TB MED 250

DEPARTMENT OF THE ARMY TECHNICAL BULLETIN

RECORDING DENTAL EXAMINATIONS, DIAGNOSES, AND TREATMENTS; AND APPOINTMENT CONTROL

APPROVED FOR PUBLIC RELEASE; DISTRIBUTION IS UNLIMITED

HEADQUARTERS, DEPARTMENT OF THE ARMY

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NO. MED 250

HEADQUARTERS
DEPARTMENT OF THE ARMY
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*This bulletin supersedes TB MED 250, 28 November 1975.

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CHAPTER 1
INTRODUCTION

1–1. Purpose

This bulletin provides detailed instructions for the uniform recording of initial dental processing, dental examinations, diagnoses, and treatments in the SF 603 (Health Record—Dental) and SF 603A (Health Record—Dental—Continuation), throughout the U.S. Army. The dental health record is a permanent document designed to furnish a comprehensive dental history of each individual. This record will serve for treatment planning and documentation, forensic, legal, and quality assurance purposes. All entries must be accurate, complete, and concise if the best interest of the patient, the Government, and the dental care provider are to be served.

1–2. General

a. The detailed instructions for completing SF 603 and SF 603A are presented in the sequence that will normally be followed during the course of patient treatment. Administrative information is presented in chapters 2 and 3; authorized symbols for charting the SF 603 and SF 603A are found in chapter 4; and recording restorations, completed treatments, and services rendered are found in chapter 5. Guidance on appointment control is contained in chapter 6.

b. Instructions in this bulletin also apply to dental entries in other hospital and clinical records to the extent that they do not conflict with Army regulations pertaining to the preparation and maintenance of those records.

c. Instructions in this bulletin will not apply to the charting of dental conditions in SF 88 (Report of Medical Examination). These charts will continue to be completed in accordance with AR 40–501 and with instructions printed on the form.

d. All pertinent facts and information must be *legibly* recorded in SF 603 or SF 603A, block 17, using black ink.

e. All references in this bulletin to techniques or materials are used purely for illustration purposes. They do not constitute approval or endorsement by the U.S. Army or the dental profession.

f. All names and identification information are completely fictitious and used solely for example. Any similarity between the names used in this bulletin and any actual people is purely coincidental.

1–3. Abbreviations and terms applicable to this bulletin

See the glossary and appendixes.

1–4. References

See appendix A.

CHAPTER 2

ADMINISTRATIVE DATA

2–1. Terminal Digit Filing System

a. The Terminal Digit Filing System (TDFS) is used to file dental records. DA Form 3444 series (Terminal Digit File for Treatment Record) is used for this purpose. Complete instructions for the use of this system are contained in AR 40–66.

b. Instructions. The DA Form 3444 series folders come in 10 different colors. To complete TDFS in dental treatment facilities, the following should be done:

(1) Obtain the sponsor's social security number (SSN) and select the appropriately colored folder using the last two digits (primary group).

Table 2–1. Terminal Digit Filing System color coding

Primary group	*Color of folder*	*DA Form*
00–09	Orange	3444
10–19	Light Green	3444–1
20–29	Yellow	3444–2
30–39	Grey	3444–3
40–49	Tan	3444–4
50–59	Light Blue	3444–5
60–69	White	3444–6
70–79	Brown	3444–7
80–89	Pink	3444–8
90–99	Red	3444–9

(2) Put an identification label in the "Patient's Identification" block on the top right of the front cover of the record jacket. This label should contain the information listed below. All of this information is contained on the patient's medical card. The medical card may be used to imprint a label for this block. If an imprinter is unavailable then only (*a*), (*b*), and (*f*) below should be written in.

(*a*) Family member prefix (FMP) and sponsor's SSN. The use of the FMP (see table 2–2) identifies the patient, especially in cases where the clinic handles records for family members, retirees, etc. These two numbers are also placed inside the two circles in the upper margin of the back cover, located in front of the SSN blocks.

(*b*) Patient's name.

(*c*) Year of birth.

(*d*) Sex.

(*e*) Status.

(*f*) Sponsor's grade and name.

(*g*) Patient's organization.

Table 2–2. Family member prefix

01–09	Children in order of birth
20	Sponsor
30	Spouse
40	Mother
45	Father
50	Mother-in-Law
55	Father-in-Law
60, 61, 62, etc.	Other relatives
00	Civilians and others not listed

(3) Inform the patient of the privacy act requirements and complete DD Form 2005 (Privacy Act Statement—Health Care Records), located inside the back cover of the folder.

(4) Enter the patient's name in the upper left hand corner in block letters only when records are to be filed alphabetically.

(5) Enter the name of the clinic responsible for maintaining the folder in the lower right of the front cover. This entry should be made in pencil and may be placed on a white adhesive label for legibility and ease of changing.

(6) Code the last digit of the SSN by covering the appropriate numbered blocks in both the right and top margins with black tape.

(7) Enter the rest of the SSN inside the blocks provided in the upper margin of the back cover.

(8) For records of active duty soldiers the "R" blocks are used to indicate whether they have a duplicate identification panographic radiograph on file in the Central Panograph Storage Facility (CPSF). When the first duplicate film is made for submission to the CPSF the "R" blocks will be coded with red tape and block 17 of the SFs 603 and 603A will be annotated "CPSF dup," dated, and signed. When confirmation of enrollment in the CPSF is received (either hardcopy or Defense Enrollment/Eligibility Reporting System (DEERS) check) the tape code on the "R" blocks will be changed to green tape and the SF 603 and SF 603A annotated "CPSF confirmed," dated, and signed. If subsequent films are sent for storage, tape codes will not be changed. Annotation of the SF 603 and SF 603A that a new film has been submitted is all that is required.

(9) For records of non-active duty personnel cover the "R" blocks in the right and top margins with appropriately colored tape to indicate when the record is to be retired. These records are

Johnson Robert J. | 0 | 1 | 2 | [redacted] | 4 | 5 | 6 | 7 | 8 | 9 | [redacted] | 9 | 4 | 6 | 3 |

LAST NAME FIRST MI

(2) (0) | 1 | 8 | 3 | - | 4 | 6 | -

Johnson, Robert J.

PATIENT IDENTIFICATION

ALPHABETICAL AND
TERMINAL DIGIT FILE FOR

TREATMENT RECORD

For use of this form, see AR 40-66; the proponent agency is Office of The Surgeon General.

NOTE TO PHYSICIAN:

- [X] MEDICAL CONDITION (Medical Warning Tag)
- [ ] PERSONNEL RELIABILITY PROGRAM (SCREENING)
- [ ] RADIATION SCREENING PROGRAM
- [ ] FLIGHT STATUS
- [ ] MEDICAL REGISTRIES
- ___ BLOOD TYPE

TYPE OF RECORD:

- [ ] INPATIENT (CLINICAL)
- [ ] OUTPATIENT TREATMENT
- [ ] HEALTH
- [X] HEALTH-DENTAL
- [ ] DENTAL (NON-MILITARY)

0 1 2 [redacted] 4 5 6 7 8 9

SAMPLE

IF FOUND RETURN TO:
ANY US POST OFFICE

POSTMASTER - FORWARD TO:
HQ, Department of Army
Washington, DC 20310

DA LABEL 162, 1 MAR 75

LORAN DENTAL [illegible]
Ft SELVOIR, VA. 22060-[illegible]

DA FORM 3444-6, 1 JAN 79

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

Figure 2–1. Sample Terminal Digit File for Treatment Record.

retired 2 years after the end of the year in which the last dental treatment was given; therefore, dental records begun in 1989 will be retired on January 1, 1992 if no treatment has been given between those dates. The following chart should be utilized when block "R" is used. (Note: Active duty records are never retired.)

Table 2–3. Retirement year tape codes

Records to be retired	*Tape color*
1985	Silver or white
1986	Black
1987	Orange
1988	Red
1989	Blue
1990	Green
1991	Yellow
1992	Silver or white
1993	Black
1994	Orange
1995	Red
1996	Blue
1997	Green
1998	Yellow

(10) Cover block "S" in both the right and top margins with appropriately colored tape to indicate the status of the patient. The colors to be used are:

Table 2–4. Status tape codes

Active duty military	Red
Military other than active duty to include retirees	Green
Foreign nationals	Silver or white
All others	Black

(11) Complete the front of the folder by marking the appropriate block under "Note to Physician" and "Type of Record." Blocks for the Personnel Reliability Program and flight status should be marked as appropriate.

(12) For nonactive duty personnel, prepare a card for the nominal index file. This file is required as a cross-reference for TDFS. As a minimum, the file should contain the patient's name, FMP and sponsor's SSN. This is a ready reference when only the patient's name is available and it is necessary to locate his or her dental record. An imprint of the medical identification card may be used for this purpose.

2–2. Forms and documents of DD Form 3444

a. Right side of the folder (topmost to bottommost form).

(1) DA Form 4515—Personnel Reliability Program Record Identifier (AR 50–5).

(2) SF 603—Health Record—Dental. SF 603A (Health Record—Dental—Continuation) is also filed here when needed for continuation of the dental record. The initial SF 603 is placed on top with SF 603As behind it in reverse chronological order with the latest on top.

(3) DA Form 3984—Dental Treatment Plan.

(4) SF 513—Medical Record—Consultation Sheet.

(5) SF 519 and SF 519A—Medical Record—Radiograph Report. (Use until stock is exhausted.)

(6) SF 519B—Radiologic Consultation Request/Report. (Replaces SF 519 and SF 519A.)

(7) SF 521—Clinical Record—Dental. (This form became obsolete on 1 July 1973.) Use for file purposes only.

(8) SF 522—Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures.

(9) DA Form 3365—Authorization for Medical Warning Tag.

(10) DD Form 2005—Privacy Act Statement—Health Care Records. This form is required in all dental records. The DA 3444 series record jacket contains this form on the inside back cover.

b. Left Side of Folder.

(1) Locally reproduced health history form if used.

(2) DA Form 5570 (Health Questionnaire for Dental Treatment). These forms also serve as an envelope for radiograph storage.

(3) Panographic or other radiographs too large to be included in the DA Form 5570 envelope.

2–3. Medical history

a. DA Form 5570 is the standard medical history form for use in dental records. Maintenance of locally prepared medical history forms within or as a part of the health record requires prior approval of the form by HQDA.

b. Medical history forms which are maintained as a part of the dental record should be reaffirmed with the patient at each visit. They should be updated, dated, and signed by patient and doctor every 6 months during a course of treatment, at the beginning of each new treatment plan, or at each annual examination. When updating lines are filled, a new DA Form 5570 will be completed and placed on top of the old with all radiographs placed in the current form. The face of the old form may be cut out or folded and placed in the new envelope.

c. Medical history findings which impact on care will be explained, as a minimum, in the "Remarks" section of DA Form 5570 and annotated with pencil in the "Remarks" section of item 15, SF 603. Further explanation of the condition may also be made in item 17. The date of entry should also be noted.

d. Medical warning identification symbol: DA Label 162 (Emergency Medical Identification Symbol) will be affixed to the patient's health record when a patient's medical condition meets the criteria established in AR 40–15.

DA LABEL 162, 1 MAR 75

Figure 2–2. Sample Emergency Medical Identification Symbol.

2–4. Informed Consent

a. Common law provides that patients have the right to determine whether they desire the dental treatment offered. In order to make this decision, the patient must know the chances for success, potential for harm, alternative treatments, and the types of injury that may occur.

b. The description of types of injury that may occur must include those things that are *likely* to be caused by the treatment. The patient *must* be told of any risk of death or serious bodily harm. Serious bodily harm is often defined as any condition which is permanent or cannot be adequately treated or reversed (that is, permanent nerve damage or damage to an adjacent tooth).

c. Well documented informed consent can save the care provider the experience of a malpractice suit, and conserve resources necessary for care of other patients. Informed consent does not absolve the provider of the responsibility of providing treatment consistent with the standard of care. The patient cannot legally consent to negligence.

d. SF 522.

(1) All non-active duty patients must complete this form as part of the doctrine of informed consent prior to initiation of a treatment plan even if that plan is only for a single visit.

(2) The procedures to be performed must be stated on the form in terms the patient can understand.

(3) The procedures and possible complications must be explained to the patient, the patient must be offered the opportunity to ask questions about the procedure, and truthful answers must be given.

(4) The steps discussed in *c* above must be noted in block 17 of the SF 603 or SF 603A.

2–5. Treatment plans

Depending upon the complexity of the proposed treatment, the treatment plan itself may be very simple and be easily recorded and tracked in the remarks section of block 16 or may require the use of DA Form 3984.

a. Temporary entries. Treatment plans are essential to establishing appropriate standards of care and eligibility for care for people who have separated from service. Treatment planning entries in the remarks space of block 16 are erased and DA Form 3984 is discarded following completion, or change, in the plan.

(1) Treatment plans must record required steps in adequate detail to be understood by a third party.

(2) All treatment plans must indicate the identity of the dental officer who made the plan. The appropriate location is the right side of block 16. The date and the dentist's initials are entered above and below the line separating the remarks section from the chart in block 16.

(3) All treatment plans must be dated.

b. Permanent entries. Failure to permanently document counseling provided to patients undergoing long-term care (that is, periodontal or orthodontic treatment) can lead to misunderstanding of, and false expectations toward, the possibility of continuing care upon permanent change of station (PCS) to a new duty station. For example, if a patient undergoing active orthodontic therapy is moved to a post where such care is not available through the dental facilities located there, the patient will be liable for the expense of continuing care in the civilian sector. This kind of information must be presented to the patient and permanently documented in the dental record before the initiation of care. The most appropriate place for this documentation is in block 17 of the SF 603 or SF 603A. The kind of things related to treatment planning that must be permanently documented in the SF 603 or SF603A are—

(1) Anatomic or physiologic abnormalities or conditions which may be pathologic or impact on future care.

HEALTH QUESTIONNAIRE FOR DENTAL TREATMENT

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

NAME		SSN
George J. Johnson		512-13-4512
UNIT	HOME TELEPHONE	OFFICE TELEPHONE
548th Eng. Bn.	314-5718	476-9827

PLACE A CHECK IN THE YES OR NO COLUMN	YES	NO
1. Have you been under a physician's care in the last 2 years?		✓
2. Have you had any serious illness, operation or hospitalization in the past?	✓	
3. Are you allergic to any drugs or medicines (novocain, penicillin, others)?	✓	
4. Are you presently taking any drugs or medicines (to include birth control pills)?		✓
5. Have you ever had hepititis or yellow jaundice?		✓
6. Has there been a change in your health in the last 2 years?		✓
7. Do you smoke cigarettes?	✓	
8. Do you drink alcoholic beverages?	✓	
9. Have you ever been sick because of dental treatments?		✓
10. Are you a "bleeder" or have you had excessive bleeding following dental treatment?		✓
11. Do you get short of breath after climbing 1 flight of stairs?		✓
12. (Female only) Are you pregnant?		

