMENT OF THE LOWER ANTERIOR TEETH INTO THE HARD PALATE, OR THE UPPER ANTERIOR TEETH INTO THE LOWER LABIAL GINGIVAE
☐	☐	e. ANTERIOR CROSSBITE *(Describe)*
☐	☐	f. MANDIBULAR PROGNATHISM
☐	☐	g. POSTERIOR OPEN BITE *(Bilateral involving more than one tooth)*
☐	☐	h. POSTERIOR CROSSBITE *(Entire quadrant)*
☐	☐	i. UNSIGHTLY CROWDING OF THE ANTERIOR TEETH
☐	☐	J. MULTIPLE CONGENITALLY MISSING TEETH

(5) ORTHODONTICS *(Check Yes or No for each question)*

Yes	No	
☐	☐	a. PAST HISTORY OF ORTHODONTIC TREATMENT *(If "Yes," date completed:* _____)
☐	☐	b. WAS INDICATION FOR ORTHODONTIC TREATMENT STRICTLY COSMETIC? *(If functional corrections were made, please describe below)*
☐	☐	c. WAS THERE EVER OR IS THERE NOW, ANY INDICATION OF POST TREATMENT ADVERSE SEQUELAE? *(If "Yes," please explain below)*
☐	☐	d. PRESENTLY UNDERGOING ACTIVE ORTHODONTIC TREATMENT *(Specify fixed or removable)*
☐	☐	e. WEARING RETAINER APPLIANCES

(6) PROSTHODONTICS *Check Yes or No for each question) (If additional space is needed, use "REMARKS" section)*

Yes	No	
☐	☐	a. MISSING TEETH *(Prosthesis required) (Describe)*
☐	☐	b. MISSING TEETH REPLACED BY AN UNSERVICEABLE PROSTHESIS *(Describe)*
☐	☐	c. ARE THERE LESS THAN EIGHT, SERVICEABLE, NATURAL TEETH IN EACH ARCH?

(7) PERIODONTAL STATUS *(Check Yes or No for each question)*

Yes	No	
☐	☐	a. MODERATE TO HEAVY CALCULUS *(Supra and/or sub-gingival)*
☐	☐	b. GINGIVITIS *(Generalized)*
☐	☐	c. ACUTE NECROTIZING ULCERATIVE GINGIVITIS
☐	☐	d. LOCAL OR GENERALIZED PERIODONTITIS *(With associated bone loss)*
☐	☐	e. JUVENILE PERIODONTITIS
☐	☐	f. PERIOCORONITIS

(8) RESULTS OF RADIOGRAPHIC EXAMINATION, IF PERFORMED *(Check Yes or No for each question)*
(If additional space is needed, use "REMARKS" section)

Yes	No	
☐	☐	a. ABNORMAL RADIOLUCENT/RADIOPAQUE AREA *(Describe)*
☐	☐	b. IMPACTED TEETH WITH PATHOLOGY *(Describe)*
☐	☐	c. IMPACTED TEETH WITH OTHER THAN THIRD MOLARS *(Describe)*
☐	☐	d. OTHER RADIOGRAPHIC ABNORMALITIES *(Describe)*

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

Yes	No
☐	☐

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

NAME AND ADDRESS OF EXAMINING DENTIST *(Please type or print)*	SIGNATURE OF DENTIST	DATE

Privacy Act Statement

PHS-6355 "Report of Dental Examination of Applicants to the Public Health Service Commissioned Corps"

Authority:
Our authority to collect this information is 42 U.S.C. 202 et seq and Executive Order 10450.

Purpose and Use of Information: The information you and your dentist provide on this form will be used to determine whether you meet the medical standards that apply to Public Health Service (PHS) Commissioned Corps officers. This is a critical evaluation because you must be physically and mentally fit to perform satisfactorily in national or worldwide health and defense emergencies. In addition, the information will be used to begin monitoring your health and fitness for duty on an ongoing basis if you are appointed. It may be provided to other Federal Agencies that furnish you medical care, when needed to ensure continuity of care or to evaluate your eligibility for benefits from that Agency based on your medical condition. It may also be provided to health care practitioners in the private sector in the event you receive emergency medical care or to ensure continuity of care.

In very rare circumstances this information may be provided to: a congressional office at your request; officials of this Department or the Department of Justice to prepare an effective defense when the Department or any of its employees are the subject of litigation; or your legal guardian if you are found mentally incompetent by a court of law.

More information about how these records are maintained is contained in the Privacy Act System Notice of Records number 09-40-0002, PHS Commissioned Corps Medical Records, HHS/PSC/HRS, a copy of which may be obtained from the office to which you submit this form.

Information Regarding Disclosure of Your Social Security Number (SSN): Disclosure of the SSN is mandatory under provisions of the Social Security Act, since PHS Commissioned Corps officers are under social security covered employment and taxes must be withheld from their salaries. The SSN is also used as an identifier throughout an officer's career. It is used primarily to identify an officer's personnel, leave, and pay records and to related one to the other. The SSN is also used in connection with lawful requests for information from former employers, educational institutions, and financial or other organizations. The information gathered through the use of the number will be used only as necessary in personnel administration processes carried out in accordance with established regulations and published notices of systems of records. The use of the SSN is made necessary because of the large number of present and former active, inactive, and retired officers and applicants who have identical names and birth dates, and whose identities can only be distinguished by the SSN.

Effects of Nondisclosure: Failure to provide the information requested on these forms will eliminate your application from further consideration. If you withhold or falsify information about your medical condition, your appointment will be terminated, you will lose any benefits provided to you based on the false information, and you may be subject to criminal or civil prosecution.