CHECK CONDITIONS IF THEY APPLY TO YOU

☐ Heart Trouble/Chest Pain	☐ Frequent Headaches	☐ Hives or Skin Rash	☐ Epilepsy
☐ Heart Murmur	☐ Thyroid Disease	☐ Asthma/Hay Fever	☐ Ulcers/Stomach
☐ High Blood Pressure	☐ Kidney Disease	☐ Sugar Diabetes	☐ Anemia (Thin Blood)
☐ Rheumatic Fever	☐ Liver Disease	☐ Arthritis/Rheumatism	☐ Venereal Disease (VD)
☐ Stroke	☐ Sinus Disease	☐ Tuberculosis (TB)	☐ Cancer

Explain any unusual medical problems:

2. Tonsils removed - Age 8
3. Penicillin
7. 1 pack / day
8. 6-pack beer / week

SAMPLE

DATE	SIGNATURE OF PATIENT
3 MAR 89	George J. Johnson
DATE	**SIGNATURE OF DOCTOR**
3 MAR 89	Jerry Kent CPT, DC

RECHECK

DATE	DOCTOR'S SIGNATURE	REMARKS
6 Oct 89	Jerry Kent CPT, DC	no change

DA FORM 5570, OCT 86

Figure 2-3. Sample Health Questionnaire for Dental Treatment.

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE

EXAM, X-RAYS, prophy, operative

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be _____ *(Description of operation or procedure in layman's language)*

teeth cleaned and fillings

which is to be performed by or under the direction of Dr. Jones

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: None *(If "none", so state)*

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.

b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES *(Appropriate items in Parts A and B must be completed before signing)*

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

Michael R Jones MAJ, DC
(Signature of Counseling Physician/Dentist)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

Barbara Smith (Signature of Witness, excluding members of operating team)

Jane D. Johnson (Signature of Patient)

25 July 89 (Date and Time)

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team) (Signature of Sponsor/Legal Guardian) (Date and Time)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)*

Johnson, Jane Doe
D/W - Active duty Army
183-46-9463

REGISTER NO.	WARD NO.

STANDARD FORM 522 (Rev. 10-76)
General Services Administration &
Interagency Comm. on Medical Records
FPMR 101-11.806-8
522-109

SAMPLE

NSN 7540-00-634-4165

Figure 2-4. Sample Medical Record—Request for Administration of Anesthesia and for Performance of Other Procedures.

DENTAL TREATMENT PLAN

For use of this form, see TB MED 5; proponent agency is Office of TSG.

1. CONSULTATION DESIRED ☐ YES ☐ NO (If yes, complete Section III, on reverse side)

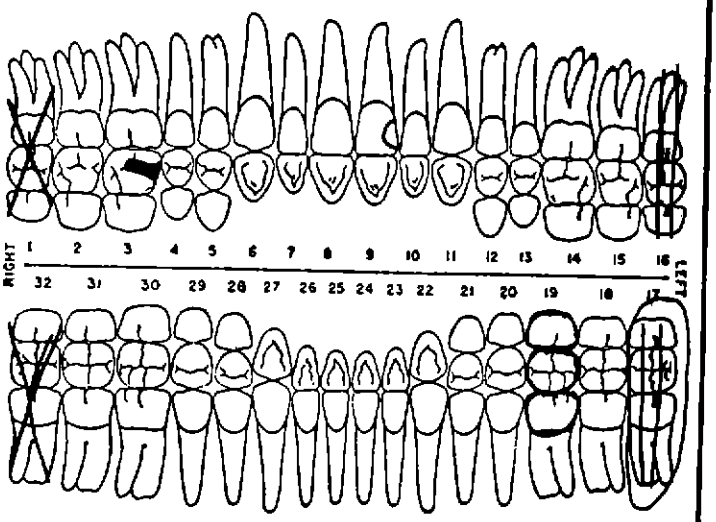
SECTION I - PLANNED TREATMENT AND SEQUENCE OF ACCOMPLISHMENT

Check items in Column c to indicate treatment planned. If sequence of treatment is other than that printed in column b, use numbers (1 thru 10) in column c to show desired order.

LINE	CODE a	TYPE TREATMENT b	PLANNED SEQUENCE c	ACCOMPLISHED d
2	A	URGENT		
3	B	PERIODONTAL		
4	C	PROPHYLAXIS ☐ SnF2 PASTE	1	
5	D	TOPICAL SnF2 REPEAT AFTER ____ MONTHS		
6	E	COUNSELING IN SELF CARE		
7	F	OCCLUSION		
8	G	SURGERY	2	
9	H	RESTORATIONS	3	
10	I	PROSTHESES Fixed #19	4	
11	J	OTHER (specify)		

CHART e

Chart ONLY missing teeth and TREATMENT TO BE ACCOMPLISHED. Do NOT chart existing Pathology or Restorations.



12. REMARKS OR INSTRUCTIONS

Use this space for additional clarification of recommended treatment or for describing treatment which does not lend itself to charting. Indicate nature of treatment and teeth or other tissues involved. Identify entry by code letter (Column a, above).

SAMPLE

13. DATE	14. TREATMENT FACILITY	15. SIGNATURE OF DENTIST RECORDING TREATMENT PLAN
29 July 89	Logan Dental Clinic Ft. Belvoir	Michael Jones MAJ, DC

SECTION II - PATIENT IDENTIFICATION

16. SEX	17. RACE	18. GRADE	19. ORGANIZATION
M	CAU	E-6	664th Eng Bn.

20. PATIENT'S LAST NAME - FIRST NAME - MIDDLE INITIAL	21. DATE OF BIRTH	22. IDENTIFICATION NUMBER
Johnson, Robert J	10 MAY 58	132-74-2152

DA FORM 1 DEC 72 3984 REPLACES DA FORM 8-276, 1 AUG 62 WHICH WILL BE USED.

Figure 2–5. Sample Dental Treatment Plan (front).

SECTION III - CONSULTATION REQUEST *(To be completed by requesting officer)*

CONSULTATION DESIRED *(Indicate by check mark(s))*			REMARKS *(If appropriate)*
23		PROSTHODONTIC	
24		PERIODONTIC	
25		ORAL SURGERY	
26		OPERATIVE	
27		CROWN AND BRIDGE	
28		OTHER *(specify)*	

29. **SECTION IV - CONSULTANT REMARKS AND RECOMMENDATIONS**
(Initial after each entry and identify entry by number)

SAMPLE

Figure 2–6. Sample Dental Treatment Plan (back).

(2) Critical sequencing or staging of treatment.

(3) Expected time for completion of complex cases or cases of extremely long duration (that is, full banded orthodontic treatment).

(4) Possible followup care which may be required at a later date.

(5) The fact that such care may or may not be available at the post where the patient may be stationed at that time and that the patient may be liable for the expense for such followup care.

2–6. Temporary records

When Army dental facilities provide dental care to a patient for whom the facility has no dental health record, the dental officer will record the treatment on SF 603A. This form, the Privacy Act Statement, the medical and dental history form, and the consent for anesthesia form (non-active duty) are completed by the patient. These forms will be stored in a manila folder, rather than a DA Form 3444 series folder and the date the temporary record was begun will be annotated on the folder. If a permanent dental health record is not recovered in 60 days, a new dental health record will be made using the forms contained in the temporary record. Further administrative guidance on this type of record can be found in AR 40–66. All informed consent, quality assurance, and medicolegal considerations must be addressed in temporary records.

2–7. Identification of teeth and surfaces

a. Individual teeth will be identified in dental records by the authorized number. When a record or form includes a chart on which the teeth are numbered, all references to tooth numbers on that record or form will conform to the numbering system on the chart. In other records and general correspondence the following numbers will be used:

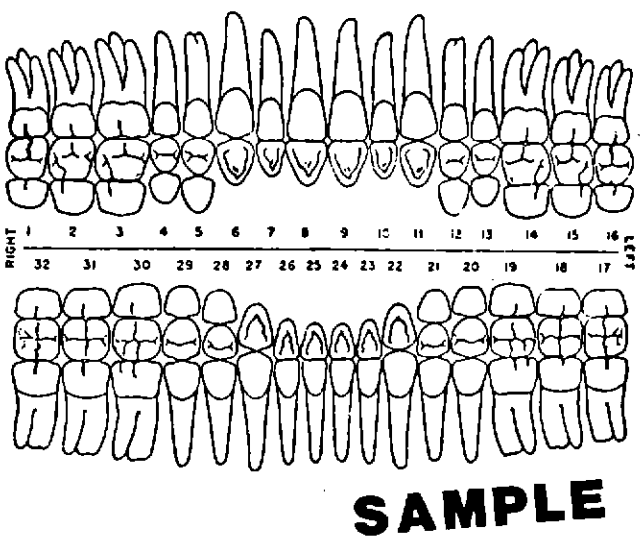


Figure 2–7. Identification of teeth.

b. The deciduous dentition will be identified in the following manner:

Table 2–5. Nomenclature for deciduous teeth.

Deciduous teeth	Right side maxillary	Right side mandibular	Left side maxillary	Left side mandibular
Second molar	4 Dec	29 Dec		
First molar	5 Dec	28 Dec		
Cuspid	6 Dec	27 Dec		
Lateral incisor	7 Dec	26 Dec		
Central incisor	8 Dec	25 Dec		
Central incisor			9 Dec	24 Dec
Lateral incisor			10 Dec	23 Dec
Cuspid			11 Dec	22 Dec
First molar			12 Dec	21 Dec
Second molar			13 Dec	20 Dec

c. The following abbreviations designate individual tooth surfaces:

Table 2–6. Abbreviations for tooth surfaces

B	Buccal
D	Distal
F	Facial
I	Incisal
L	Lingual
M	Mesial
O	Occlusal

These abbreviations are used in combination to indicate multiple surfaces (for example, MO designates a combination of the mesial and occlusal; MF indicates the mesio-facial).

CHAPTER 3

SF 603 AND SF 603A

3–1. General information

The front side of the SF 603 is used to initiate a dental record. It contains complete patient identification information and a series of dental charts, the use of which will be discussed below. The back side of the SF 603 is the same as the SF 603A. The SF 603 and SF 603A are used to record dental treatment and simple treatment plans. The next two pages contain examples (figs 3–1 and 3–2) of these forms.

3–2. SF 603, Section I

a. Section I is used to record missing teeth, existing restorations, diseases and abnormalities when initiating a dental record. Part 5 of Section I may be used to chart initial treatment needs.

b. Part 4 of Section I is charted in ink, using the symbols discussed in this bulletin, whenever initial dental processing is performed and there is no panographic radiograph capability. A panograph must be added to the record at the earliest possible time. Any abnormalities which cannot be charted using the graphic chart and symbols discussed in this bulletin will be noted in the "Remarks" section (see fig 3–3).

c. The entry will be dated, place of examination recorded, and signed by the dental officer doing the examination. Since this chart may have to be used for forensic identification purposes, restorations drawn in this section must accurately portray the restoration in the mouth.

3–3. SF 603, Section II (see fig 3–4)

a. Permanent entries. The following entries are made by the military personnel officer or by the dental treatment facility. Entries will be typewritten or printed in permanent black ink.

(1) *Sex (item 6).* Enter M for male or F for female.

(2) *Race (item 7).* This entry is optional. If it is used, enter Cau for Caucasian, Bl for Black, Oth for a member of any other race, and Unk for Unknown.

(3) *Component or Branch (item 10).* The applicable entry from the list below will be recorded.

(*a*) Army members on active duty (including Army Reservists and National Guard on extended active duty)—Army.

(*b*) National Oceanic and Atmospheric Administration—NOAA.

(*c*) Other U.S. Army Reserve—USAR.

(*d*) Other Army National Guard—ARNG.

(*e*) U.S. Navy—USN.

(*f*) U.S. Marine Corps—USMC.

(*g*) U.S. Air Force—USAF.

(*h*) U.S. Coast Guard—USCG.

(*i*) U.S. Public Health Service—PHS.

(*j*) U.S. Military Academy Cadets—USMA.

(*k*) U.S. Naval Academy Midshipman—USNA.

(*l*) U.S. Air Force Academy Cadets—USAFA.

(*m*) Reserve Officers' Training Corps—ROTC.

(*n*) Civilian employees of Federal agencies; indicate the Federal department.

(*o*) Foreign military; indicate the armed force.

(4) *Service, Dept, or Agency (item 11).* Enter Army, Navy, Air Force, etc., or whatever service, department, or agency to which the sponsor belongs.

(5) *Patient's Name and Date of Birth (items 12 and 13).* Self-explanatory.

(6) *Identification No. (item 14).* Enter the SSN of military personnel (active and retired). For family members, enter the FMP followed by the sponsor's SSN.

b. Temporary entries. The following entries in Section II will be made in no. 1 or no. 2 pencil by the military personnel officer or by the dental treatment facility. The dental record custodian will make changes as they occur.

(1) *Grade, Rating, or Position (item 8).*

(*a*) *Active duty personnel.* Enter rank. Examples: PV1, SSG, MAJ.

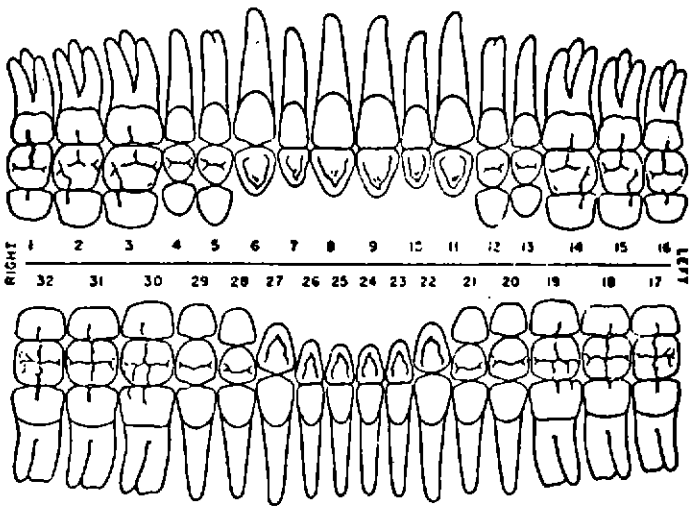
GENERAL SERVICES ADMINISTF N AND
INTERAGENCY COMMITTEE ON I .CAL RECORD
FIRMR (41 CFR) 201-45.505 OCTOBER 1975

HEALTH RECORD | **DENTAL**

SECTION I. DENTAL EXAMINATION

1. PURPOSE OF EXAMINATION					2. TYPE OF EXAM.	3. DENTAL CLASSIFICATION
	INITIAL		SEPARATION	OTHER (*Specify*)	1 2 3 4	1 2 3 4 5

4. MISSING TEETH AND EXISTING RESTORATIONS

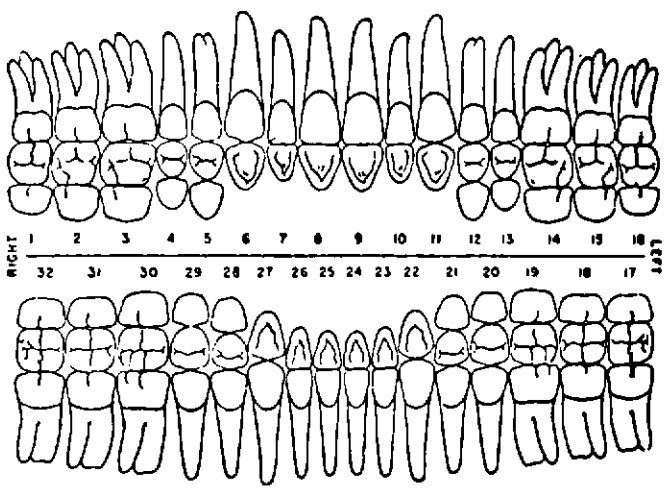


REMARKS

SAMPLE

PLACE OF EXAMINATION	DATE
SIGNATURE OF DENTIST COMPLETING THIS SECTION	

5. DISEASES, ABNORMALITIES, AND X-RAYS



A. CALCULUS

	SLIGHT		MODERATE		HEAVY

B. PERIODONTOCLASIA

	LOCAL		GENERAL

	INCIPIENT		MODERATE		SEVERE

C. STOMATITIS (*Specify*)

	GINGIVITIS		VINCENT'S

D. DENTURES NEEDED
(*Include dentures needed after indicated extractions*)

FULL		PARTIAL	
U	L	U	L

ABNORMALITIES OF OCCLUSION—REMARKS

E. INDICATE X-RAYS USED IN THIS EXAMINATION

	FULL MOUTH PERIAPICAL		POSTERIOR BITE-WINGS		OTHER (*Specify*)

DATE	PLACE OF EXAMINATION	SIGNATURE OF DENTIST COMPLETING THIS SECTION

SECTION II. PATIENT DATA

6. SEX	7. RACE	8. GRADE, RATING, OR POSITION	9. ORGANIZATION UNIT	10. COMPONENT OR BRANCH	11. SERVICE, DEPT., OR AGENCY

12. PATIENT'S LAST NAME—FIRST NAME—MIDDLE NAME	13. DATE OF BIRTH (DAY-MONTH-YEAR)	14. IDENTIFICATION NO.

NSN 7540-00-634-4179

DENTAL
Standard Form 603
603-104

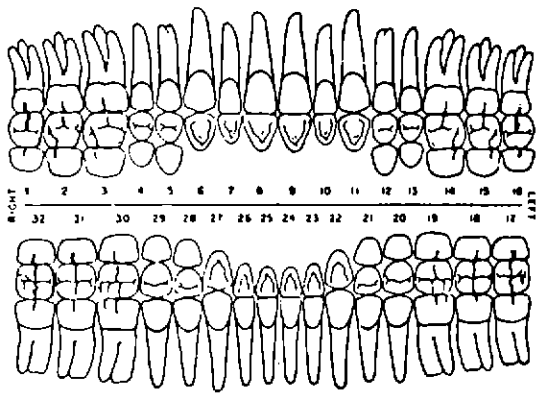
Figure 3-1. Sample Health Record—Dental.

Standard Form 603-A

HEALTH RECORD | **DENTAL—Continuation**

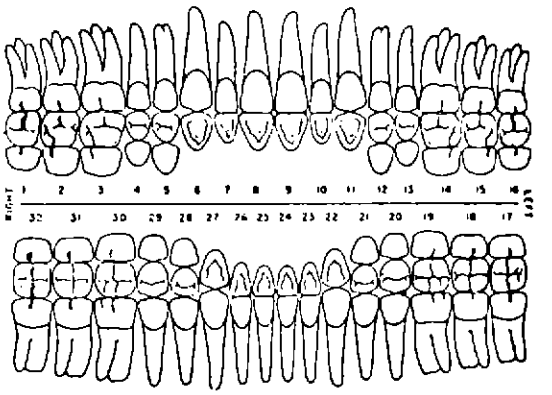
SECTION III. ATTENDANCE RECORD

15. RESTORATIONS AND TREATMENTS (*Completed during service*)



REMARKS

16. SUBSEQUENT DISEASES AND ABNORMALITIES



REMARKS

17. SERVICES RENDERED

DATE	DIAGNOSIS—TREATMENT	CLASS	OPERATOR AND DENTAL FACILITY	INITIALS

SAMPLE

PATIENT'S LAST NAME—FIRST NAME MIDDLE NAME

IDENTIFICATION NO

DOD EXCEPTION TO SF 603-A APPROVED BY GSA/FRMS 1-86

GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FPMR (41 CFR) 201-45.505
OCTOBER 1975 603-205

Figure 3-2. Sample Health Record—Dental—Continuation.

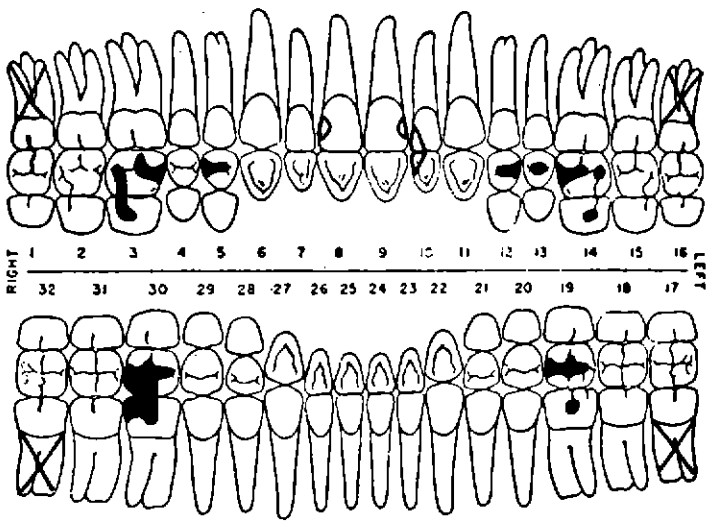
GENERAL SERVICES ADMINISTR/ N AND
INTERAGENCY COMMITTEE ON I AL RECORDS
FIRMR (41 CFR) 201-45.505 OCTOBER 1975

HEALTH RECORD | **DENTAL**

SECTION I. DENTAL EXAMINATION

1. PURPOSE OF EXAMINATION			2. TYPE OF EXAM.	3. DENTAL CLASSIFICATION
X INITIAL	SEPARATION	OTHER (*Specify*)	1 2 3 4	1 2 3 4 5

4. MISSING TEETH AND EXISTING RESTORATIONS



REMARKS

LARGE MAXILLARY TORUS APPROXIMATELY 1 CM IN DIAMETER

SAMPLE

PLACE OF EXAMINATION	DATE
FT SILL, OK	15 OCT 86

SIGNATURE OF DENTIST COMPLETING THIS SECTION
Michael J. Mathews, LTC, DC

Figure 3–3. SF 603 Section I (sample).

(*b*) *Retired personnel.* Enter "RET/rank" (for example, RET/SGM).

(*c*) *Family member*: Identify relationship to sponsor followed by sponsor's rank, first name, and middle initial. Example: Son/SFC John L.

(2) *Organization Unit (item 9).* Enter the unit of active duty military personnel and/or sponsor.

(3) *Separation from the service.* It is often extremely useful for dental personnel to know the expiration term of service (ETS), or the date eligible to return from overseas (DEROS) of the individual undergoing treatment. A penciled entry of this date will be made in the right hand corner of the space containing the patient's name (item 12). Examples:

(*a*) Expiration term of service, July 78 "(ETS 7/78)."

(*b*) Relief from active duty, September 1981 "(REFRAD 9/81)."

(*c*) Relief from active duty for training, October, 1982 "(REFRADT 10/82)."

(*d*) Retire, August 1983 "(RET 8/83)."

(*e*) Date eligible to return from overseas, December 1985 "(DEROS 12/85)."

3–4. SF 603 and SF 603A, Section III

a. Block 15 (see fig 3–5).

(1) This part of the SF 603 and SF 603A is used to record restorations and treatment of defects performed after the initial dental processing.

(2) Entries are made in black ink.

(3) Remarks block—Normally this space requires no entries. It should be annotated, however, to reflect that there is a significant item in the medical history.

b. Block 16 (see fig 3–5).

(1) This part of the SF 603 and SF 603A is an examination chart. It is used to record those defects which are discovered at the time of initial and subsequent examinations.

(2) Entries are made in pencil and individual entries erased as each related treatment is completed and appropriate entries are made in block 15.

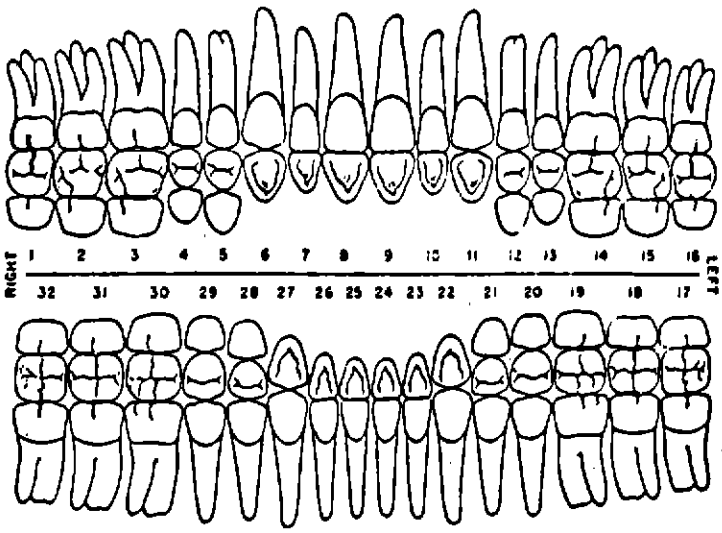
(3) Remarks block—Indicate in pencil the date of examination. If the patient is dental class 3, indicate the reason for this classification. This space may also be used by the dentist to sequence simple treatment plans.

HEALTH RECORD | **DENTAL**

SECTION I. DENTAL EXAMINATION

1. PURPOSE OF EXAMINATION			2. TYPE OF EXAM.	3. DENTAL CLASSIFICATION
INITIAL	SEPARATION	OTHER (*Specify*)	1 2 3 4	1 2 3 4 5

4. MISSING TEETH AND EXISTING RESTORATIONS



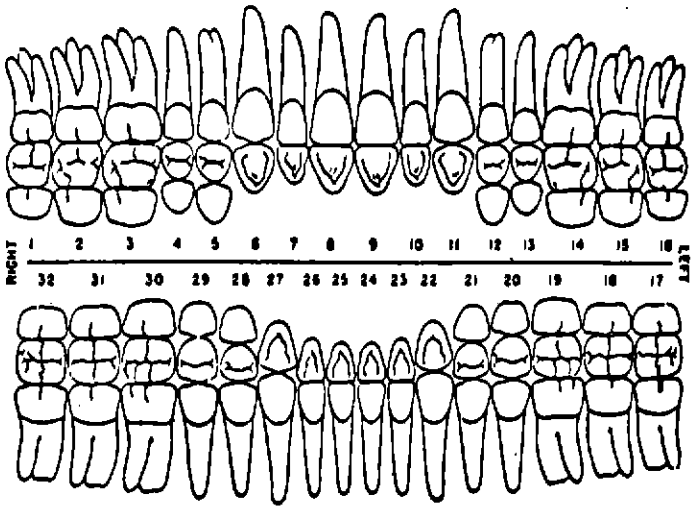
REMARKS

SAMPLE

PLACE OF EXAMINATION | DATE

SIGNATURE OF DENTIST COMPLETING THIS SECTION

5. DISEASES, ABNORMALITIES, AND X-RAYS



A. CALCULUS: SLIGHT | MODERATE | HEAVY

B. PERIODONTOCLASIA: LOCAL | GENERAL; INCIPIENT | MODERATE | SEVERE

C. STOMATITIS (*Specify*): GINGIVITIS | VINCENT'S

D. DENTURES NEEDED (*Include dentures needed after indicated extractions*)

FULL		PARTIAL	
U	L	U	L

ABNORMALITIES OF OCCLUSION—REMARKS

E. INDICATE X-RAYS USED IN THIS EXAMINATION: FULL MOUTH PERIAPICAL | POSTERIOR BITE-WINGS | OTHER (*Specify*) PANOGRAPH

DATE: 15 OCT 86 | PLACE OF EXAMINATION: FT SILL, OK | SIGNATURE OF DENTIST COMPLETING THIS SECTION: Michael J. Mathews LTC DC

SECTION II. PATIENT DATA

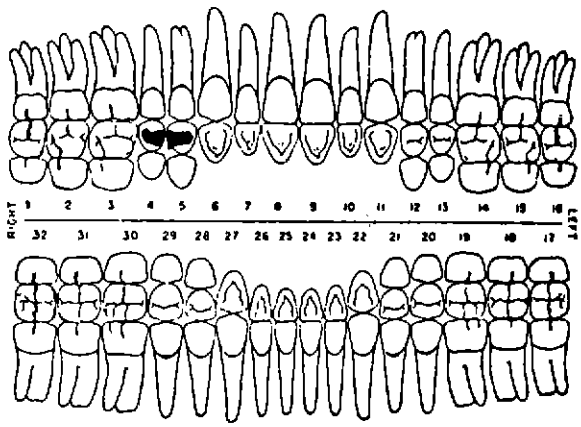
6. SEX	7. RACE	8. GRADE, RATING, OR POSITION	9. ORGANIZATION UNIT (P)	10. COMPONENT OR BRANCH	11. SERVICE, DEPT., OR AGENCY
M	CAU	PFC	C 3/35 FA	ARMY	ARMY

12. PATIENT'S LAST NAME—FIRST NAME—MIDDLE NAME		13. DATE OF BIRTH (DAY-MONTH-YEAR)	14. IDENTIFICATION NO.
JONES, CHARLES LEE	(P) (ETS 5/93)	22 MAR 70	680-95-1234

Figure 3–4. SF 603 with ID section completed (sample).

SECTION III. ATTENDANCE RECORD

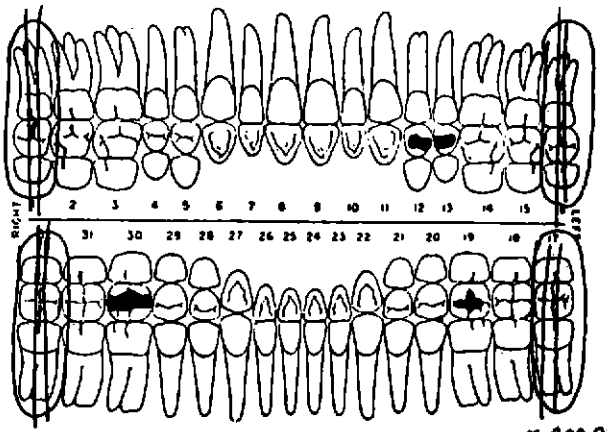
15. RESTORATIONS AND TREATMENTS (*Completed during service*)



REMARKS

SAMPLE

16. SUBSEQUENT DISEASES AND ABNORMALITIES



REMARKS CLASS 3 - LOST RESTORATION #30 5 APR 88 MJM

① OPER

② PRO

③ OS EVAL #'s 1, 16, 17, 32

Figure 3–5. Blocks 15 and 16 completed (sample).

c. Entries in block 17—Services Rendered (see fig 3–6).

(1) All entries will be made legibly in black ink.

(2) Entries will include every treatment as well as major steps involved in multivisit treatments.

(3) Extensive narrative entries may be entered across the entire page when necessary.

(4) Date column—Enter the current year on the first line. Subsequent dates on the following lines will include only the day and month of each treatment visit. When the year changes enter the new year on the next line. (See example below.)

(5) Diagnosis—Treatment column. Treatments should be entered in chronological order as performed during the appointment. Whenever possible, a tabular format for treatments performed should be used. This format greatly aids searching for data about a specific tooth, or area, and speeds record audits. The basic format for the entry is—

(*a*) Chief complaint (if appropriate).
(*b*) Patient preparation procedures.
(*c*) Tooth number(s).
(*d*) Diagnosis (if appropriate).
(*e*) Treatment(s).

17. SERVICES RENDERED

DATE	DIAGNOSIS--TREATMENT	CLASS	OPERATOR AND DENTAL FACILITY	INITIALS
1988			DC #3, Ft. Elsewhere	
12 Jan	CC sensitivity to cold in Max R Quad			
	Dx - Multiple broken down restorations			
	Exam, LA (1.8 cc 2% Lidocaine c̄ 1:100,000 epi)			
	RD			
	#2 - Def res - O - Dycal - v - AM			
	#3 - Def res - O - Dycal - v - AM			
	#4 - Def res - O - Dycal - v - AM	2	C. H. Fields, CPT, DC	CF

SAMPLE

Figure 3–6. SF 603 and 603A, block 17 completed (sample).

(6) DOD dental classification per AR 40–35 (Class colm).

(*a*) Dental fitness classification (per AR 40–35) is performed at all examinations in which the dental record is present, to include screening examinations, preparation of replacements for oversea movement (POR) examinations, etc. and is recorded in the "Class" column of block 17 of SF 603 and SF 603A. Fitness classifications apply to active duty soldiers only.

(*b*) Indicate the date of examination in pencil in the Remarks portion of block 16. For Class 3 patients, the reason(s) for placing the patient in Class 3 should be indicated in descending order of clinical importance (see fig 3–5 above).

(*c*) The dental fitness classification will be placed in the Class column of block 17. For active duty personnel the dental fitness classification will be indicated on the outside of the record jacket by colored tape codes. The appropriate tape code will be placed in the space to the left of the "O" block on the upper edge of the back of the record jacket and above the "O" block on the right edge. The following codes will be used:

Table 3–1. Color coding for dental fitness classification

Blue	Class 1
White	Class 2
Red	Class 3
Green	Class 4

(7) Operator and dental facility.

(*a*) The name of the facility will be shown in block 17 for the first entry made at that facility.

(*b*) The operator's name, rank, and corps, occupation or degree will be shown for each treatment. Expanded duty assistants, DTA or PDS (91EX2), must also show the name of the supervising dentist on the last line of entry.

(*c*) Examples:

1 Military dental officer: Paul A. Smith, LTC, DC.

2 Civilian providers: Paul S. Jones, DDS or Suzie Smith, RDH.

3 91EX2: John D. Filler, SSG, PDS/Paul A. Smith, LTC, DC.

4 Others: Donald D. Glass SP4.

(8) Authentication of entries. The care provider will sign or initial all entries and be responsible for the accuracy and completeness of all entries. Entries transcribed from records received from civilian or foreign military facilities will carry the name and signature (or initials) of the person making the transcription.

3–5. SF 603A, Continuation sheet

a. SF 603A is used as a continuation sheet for SF 603 and will be added to the dental record when there is not enough space for recording treatment or when accumulated entries in the charts of Section III, SF 603, become confusing. Entries are made on SF 603A in the same manner as on SF 603. For convenience, any remaining entries in block 16 on the original SF 603 may be carried over to SF 603A. When initiating a new SF 603A, the patient's last name, first name, middle initial, and identification number must be placed along the right hand margin where indicated.

b. Occasionally a new SF 603A with treatment entries will be added to a record before the previous SF 603 or SF603A has been filled. In this instance the empty portion of block 17 on the old form must be rendered unusable so that the proper chronology of the record will be maintained. This is done by drawing a diagonal line from corner to corner through the unused portion of the two large columns in block 17.

CHAPTER 4
RECORDING EXAMINATIONS

4–1. General information

a. Only accepted dental or medical abbreviations will be used. When unabbreviated entries are made, their phrasing should be clear and brief and complete enough to answer all future inquiries concerning the quality of care provided.

b. Punctuation is needed to clarify record entries. Simplicity of the entry is the key to ease of understanding. When abbreviations are used, they will be separated from each other with dashes, for example, #2–CAR–F–AM.

4–2. SOAP notes

A simple format for recording information described above is the SOAP note. This format (see fig 4–1) encourages the recording of the following information in the SF 603 and SF 603A and is also commonly used for answering consultations (SF 513).

a. Subjective findings (S): This is a detailed account of the patient's chief complaint and other complaints or feelings of the patient.

b. Objective findings (O): Examination findings which may affect treatment or future care.

c. Appraisal (A): Conclusions and diagnoses (problem list) based on the above two items and including any circumstances beyond the dentist's control which may affect the outcome of the treatment (that is, keep appointments, or failure to follow the dentist's instructions), imminent PCS or ETS and portions of the case history necessary for a full understanding of the condition to be treated or having a bearing on the prognosis or followup treatment. Discussion of these items with the patient should be recorded here.

d. Plan (P): Treatment plan which addresses the problems in the appraisal. This need not be a tooth by tooth plan, but a general outline of the care to be provided and any counseling of the patient regarding possible problems and the availability of future care. The plan should include—

(1) Treatment goals or objectives.

(2) Recommendations or instructions for future treatment or followup care.

(3) Information concerning the probable prognosis in doubtful or complicated cases.

(4) Remarks concerning serious defect(s) found on the examination for which treatment is not provided for any reason.

4–3. Recording examinations (see fig 4–2)

a. Examination findings are recorded in block 16 of SF 603 and SF 603A in pencil. The narrative entry is noted in block 17 in ink.

b. Individual entries in block 16 are erased as each related treatment is completed and the appropriate entries made in block 15 in ink.

c. Entries in the Remarks space of block 16 are also made in pencil.

(1) Indicate the date of examination and, if the dental fitness classification is Class 3, indicate the reason.

17. SERVICES RENDERED

DATE	DIAGNOSIS--TREATMENT	CLASS	OPERATOR AND DENTAL FACILITY	INITIALS
1988			DC #3, Ft. Elsewhere	
5 May	19 yo FM/D with R facial pain reports to clinic			
	S: R facial pain X 48 hrs, temp 100.5° yesterday, hard to chew			
	O: Temp 101° today, minor edema over R mand angle			
	gingival swelling and exudate present tooth #32			
	muscles of mastication all WNL, no caries or perio problems			
	A: Pericoronitis #32, record indicates lack of cooperation			
	P: Refer to OS for eval for removal			
	#1 and #32		James A. Reid, CPT, DC	JR

SAMPLE

Figure 4–1. SOAP note (sample).

(2) This space may also be used by the dentist to sequence simplified treatment plans.

d. Entries in block 17.

(1) The year and name of the facility will be entered under the "Date" and "Operator and Dental Facility" headings of the SF 603 and SF 603A when the dental health record is assigned to the custody of a clinic. Whenever the record is transferred to a different clinic for management or treatment purposes, this entry will be made to reflect the change during inprocessing.

(2) A combination of narrative and tabular format will be used in block 17 of SF 603 and SF 603A to record all services rendered. Record entries should follow the chronological sequence of treatment provided. Narrative entries must be brief, but complete and legible.

(3) Record restorative treatment for multiple teeth in a tabular format. Note the treatment for each tooth on a separate line beginning at the left hand margin. Keep the parts of each entry, when possible, aligned in columns. This form of entry permits more rapid record review when searching for information about a specific tooth, or when auditing records.

e. Figure 4–2 demonstrates the proper recording of an annual examination, dental fitness classification, informed consent statement, and abbreviated treatment plan in the Remarks space of block 16.

(1) Caries are charted for teeth 2 through 5, 8, 14, and 19.

(2) Defective restoration is charted for tooth 30.

(3) Temporary restoration is recorded for tooth 18.

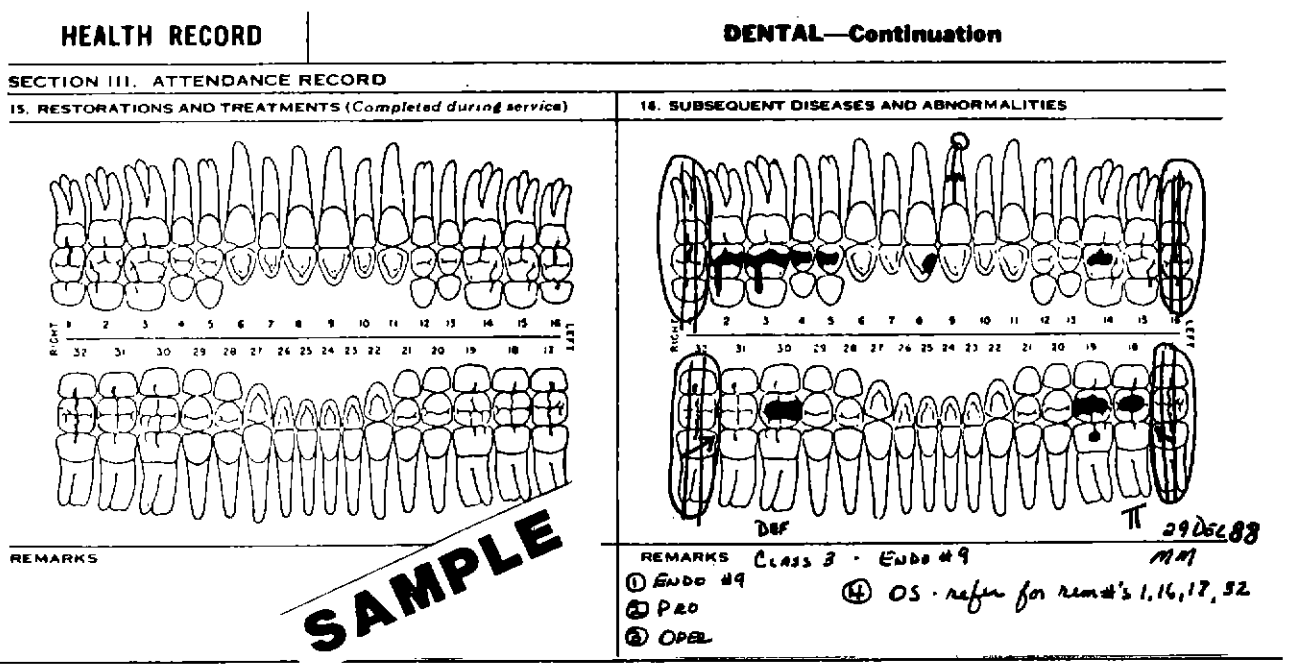
(4) A fractured tooth is charted for number 9.

(5) Tooth 9 requires root canal treatment and has a radiolucency at the apex.

(6) Teeth 1, 16, 17, and 32 are impacted and require removal.

(7) Teeth 17 and 32 are mesioangular impactions.

f. Figure 4–3 illustrates partial completion of the treatment plan for the patient whose examination was recorded in figure 4–2. It demonstrates removal of symbols from block 16 and recording



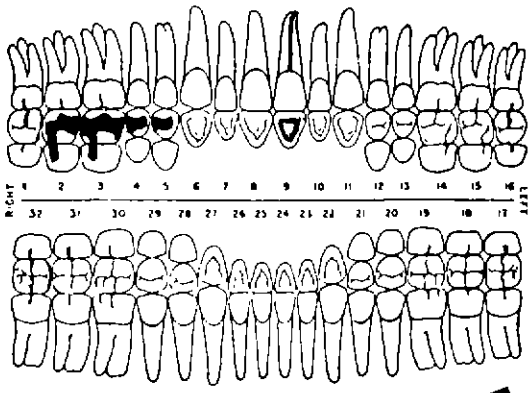
17. SERVICES RENDERED

DATE	DIAGNOSIS--TREATMENT	CLASS	OPERATOR AND DENTAL FACILITY	INITIALS
1988			DC #3, Ft. Elsewhere	
29 Dec	Oral Exam. Med hx non-contributory			
	TxP and possible complications explained to pnt. Pnt had no questions			
	regarding the proposed care and agrees to TxP			
	2 BWX, PAX #9			
	Class 3 - #9 needs endo	3	Michael W. Masters, MAJ, DC	MM

Figure 4–2. Recording examination findings (sample).

SECTION III. ATTENDANCE RECORD

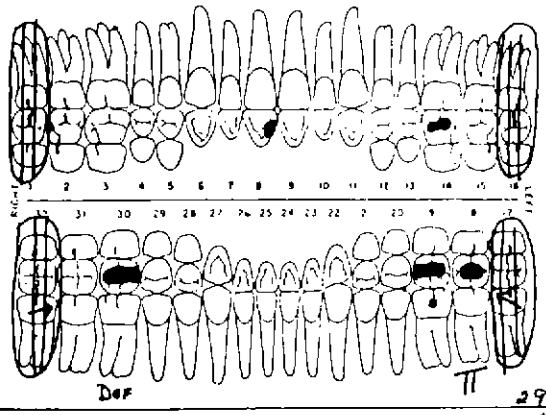
15. RESTORATIONS AND TREATMENTS (*Completed during service*)



REMARKS

SAMPLE

16. SUBSEQUENT DISEASES AND ABNORMALITIES



REMARKS

④ O.S. - refer for exam #'s 1,16,17,32

③ Oper

17. SERVICES RENDERED

DATE	DIAGNOSIS--TREATMENT	CLASS	OPERATOR AND DENTAL FACILITY	INITIALS
1988			DC #3, Ft. Elsewhere	
29 Dec	Oral exam. Med hx non-contributory			
	TxP and possible complications explained to pnt. Pnt had no questions			
	regarding the proposed care and agrees to TxP, 2 BWX, PAX #9			
	Class 3 - #9 needs endo	3	Michael W. Masters, MAJ, DC	MM
30 Dec	Endo - LA (1.8 cc 2% Lidocaine c̄ 1:100,000 epi) top			
	RD			
	#9 opened, nonvital Cl & Sh size 50 at 24mm			
	RCF c̄ GP and ZNOE sealer, 2 PAX			
	#9-Def-L-etch-Prisma (u)	2	Michael W. Masters, MAJ, DC	MM
1989			DC #3, Ft. Elsewhere	
4 Jan	Adult pro, perio scale area 22-27			
	2% SNF pro paste	2	Marie Roberts, RDH	MR
15 Jan	Oper - LA (1.8 cc 2% Lidocaine c̄ 1:100,000 epi) top			
	RD			
	#2-car-MOL-Dycal-v-am			
	#3-car-MODL-Dycal-v-am			
	#4-car-DO-Dycal-v-am			
	#5-car-DO-Dycal-v-am	2	Michael W. Masters, MAJ, DC	MM
25 Jan	O.S. exam - eval imp #1,16,17,32			
	Rec removal	2	H. Marshall Lewis, LTC, DC	MH

Figure 4–3. Charting treatment (sample).

them in block 15 when treatment is performed, change of dental classification, beginning of a new calendar year, and temporary transfer of the record to a different clinic.

4–4. Symbols for recording of examinations

a. Caries (see fig 4–2).

(1) *Abbreviation*: car.

(2) *Block 16*: Draw an outline of the carious portion of the affected tooth and blacken it in completely. When the caries extends on to the facial or lingual surfaces, the outline will be shown on the appropriate aspect of the pictured tooth.

(3) *Block 17*: No entry required unless the condition cannot be adequately illustrated in block 16.

b. Defective restoration (see fig 4–2).

(1) *Abbreviation*: def res.

(2) *Block 16*: Outline restoration and extent of caries as above and write "Def" by the apex of the root to indicate that the existing restoration is defective.

(3) *Block 17*: No entry required unless the condition cannot be adequately illustrated in block 16.

c. Temporary restoration or temporary treatment (see fig 4–2).

(1) *Abbreviation:* Tem rest or TT.

(2) *Block 16*: Temporary restorations are recorded in block 16 only. Chart the caries or defective restoration as described above and mark the apical area of the root of the tooth with the symbol "TT." Indicate the material used.

(3) *Block 17*: No entry required for diagnosis.

d. Deciduous teeth (see fig 4–4).

(1) *Abbreviation*: Dec.

(2) *Block 16*:

(*a*) If both the deciduous tooth and the corresponding permanent tooth are present, show this on the chart by placing the number of the deciduous tooth in its relative position to the number of the permanent tooth and draw a block "D" around the number of the deciduous tooth. In these cases, pathological conditions such as caries must be explained in the narrative.

(*b*) If the permanent tooth is not present and the deciduous tooth is present, show this by inscribing a block "D" around the number of the corresponding permanent tooth. In these cases, pathological conditions may be symbolized on the corresponding permanent tooth. Diseases, which cannot be clearly symbolized, must be included in the narrative.

(*c*) Indicate the needed extraction of a deciduous tooth by drawing two short parallel lines above and below the block "D."

(3) *Block 17*: Describe pathological conditions or abnormalities which cannot be adequately demonstrated by the coding described above.

e. Supernumerary teeth (see fig 4–4).

(1) *Abbreviation*: spnmry.

(2) *Block 16*: Draw in the supernumerary tooth attempting to indicate the true position and size.

(3) *Block 17*: Describe the condition, if the sketch cannot portray the actual situation, and indicate any recommendations regarding its treatment.

f. Diastema (see fig 4–4).

(1) *Abbreviation*: none.

(2) *Block 16*: If desired, indicate presence and size of diastemas by arrows pointing laterally from the normal contact areas. Indicate size in millimeters by a number between arrows.

(3) *Block 17*: No entry required unless the condition cannot be adequately illustrated in block 16.

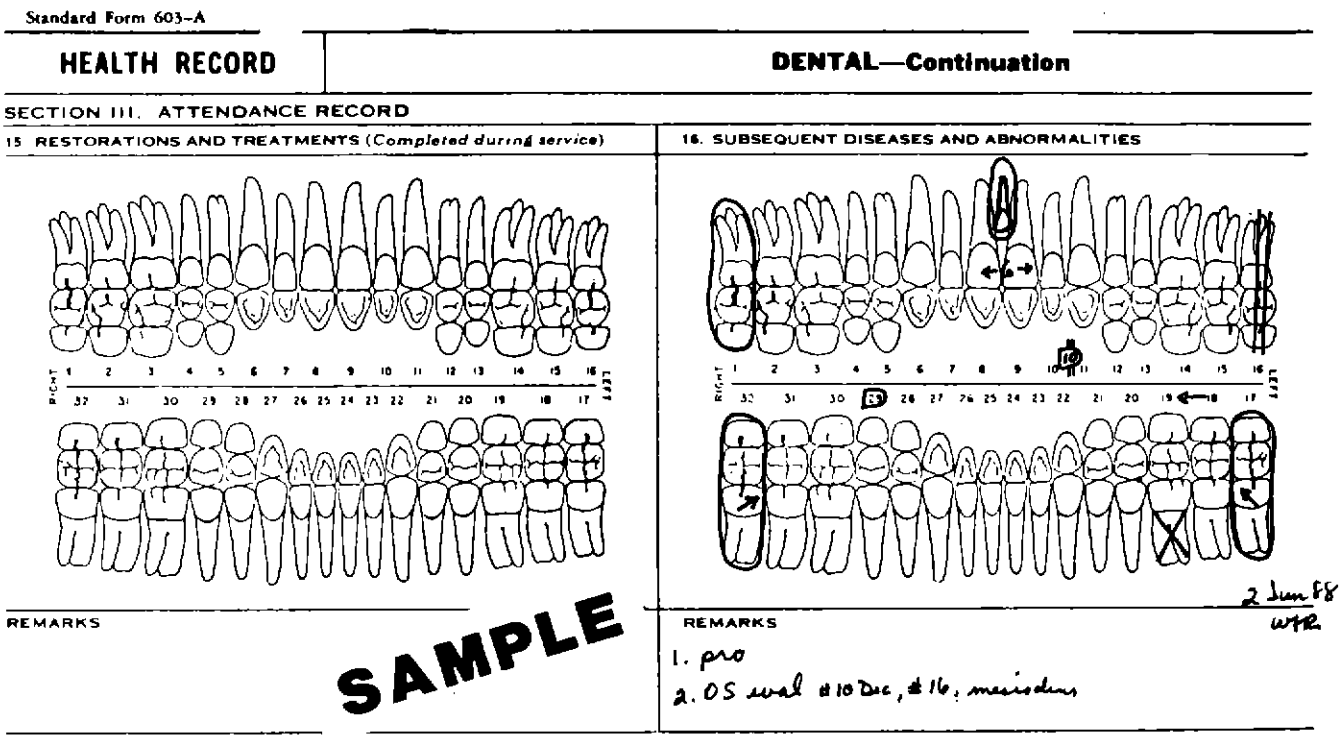


Figure 4–4. Recording examination findings (sample).

g. Drifted tooth (see fig 4–4).

(1) *Abbreviation*: none.

(2) *Block 16*: From the number of the tooth that has moved, draw a small arrow with the point of the arrow indicating the approximate position to which the tooth has moved.

(3) *Block 17*: A narrative entry may be required to further explain the position of the tooth.

h. Unerupted or impacted teeth (see fig 4–4).

(1) *Abbreviation*: Uner or imp.

(2) *Block 16*: Enclose the entire view of the tooth in an oval. Indicate the long axis of the tooth by a small arrow on the facial surface with its tip indicating the angulation of the impaction.

(3) *Block 17*: No entry required unless the condition cannot be adequately illustrated in block 16.

i. Extraction indicated (see fig 4–4).

(1) *Abbreviation*: ext.

(2) *Block 16*: Draw two parallel vertical lines through the crown(s) and root(s) involved. This also applies to unerupted or impacted teeth when extraction is indicated.

(3) *Block 17*: No entry required unless the condition cannot be adequately illustrated in block 16.

j. Summary of fig 4–4 (see fig 4–4).

(1) Areas 10 and 11 illustrate a retained deciduous tooth with the permanent successor in place. It is marked for extraction.

(2) Tooth 29 is a retained deciduous tooth with no successor.

(3) Area 8 and 9 charts an impacted supernumerary tooth.

(4) Teeth 8 and 9 are separated by a 6 mm diastema.

(5) Tooth 19 is missing.

(6) Tooth 18 has drifted into the space left by 19.

(7) Teeth 1, 17, 32, and the mesiodens are impacted.

(8) Tooth 16 requires removal.

(9) Tooth 17 and 32 have a mesial angulation.

k. Missing or extracted teeth (see fig 4–5).

(1) *Abbreviation*: none.

(2) *Block 16*: Indicate missing or extracted teeth by inscribing an X across the roots.

(3) *Block 17*: No entry required unless the condition cannot be adequately illustrated in block 16.

l. Fractured tooth or root (see fig 4–5).

(1) *Abbreviation*: fx.

(2) *Block 16*: Place a zigzag line in the fracture's relative location on the tooth or root.

(3) *Block 17*: The narrative entry must describe the findings.

m. Resorption of root (see fig 4–5).

(1) *Abbreviation*: none.

(2) *Block 16*: Indicate the coronal extent of the resorption with a wavy line across the root. Place an X over the portion of the missing root. Indicate periapical pathology as described below.

(3) *Block 17*: Describe the extent of the resorption in a narrative entry.

n. Radiolucent or radiopaque lesions (see fig 4–5).

(1) *Abbreviation*: none.

(2) *Block 16*: Outline the approximate form and size in its relative position to the affected tooth or teeth. A radiopaque lesion is indicated by blackening in the outlined lesion. A radiolucent lesion is only outlined.

(3) *Block 17*: An entry should be made as to the diagnosis or diagnostic steps to be used to gain a diagnosis.

o. Endodontic treatment indicated (see fig 4–5).

(1) *Abbreviation*: endo Tx.

(2) *Block 16*: Place a vertical line the length of the root for each root to be treated.

(3) *Block 17*: No entry required unless the condition cannot be adequately illustrated in block 16.

p. Retained root (see fig 4–5).

(1) *Abbreviation*: ret Rt.

(2) *Block 16*: Indicate in the same manner as for a fractured root, but place an X over the missing portion of the tooth.

(3) *Block 17*: No entry required unless the condition cannot be adequately described in block 16.

q. Periodontal classification (see fig 4–5).

(1) *Abbreviation*: See classes below.

(*a*) *Normal*: No gingival inflammation nor bony destruction.

(*b*) *Type I*: Gingivitis. Inflammation of the gingiva characterized clinically by gingival hyperplasia, edema, tissue retractability, gingival pocked formation and no bone loss.

(*c*) *Type II*: Early periodontitis. Progression of gingival inflammation into the alveolar bone crest and early bone loss resulting in moderate pocket formation.

(*d*) *Type III*: Moderate periodontitis. A more advanced state of the above condition, with increased destruction of periodontal structures associated with moderate to deep pockets, moderate to severe bone loss, and tooth mobility.

(*e*) *Type IV*: Advanced periodontitis. Severe periodontitis with advanced destruction of periodontal structures, deep pockets, periodontic-endodontic involvement and severe tooth mobility.

(2) *Block 16*:

(*a*) The chart in block 16 of the SF 603 and SF 603A can be divided into sextants with vertical lines penciled in on the distal of all the canines.

(*b*) Roman numerals are placed in that portion of block 16 indicating the disease level for that sextant. The date that the sextants were classified is entered in the remarks area of block 16.

(3) *Block 17*: A narrative entry is used to further define or explain the diagnosis as charted.

r. Periodontal pocket charting (see fig 4–5).

(1) *Abbreviation*: none.

(2) *Block 16*: Three-point pocket measurement for the facial side of the tooth may be recorded by indicating the pocket depth in millimeters at the apex of the root or roots in the chart. For the lingual surface, three-point measurements are recorded below the illustration of the crown.

(3) *Block 17*: No entry required unless the condition cannot be adequately illustrated in block 16.

s. Furcation involvement (see fig 4–5).

(1) *Abbreviation*: none.

(2) *Block 16*: Furcation involvements are charted in the furcation of the involved tooth or teeth.

(*a*) *Class I*: Soft tissue defect with no bony involvement. Indicated by the symbol ∧ in the furcation of the tooth or teeth.

(*b*) *Class II*: Bony defect that involves any invasion into the furcation but is not a through and through defect. Indicated by a symbol △ in the furcation of the tooth or teeth.

(*c*) *Class III*: Bony defect that involves through and through invasion of furcation. Indicated by the symbol ▲ in the furcation of the tooth.

(3) No entry required unless the condition cannot be adequately illustrated in block 16.

t. Free gingival margin (see fig 4–5).

(1) *Abbreviation*: FGM.

(2) *Block 16*: The FGM may be indicated by drawing a solid line in the appropriate relationship to the crown of the tooth.

(3) *Block 17*: No entry required unless the condition cannot be adequately illustrated in block 16.

u. Mucogingival junction (see fig 4–5).

(1) *Abbreviation*: MGJ.

(2) *Block 16*: The MGJ may be indicated by drawing a dashed line in the appropriate relationship to the crown of the tooth and/or the FGM.

(3) *Block 17*: No entry required unless the condition cannot be adequately illustrated in block 16.

v. Mobility (see fig 4–5).

(1) *Abbreviation*: none.

(2) *Block 16.*: Mobility classification is placed within the outline of the facial surface of the crown. The classification number is circled.

(*a*) *Class 1*: Lateral movement greater than 0.5 mm and less than 1 mm.

(*b*) *Class 2*: Lateral movement greater than 1 mm.

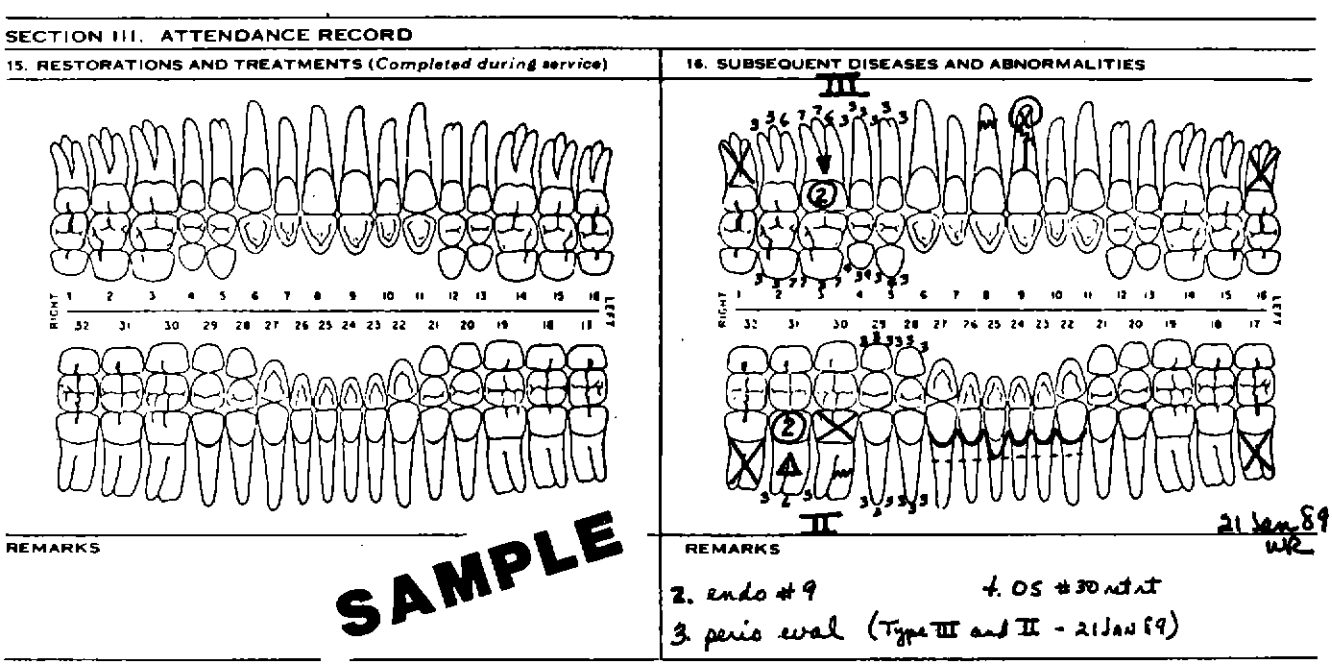


Figure 4–5. Recording periodontal findings (sample).

(c) *Class 3*: Tooth is depressable in the socket.

(3) *Block 17*: No entry required unless the condition cannot be adequately recorded in block 16.

w. Summary of figure 4–5.

(1) Tooth 8, fractured root—no treatment indicated.

(2) Tooth 9, resorbed root with radiolucent lesion. Endodontic treatment indicated.

(3) Tooth 30 mesial root retained—no pathology.

(4) Pockets are charted for maxillary and mandibular right sextants.

(5) Tooth 31, Class II furcation involvement.

(6) Tooth 3, Class III furcation involvement.

(7) FGM and MGJ charted, area 22 through 27.

(8) Teeth 3 and 31 are Class 2 mobile.

(9) Teeth 1, 16, 17, and 32 are missing.

(10) Maxillary right sextant—perio classification type III noted 21 Jan 89.

(11) Mandibular right sextant—perio classification type II noted 21 Jan 89.

x. Orthodontic findings (see fig 4–6). Orthodontic findings are generally recorded in separate records. Entries required in the SF 603 are the diagnostic findings, initiation of treatment, end of treatment, retention recommendations, pre- and post-treatment TMJ findings, notes regarding patient cooperation, and comments regarding any untoward results or situations which could generate quality assurance (QA) issues.

17. SERVICES RENDERED

DATE	DIAGNOSIS--TREATMENT	CLASS	OPERATOR AND DENTAL FACILITY	INITIALS
1988			DC #3, Ft. Elsewhere	
26 Apr	Ortho eval. 11yo W Male with Class II, division 1 malocclusion with a deep bite. Attempt will be made to treat without extraction. There is no hx of HA, TMJ pain or dysfunction. Occlusal analysis and inter-maxillary relation evaluation are pending. Radiographs WNL Plan and risks explained to pnt and mother. They asked appropriate questions and answers were given.			
	They agree to TxP		Harley E. Bender, COL, DC	HB

SAMPLE

Figure 4–6. Recording orthodontic findings (sample).

CHAPTER 5

RECORDING RESTORATIONS, COMPLETED TREATMENTS, AND SERVICES RENDERED

5–1. General information

a. The SF 603 and SF 603A are a permanent document designed to furnish a comprehensive dental history of each individual. This record will serve for treatment documentation, forensic, legal, and quality assurance purposes. All entries must be accurate, complete, and concise if the best interest of the patient, the Government, and the dental care provider are to be served.

b. All treatments performed and other pertinent facts and information must be *legibly* recorded in SF 603 or SF 603A, blocks 15 and 17, using black ink.

c. Advances in dental materials have created the situation where dental material incompatibility can influence the outcome of the treatment. In all cases where the choice of material could effect successive treatment by bond failure, galvanism, soldering failure, etc., the brand name of the material will be specified. In all cases returned from the dental laboratory, where a material, or materials, are specified by name, that name will be entered into the record.

(1) Generic type or brand name should be recorded for both bases and varnishes.

(2) When a resin restoration is being recorded, the brand name of the resin restorative material should be substituted for the abbreviation when the type of material could influence future replacement or repair.

(3) Cast restorations must include the brand name (preferable) or generic type of metal used in fabrication.

(4) Recording of implants must include the brand name and any other specific information regarding size or composition which could influence the future prosthetic or surgical management of the case.

(5) Recording of local anesthetic administration must include the number of cubic centimeters (milliliters) or number of carpules administered, the generic or brand name, and the type and ratio of vasoconstrictor used. (See fig 4–3.)

5–2. Refusal of treatment (see fig 5–1)

The procedures contained in AR 600–20 will be used when an active duty member refuses treatment. For a family member or retired member, the refusal of treatment will be recorded in a dated statement in block 17 and will include—

a. The condition for which treatment is recommended.

b. The fact that the dentist has counseled the patient of possible complications that can develop by refusing treatment.

c. The fact that neither the dentist, the dental facility, nor the Army will be liable for any complication that may develop as a result of the refusal.

d. The fact that the patient refused treatment. This statement will be signed by the patient, the dentist, and at least one witness. If the patient refuses to sign, this fact will also be included and the statement will be signed by the dentist and at least one witness.

5–3 Return of prosthesis (see fig 5–2)

a. When a restoration or prosthesis containing precious metal is removed as a single piece, or in segments, from a patient's mouth, it will be offered to him or her. The patient's acceptance or nonacceptance of the prosthesis will be recorded in a dated entry which includes a brief description identifying the prosthesis, followed by the patient's signature.

b. If the patient does not accept the precious metal contained in a restoration or appliance, it will be disposed of per AR 755–3.

5–4. Referral to quarters (see fig 5–3)

Referral to quarters will be recorded on SF 603 or SF 603A. Specific notations will include reason for referral, estimated duration, and extension of such status. The patient must be seen at the end of the quarters period and an entry made when the individual is returned to duty per AR 600–6.

5–5. Discovery of undocumented treatment (see fig 5–4)

Any previously unrecorded restorations or treatment received after initial dental processing will be described in appropriate written entries in block 17 when discovered. Restorations and treatments to be so recorded will not be limited to those received from military facilities, but will include

17. SERVICES RENDERED

DATE	DIAGNOSIS-TREATMENT	CLASS	OPERATOR AND DENTAL FACILITY	INITIALS
1988			DC#3, Ft. Elsewhere	
5 May	Tx P calls for the removal of imp #1 and 32. #32 is a soft tissue impaction and has caused multiple acute episodes of pecor. The pnt has been counselled regarding the possible serious problems that could occur if the teeth are not removed. She understands the potential for serious problems, but refuses the recommended tx. She also understands that the Army, this facility, and I are not responsible for future problems related to this condition.		Sally Austin, R.D.H.	SA
	X Pam Jones		H.Marshall Lewis, LTC, DC	MH

SAMPLE

Figure 5–1. Refusal of treatment (sample).

17. SERVICES RENDERED

DATE	DIAGNOSIS--TREATMENT	CLASS	OPERATOR AND DENTAL FACILITY	INITIALS
1988			DC #3, Ft. Elsewhere	
9 Mar	LA (1.8 cc 2% Lidocaine c 1:100,000 epi)			
	#2 FCC rem and given to the patient	X	Wm H Lawrence	
	reprep for new FCC, tem cr.	2	Thomas A. Bigbee, CPT, DC	TAB
11 Mar	LA (1.8 cc 2% Lidocaine c 1:100,000 epi)			
	Inlay DO #3 rem in fragments. Pnt			
	declines the scrap metal.	X	Wm H Lawrence	
	#3 DOL onlay prep, tem cr.	2	Thomas A. Bigbee, CPT, DC	TAB

SAMPLE

Figure 5–2. Return of prosthesis (sample).

17. SERVICES RENDERED

DATE	DIAGNOSIS--TREATMENT	CLASS	OPERATOR AND DENTAL FACILITY	INITIALS
1988			DC #3, Ft. Elsewhere	
5 Jan	Pnt requires the removal of imp teeth #1,32. Procedure explained to pnt			
	as were possible complications. Pnt asked appropriate questions and			
	answers were given. Pnt consents to the procedure.			
	LA (2 x 1.8 cc 2% Lidocaine c̄ 1:100,000 epi) top			
	#'s 1, 32 imp rem, 2BSS			
	routine postop instructions			
	Rx Tylenol #3 x 15,1 or 2 q 4 h prn pain			
	qrtrs until 0730 h 7 Jan. RTC then.	3	H. Marshall Lewis, LTC, DC	MH
7 Jan	OS POT, postop course benign, minimal edema and pain.			
	Return to duty. RTC for su rem in 2d	2	H. Marshall Lewis, LTC, DC	MH
9 Jan	OS POT su rem. Postop course WNL	2	H. Marshall Lewis, LTC, DC	MH

SAMPLE

Figure 5–3. Referral to quarters (sample).

17. SERVICES RENDERED

DATE	DIAGNOSIS--TREATMENT	CLASS	OPERATOR AND DENTAL FACILITY	INITIALS
1988			DC #3, Ft. Elsewhere	
22 Mar	Other exam - Pnt had restoration placed while on leave.			
	#3 MO - AM	1	Michael W. Masters, MAJ, DC	mm
1 Apr	Admitted to Lawrence Army Community Hospital			
	for tx of R mand fx	3	H. Marshall Lewis, LTC, DC	MML
10 May	Discharged from LACH following successful tx of			
	mand fx by closed reduction and IMF	1	H. Marshall Lewis, LTC, DC	MML

SAMPLE

Figure 5–4. Discovery of undocumented treatment and hospitalized patients (sample).

those received from nonmilitary facilities after entry on active duty. Information obtained from the patient or from other sources which does not permit personal verification by the dental officer will be so designated in written entries.

5–6. Hospitalized patients (see fig 5–4)

Dental examinations for hospitalized patients need not be recorded on SF 603 if they are recorded on any other hospital clinical records. However, any major dental treatment provided a hospitalized patient will be summarized on SF 603 or SF 603A. Lengthy treatment of a single condition (for example, fracture) need not be recorded in detail. In most cases, a very short summary of the diagnosis, general treatment, and results will suffice, except that extractions, permanent restorations, and other treatment normally charted in Section III, SF 603 or SF 603A, will be properly charted and recorded to maintain accuracy of the dental health record for identification purposes.

5–7. Errors (see fig 5–5)

Erasures, liquid paper, or correction tape will not be used to correct erroneous entries. The incorrect entry will be deleted by drawing a single line through the entry and will be dated and initialed at the right-hand edge of the line by the person making the correction. Correct data will be entered on the next available blank line and properly authenticated. If required, block 15 will be altered, as indicated, to reflect the correction when a charted restoration is involved.

5–8. Nuclear and chemical surety (see fig 5–6)

a. Dental personnel share in the responsibility for the U.S. Army Nuclear Surety Program and Chemical Surety Program. They must report to the commander of the unit in the Personnel Reliability Program (PRP) any incident, condition, or medication that could result in temporary or permanent disqualifications.

b. AR 50–5, chapter 3, on the PRP provides definitive guidance and is supplemented by local regulations.

5–9. Restorative dentistry (see fig 5–7)

a. Amalgam restorations.

(1) *Abbreviation*: am.

(2) *Block 15*: Outline the completed restoration as accurately as possible in black ink in block 15 of the SF 603 or SF 603A. When the restoration involves the proximal surfaces, the interproximal embrasures need not be shown on the facial or lingual aspects of the pictured tooth unless the restoration is carried farther than normal onto these surfaces.

(3) *Block 17*: The narrative or tabular entry contains the abbreviation "am" to indicate the material used.

b. Pin retention.

(1) *Abbreviation*: Pin.

(2) *Block 15*: No entry.

(3) *Block 17*: The placement of retentive pins for a retention of a non-cast restoration will be recorded in block 17 of SF 603 or SF 603A. A notation indicating the number of pins placed is made after the type of restorative material recorded.

c. Non-metallic permanent restorations. This category of restorations includes restorative resins, glass ionomers, and porcelain or acrylic facings used in fixed partial dentures and pit and fissure occlusal sealants.

(1) *Abbreviations*:

(*a*) Resin: res.

(*b*) Composite resin: com res.

(*c*) Glass ionomers: ion.

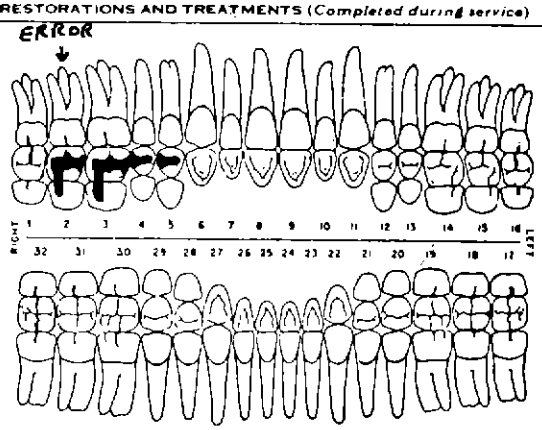
(*d*) Acrylic: acr.

(*e*) Porcelain: porc.

HEALTH RECORD | **DENTAL—Continuation**

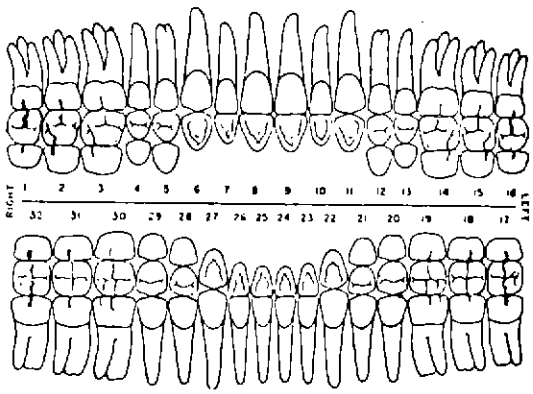
SECTION III. ATTENDANCE RECORD

15. RESTORATIONS AND TREATMENTS (*Completed during service*)



REMARKS

16. SUBSEQUENT DISEASES AND ABNORMALITIES



REMARKS

SAMPLE

17. SERVICES RENDERED

DATE	DIAGNOSIS--TREATMENT	CLASS	OPERATOR AND DENTAL FACILITY	INITIALS
1988			DC #3, Ft. Elsewhere	
15 Jan	LA (1.8 cc 2% Lidocaine c̄ 1:100,000 epi)			
	RD			
	~~#2-car-MOL-Dycal-v-am~~ MM 16 Jan 88			
	#4-car-DO-Dycal-v-am			
	#5-car-DO-Dycal-v-am	2	Michael W. Masters, MAJ, DC	MM
16 Jan	Error noted in previous entry			
	#3-car-MOL-Dycal-v-am	1	Michael W. Masters, MAJ, DC	MM

Figure 5–5. Correction of errors (sample).

17. SERVICES RENDERED

DATE	DIAGNOSIS--TREATMENT	CLASS	OPERATOR AND DENTAL FACILITY	INITIALS
1988			DC #3, Ft. Elsewhere	
5 Jan	Pnt requires removal of imp teeth #1,32. Procedure explained to pnt as			
	were possible complications. Pnt asked appropriate questions and answers			
	were given. Pnt consents to procedure.			
	LA (2 x 1.8 cc 2% Lidocaine c̄ 1:100,000 epi) top			
	#1, 32 imp, rem 2BSS			
	routine postop instructions			
	Rx Tylenol #3 x 15, 1 q 3-4 h prn pain			
	qrtrs until 0730 h 7 Jan. RTC then.			
	SGT Jones, A Co 3/35 FA (555-1234) notified			
	at 1500 h by SSG Disko	3	H. Marshall Lewis, LTC, DC	MH

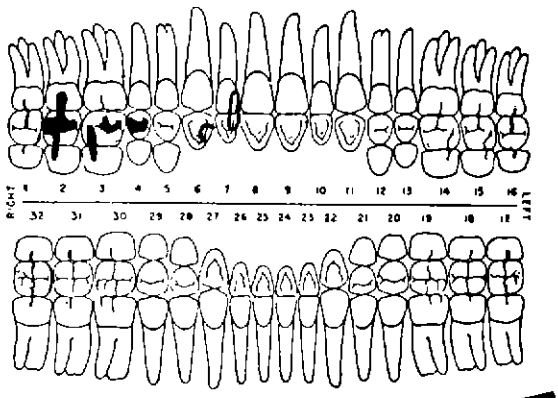
SAMPLE

Figure 5–6. Nuclear and chemical surety (sample).

HEALTH RECORD | **DENTAL—Continuation**

SECTION III. ATTENDANCE RECORD

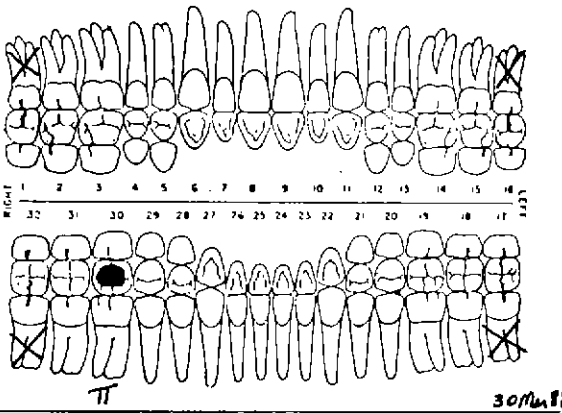
15. RESTORATIONS AND TREATMENTS (*Completed during service*)



REMARKS

SAMPLE

16. SUBSEQUENT DISEASES AND ABNORMALITIES



REMARKS

fpd · #30 FCC

17. SERVICES RENDERED

DATE	DIAGNOSIS--TREATMENT	CLASS	OPERATOR AND DENTAL FACILITY	INITIALS
1988			DC #3, Ft. Elsewhere	
22 Mar	Oper - LA (2 x 1.8 cc 2% Lidocaine c̄ 1:100,000 epi) top			
	RD			
	#2-car-DOFL-dycal-cop-am, 2 pins			
	#3-car-OL-dycal-cop-am			
	#3-car-O-cop-am			
	#4-def-DO-dycal-cop-am	2	Michael W. Masters, MAJ, DC	MM
30 Mar	Oper - LA (1.8 cc 2% Lidocaine c̄ 1:100,000 epi) top			
	RD			
	#30-def-O-dycal-IPC-v-IRM			
	Reeval in 6 mos. for decrease in thermal sensitivity			
	Recommend FCC if tooth still vital	2	Michael W. Masters, MAJ, DC	MM
5 Apr	Oper - LA (1.8 cc 3% Mepivacaine) top			
	RD			
	#6-car-M-dycal-etch-Herculite (LY)			
	#7-fx-MI-B-etch-Scotchguard-Herculite (LY)			
	glaze	2	Michael W. Masters, MAJ, DC	MM
10 Apr	Rest pol #2,3,4			
	Pnt placed on recall for eval #30			
	in 6 mos	2	Michael W. Masters, MAJ, DC	MM
15 Apr	Adult pro,2 sextants scaled,TFA,		Marie Roberts, RDH	ML
	OHI	1	Michael W. Masters, MAJ, DC	MM

Figure 5–7. Restorative dentistry and oral hygiene (sample).

(2) *Block 15*: Outline the completed restoration as accurately as possible in black ink in block 15 of SF 603 or SF 603A but do not blacken it in. When the restoration involves either one or both of the proximal surfaces of a posterior tooth, the interproximal embrasures need not be shown on the facial or lingual aspects of the pictured tooth.

(3) *Block 17*: The narrative or tabular entry contains the appropriate abbreviation to indicate the material used. The brand name should be substituted for the abbreviation when the type of material could influence future replacement or repair.

d. Acid etch.

(1) *Abbreviation*: etch.

(2) *Block 15*: No entry.

(3) *Block 17*: When an acid etch technique is used in conjunction with a composite resin it will be recorded as "etch" after the recorded base in block 17 of SF 603 or SF 603A.

e. Bonding agents.

(1) *Abbreviation*: none.

(2) *Block 15*: No entry.

(3) *Block 17*: When a bonding agent other than that provided in the restorative resin kit is used, the brand name will be recorded.

f. Glaze.

(1) *Abbreviation*: glaze.

(2) *Block 15*: No entry.

(3) *Block 17*: When a composite resin is glazed, it will be recorded as "glaze" in block 17 of SF 603 or SF 603A after the type of composite resin placed.

g. Temporary or sedative treatment.

(1) *Abbreviation*: tem rest or TT.

(2) *Block 15*: No entry.

(3) *Block 17*: Placement of materials in this category are entered in block of SF 603 or SF 603A as a pencil entry utilizing the abbreviation "TT" under the tooth being treated with the surfaces of teeth involved in the restoration blackened in pencil. A narrative entry in block 17 is required.

h. Bases and liners:

(1) *Abbreviation*: B.

(2) *Block 15*: No entry.

(3) *Block 17*: The narrative or tabular entry contains the appropriate abbreviation. The brand name may be substituted for the abbreviation. The brand name or generic type of material must be specified when the type of material could influence future prognosis replacement or repair.

i. Pulp caps (direct or indirect).

(1) *Abbreviation*: DPC or IPC.

(2) *Block 15*: No entry.

(3) *Block 17*: The narrative or tabular entry contains the appropriate abbreviation. The brand name of the pulp capping material should be indicated.

j. Varnishes.

(1) *Abbreviation*:

(*a*) Generic varnish: v.

(*b*) Copal varnish: cop.

(2) *Block 15*: No entry.

(3) *Block 17*: The narrative or tabular entry contains the appropriate abbreviation. The brand name may be substituted for the abbreviation when desired.

k. Polishing restorations.

(1) *Abbreviation*: rest pol.

(2) *Block 15*: No entry.

(3) *Block 17*: Enter the tooth number and the fact that the restoration was polished. An entry is not required for restorations polished during the insertion appointment when the polishing procedure is part of the normal insertion process (that is, composite resin restorations). An entry is made if the restoration is polished at a subsequent visit.

5–10. Preventive dentistry (see fig 5–7)

a. Oral prophylaxis.

(1) *Abbreviation*: pro.

(2) *Block 15*: No entry.

(3) *Block 17*: Narrative entry is required. If the prophylaxis paste contains fluoride, the type of fluoride compound should be recorded in the narrative.

b. Topical fluoride application.

(1) *Abbreviation*: TFA.

(2) *Block 15*: No entry.

(3) *Block 17*: Narrative entry is required. Type of fluoride, concentration, and duration of application should be included.

c. Pit and fissure occlusal sealants (PFS).

(1) *Abbreviation*: PFS.

(2) *Block 15*: No entry.

(3) *Block 17*: Narrative entry required. Separate charting of the acid etching procedure for pit and fissure sealants is not required.

5–11. Endodontics (see fig 5–8)

a. Endodontic diagnostic tests: Includes electronic pulp testing, thermal testing, and test cavity.

(1) *Abbreviation*: endo dx test.

(2) *Block 15*: No entry.

(3) *Block 17*: A narrative entry is required to describe the type of test and the results.

b. Access preparation and irrigation.

(1) *Abbreviation*: irrig.

(2) *Block 15*: No entry.

(3) *Block 17*: Any significant comments about the access preparation and a note about irrigation should be included in the narrative entry.

c. Endodontic interim treatment.

(1) *Abbreviation*: endo tx.

(2) *Block 15*: None.

(3) *Block 17*: Narrative entry only. The type of temporary restoration should be noted.

d. Root canal filling.

(1) *Abbreviation*: RCF.

(2) *Block 15*: Outline the canal(s) and blacken to the approximate level of the filled portion.

(3) *Block 17*: Narrative or tabular entry only.

e. Apicoectomy with or without retrofilling.

(1) *Abbreviation*: apico.

(2) *Block 15*: Draw a triangle at the apex of the root involved, with the base of the triangle at the approximate level of the root amputation and

the apex of the triangle pointed away from the crown of the tooth. A retrofill is indicated by a small circle within the triangle in the approximate location of the filled preparation. The circle is blackened in if a metallic material is used and left unfilled if a non-metallic material is used.

(3) *Block 17*: Narrative entry describing the procedure that was accomplished.

f. Apicocurettage.

(1) *Abbreviation*: Apicur.

(2) *Block 15*: No entry.

(3) *Block 17*: A narrative entry will be made to describe the procedure.

g. Bleaching of a discolored tooth.

(1) *Abbreviation*: None.

(2) *Block 15*: No entry.

(3) *Block 17*: A narrative entry describing the procedure is required.

5–12. Periodontics

a. The same symbols described in chapter 3 are used to indicate the post treatment status of the periodontium in block 15. The date the periodontal treatment was completed is entered in the Remarks space of block 15.

b. Narrative entries are required in block 17 for each appointment.

5–13. Fixed prosthodontics (see fig 5–9)

The intermediate steps involved in construction of single cast restoration or a fixed partial denture should be clearly explained in block 17 of SF 603 or SF 603A.

a. Full cast crown, partial veneer crown, or inlay (precious and non-precious).

(1) *Abbreviation*: FCC, PVC or inl.

(2) *Block 15*: All individual cast restorations are outlined on the chart as accurately as possible with PARALLEL HORIZONTAL LINES within the outline.

(3) *Block 17*: A narrative entry describing the restoration, metal type and the cement used is required.

b. Fixed partial dentures.

(1) *Abbreviation*: FPD.

(2) *Block 15*:

(*a*) Outline the restoration showing the line of junction of the different materials. Indicate the metal portion of the restoration using DIAGONAL PARALLEL LINES. Any portion of restoration made of tooth colored material will not be lined through.

(*b*) Draw a HORIZONTAL LINE immediately above the numbers of the teeth replaced by the fixed partial denture. Do not include abutment teeth.

(3) *Block 17*: A narrative entry describing the restoration, metal type and the cement used is required. Specify brand name or generic type of cement used.

c. Post and core.

(1) *Abbreviation*: P&C.

(2) *Block 15*: Outline the approximate diameter, shape, and length of the post and darken it in.

(3) *Block 17*: A narrative entry describing the technique and/or material and cement used for the post is required.

5–14. Removable prosthodontics (see fig 5–9)

a. Removable partial dentures.

(1) *Abbreviation*: RPD.

(2) *Block 15*: Draw a HORIZONTAL line immediately above the numbers of replaced missing teeth. Do not include abutment teeth within the limits of the line.

(3) *Block 17*: These prosthodontic appliances will be identified by a description of the material used in the framework and base(s). The abutment teeth with clasps will be identified and intermediate steps should be explained to include type, shade, and mold of replacement teeth.

b. Complete dentures.

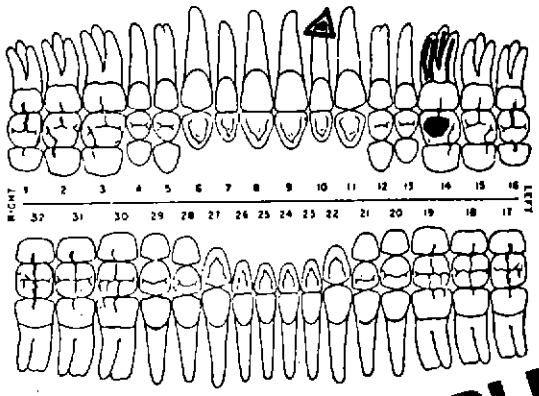
(1) *Abbreviation*: comp dtr.

(2) *Block 15*: Draw a HORIZONTAL line immediately above the numbers of replaced missing teeth.

(3) *Block 17*: These prosthodontic appliances will be identified by a description of the material used in the framework and base(s). Intermediate steps should be explained to include type, shade, and mold of replacement teeth.

SECTION III. ATTENDANCE RECORD

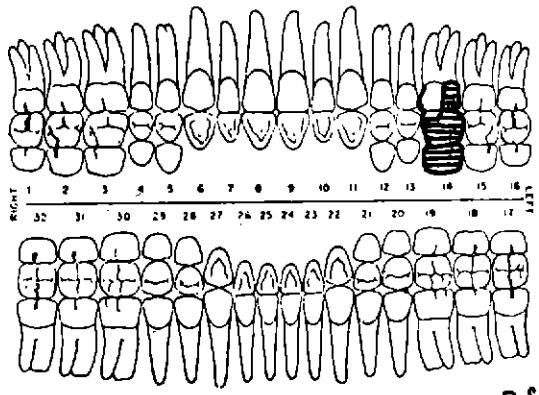
15. RESTORATIONS AND TREATMENTS (*Completed during service*)



REMARKS

SAMPLE

16. SUBSEQUENT DISEASES AND ABNORMALITIES



REMARKS Cl3 - apical surgery #10, 10Nov88 8 Sep 88 ER

Fxd eval

17. SERVICES RENDERED

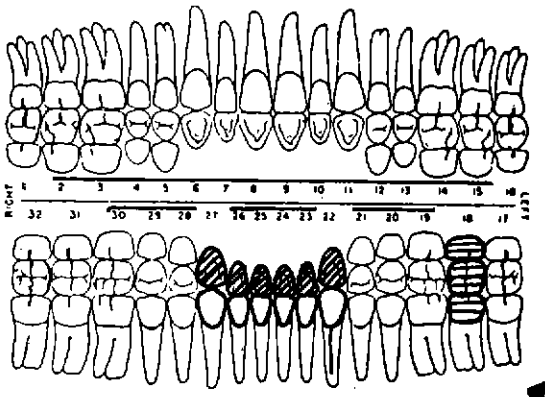
DATE	DIAGNOSIS--TREATMENT	CLASS	OPERATOR AND DENTAL FACILITY	INITIALS
1988			DC #3, Ft. Elsewhere	
4 Sep	Exam (sick call)			
	S: cc pain max L quad			
	D: #14 sensitive to percussion and tests nonvital to electric pulp test.			
	PAX indicates periapical radiolucency			
	A: #14 nonvital pulp, P: RCF			
	Condition and proposed tx explained to pnt, as were alternate means of tx			
	and routine problems encountered. He consents to endo tx.			
	LA (1.8 cc 2% Lidocaine c̄ 1:100,000 epi) top, RD			
	#14 endo access, 4 canals cl & sh			
	MB canal size 25 at 25mm from DB cusp			
	ML canal size 25 at 23mm from DB cusp			
	D canal size 30 at 25mm from MB cusp			
	L canal size 40 at 22mm from MB cusp			
	irrig saline, seal dry cotton pellet c IRM			
	reappt for RCF	3	Elias Root, COL, DC	ER
8 Sep	Endo, RD			
	#14 reopen, irrig, dry, RCF c̄ GP, ZNOE sealer			
	#14-O-cop-am, Recommend FCC	2	Elias Root, COL, DC	ER
10 Nov	Exam (sick call)			
	S: cc discomfort area #10			
	O: RCF 2 y ago, 2 PAX show periapical radiolucency increase in size			
	tooth filled c twist off silver point			
	A: Failed RCF - unable to retreat through crown			
	P: Apico with retrofill. Preop instructions to pnt. He consents to tx.			
	LA (2 X 1.8 cc 2% Lidocaine c̄ 1:100,000 epi) top			
	full thickness flap #8-11. PA lesion #10 curetted, Bx.			
	Retrofill with am. 3BSS, post-op instructions			
	Rx Tylenol #3 X 10. 1 q 3-4 h per pain			
	qrtrs until 0730 h 11 Nov. RTC then	3	Elias Root, COL, DC	ER

Figure 5–8. Endodontics (sample).

HEALTH RECORD | **DENTAL—Continuation**

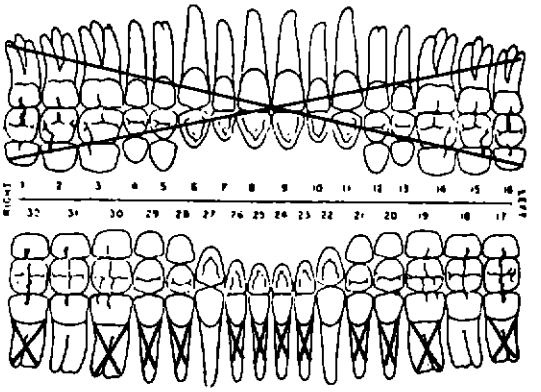
SECTION III. ATTENDANCE RECORD

15. RESTORATIONS AND TREATMENTS (*Completed during service*)



REMARKS

16. SUBSEQUENT DISEASES AND ABNORMALITIES



REMARKS

SAMPLE

17. SERVICES RENDERED

DATE	DIAGNOSIS--TREATMENT	CLASS	OPERATOR AND DENTAL FACILITY	INITIALS
1988			DC #3, Ft. Elsewhere	
4 Jun	Fxd - Cast gold post inserted #22 c̄ ZNOP.			
	#22,27 prep for FPD. Final imprs c̄ polysulfide rubber			
	Tem FPD cemented c̄ Tempbond			
	#18 FCC - cop - ZNOP cement	2	James Narrows, LTC, DC	JN
9 Jun	Rem - final imprs for max comp dtr			
	and mand RPD	2	James Narrows, LTC, DC	JN
15 Jun	Rem - adj wax rims, CJR			
	sh 65 Bio, mold 11D, 20 resin post	2	James Narrows, LTC, DC	JN
20 Jun	Rem - wax tryin/adj			
	mand framework tryin/adj	2	James Narrows, LTC, DC	JN
27 Jun	Fxd			
	#22-27 FPD (Nobellium) adj, stain, glaze			
	- cop - ZNOP	2	James Narrows, LTC, DC	JN
7 Jul	Rem - Max comp dtr, mand RPD adj, ins			
	OHI	2	James Narrows, LTC, DC	JN
14 Jul	Rem/Fxd POT - minor adj area #11-12			
	recall in 6 mos	2	James Narrows, LTC, DC	JN

Figure 5–9. Fixed and removable prosthodontics (sample).

5–15. Oral surgery (see fig 5–10)

a. Tooth removal or extraction (simple, complex, or impacted).

(1) *Abbreviation*: rem or ext.

(2) *Block 15*: Place an X through the roots of the tooth removed.

(3) *Block 17*: A complete narrative entry is required including required informed consent, number and type of sutures placed, prescriptions written, and quarters assignment.

b. Post surgical treatment (post operative treatment).

(1) *Abbreviation*: PST (POT).

(2) *Block 15*: No entry.

(3) *Block 17*: Narrative entry required describing the course of healing, post surgical treatment performed, and disposition.

c. Biopsy.

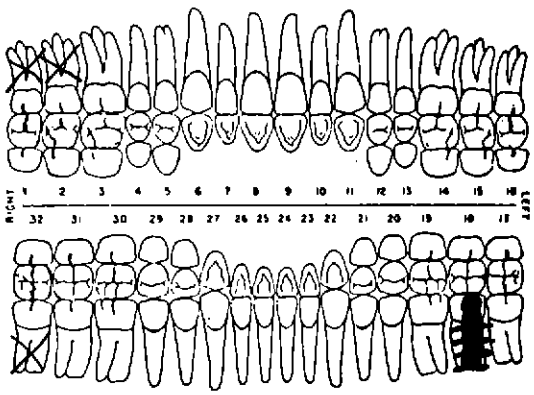
(1) *Abbreviation*: Bx.

(2) *Block 15*: No entry.

(3) *Block 17*: Narrative entries required describing the procedure course of healing, post surgical treatment performed, and disposition. Final diagnosis must also be recorded as well as a note discussing the information presented to the patient following the pathological report.

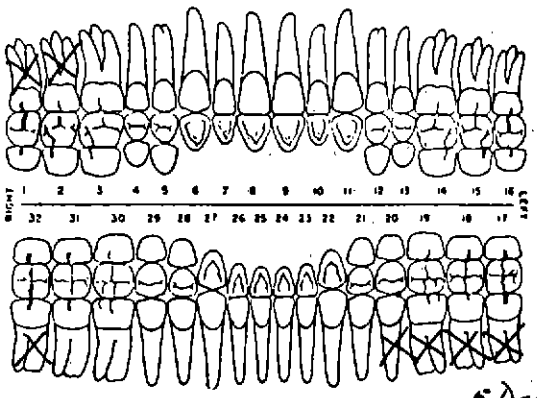
SECTION III. ATTENDANCE RECORD

15. RESTORATIONS AND TREATMENTS (*Completed during service*)



REMARKS

16. SUBSEQUENT DISEASES AND ABNORMALITIES



REMARKS C3 - OS recovery · 1 Dec 88 5 Dec 88 MJ

PERIO/FXD EVAL/FU

SAMPLE

17. SERVICES RENDERED

DATE	DIAGNOSIS--TREATMENT	CLASS	OPERATOR AND DENTAL FACILITY	INITIALS
1988			DC #3, Ft. Elsewhere	
4 Sep	Exam. CC pain max L quad. #2 NRC, #1,32 imp, #32 Pecor. PANX, 2 PAX.			
	Recommend rem #'s 1,2,32. Condition and proposed tx explained to pnt,			
	as were alternate tx and routine problems encountered. Pnt asked			
	questions and given appropriate answers. He consents to procedures.			
	LA (2 x 1.8 cc 2% Lidocaine c̄ 1:100,000 epi) top			
	#1 imp ext			
	#2 NRC ext			
	#32 imp ext, 2BSS postop instructions			
	Rx Tylenol #3 x 15, 1 or 2 q 4 h prn pain.			
	qrtrs until 0730 h 6 Sep. RTC then	3	David O'Neill, LTC, DC	DO
6 Sep	OS POT, benign. Return to duty	2	David O'Neill, LTC, DC	DO
9 Sep	OS POT, su rem, healing well	2	David O'Neill, LTC, DC	DO
12 Sep	OS POT, pnt reports with swelling over R mand angle. Temp 101°			
	LA infiltration (1.8 cc 2% Lidocaine c̄ 1:100,000 epi)			
	I & D with exudate present, C & S, iodoform gauze drain placed			
	Rx Pen VK 500 mg q 6h x 10d.	3	David O'Neill, LTC, DC	DO
14 Sep	OS POT, swelling gone, drn rem, lab results indicate infection is pen			
	sensitive. Pnt afebrile, feels fine	2	David O'Neill, LTC, DC	DO
1 Dec	O.S. operated in OR for placement of Branemark osseointegrated			
	implant in area of #18.			
	Insertion uncomplicated	3	H. Marshall Lewis, LTC, DC	MJ
5 Dec	Pnt discharged from hospital			
	PO course benign			
	Refer to Perio/Fxd Pros team for F/U			
	and restoration.	3	H. Marshall Lewis, LTC, DC	MJ

Figure 5–10. Oral surgery (sample).

d. Incision and drainage.

(1) *Abbreviation*: I&D.

(2) *Block 15*: No entry.

(3) *Block 17*: Narrative entry is required, including a diagnosis or reason for the procedure.

e. Implants.

(1) *Abbreviation*: impl.

(2) *Block 15*: Outline the shape of the implant to the approximate depth of insertion and blacken in the outline.

(3) *Block 17*: Narrative entry is required stating the type of implant, brand name, problems with insertion, and any critical information.

f. All other surgical procedures.

(1) *Abbreviation*: Standard accepted abbreviations.

(2) *Block 15*: No entry except as noted above.

(3) *Block 17*: Narrative entries required describing the informed consent, procedure, course of healing, post surgical treatment performed, and disposition. Long-term hospital treatment need not be fully documented in the SF 603 or SF 603A. Such care must be summarized in the dental health record and any information critical to future management or prognosis must be recorded.

5–16. Inhalation or intravenous sedation or analgesia

a. Information is recorded in block 17 of SF 603 of SF 603A after the information regarding the procedure that was performed.

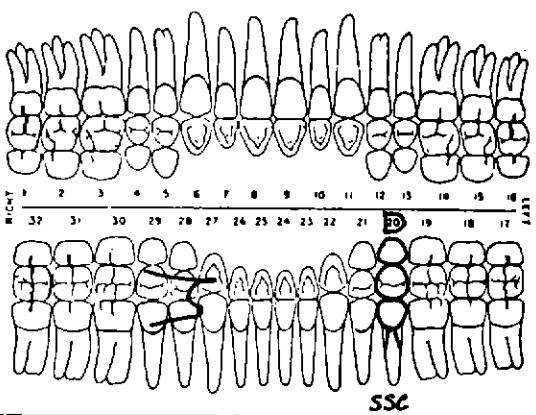
b. Policies for documentation of inhalation sedation or analgesia are under constant review. Refer to current published command guidance for proper forms and techniques for documentation.

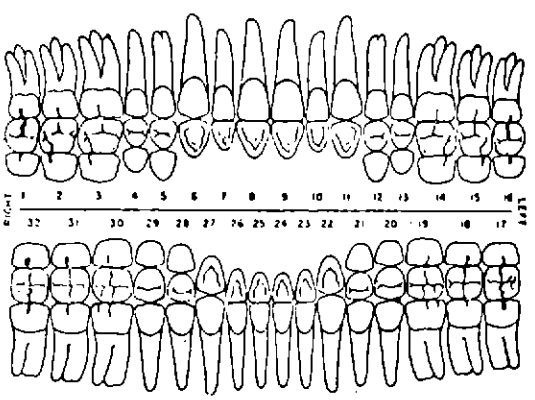
5–17. Pedodontics

With the following exceptions all previously discussed symbols are used to record pedodontic treatment (see fig 5–11).

SECTION III. ATTENDANCE RECORD

15. RESTORATIONS AND TREATMENTS (*Completed during service*) | 16. SUBSEQUENT DISEASES AND ABNORMALITIES





REMARKS | REMARKS

SAMPLE

17. SERVICES RENDERED

DATE	DIAGNOSIS--TREATMENT	CLASS	OPERATOR AND DENTAL FACILITY	INITIALS
1988			DC #3, Ft. Elsewhere	
3 Apr	Oper - LA (1.8 cc 2% Lidocaine c̄ 1:100,000 epi) top			
	RD			
	#20 Dec-car-pulpo with ZNOE, SSC cem c̄ ZNOE			
	#29 Dec-band-loop space maintainer			
	cem c̄ ZNOP		Tim J. Delaney, MAJ, DC	TD

Figure 5–11. Pedodontics (sample).

a. Pulpotomy, deciduous.

(1) *Abbreviation*: pulpo.

(2) *Block 15*: Outline the depth of canal preparation and black in the filled portion.

(3) *Block 17*: Narrative entry required. Type or brand name of filling material must be specified.

b. Stainless steel crown.

(1) *Abbreviation*: SSC.

(2) *Block 15*: Outline the crown in ink and print SSC at the apices of the root(s).

(3)*Block 17*: Standard operative dentistry type of entry required.

c. Space maintainer, simple fixed.

(1) *Abbreviation*: None.

(2) *Block 15*: Draw a black line in the shape of the space maintainer wire (loop) over the tooth space maintained, and any wire occlusal rests as they are positioned on a proximal tooth.

(3) *Block 17*: Narrative entry required.

d. Patient behavior: A notation should be made as necessary related to the behavior of the patient and any behavior management techniques used to control or modify patient actions. These behavior notations should be according to the recognized standardized scale noted below:

(1) = Totally uncooperative.

(2) – Uncooperative but treatable.

(3) + Cooperative but with difficulty.

(4) ++ Totally cooperative.

5–18. Orthodontics

Orthodontic treatment is generally recorded in separate records. Entries required in the SF 603 are the diagnostic findings, initiation of treatment, end of treatment, retention recommendations, pre- and post-treatment TMJ findings, notes regarding patient cooperation, and comments regarding any untoward results or situations which could generate QA issues.

5–19. Aviation dentistry (see fig 5–12)

a. Dental personnel are an integral part of the total healthcare and overall readiness of U.S. Army aviation personnel. Dental officers must ground aviation personnel when appropriate and be aware of proper administration procedures to return aviation personnel to flying duty following dental treatment.

b. AR 40–8 and 40–501, chapters 4 and 8, provide definitive guidance and are supplemented by aviation medicine policy letters and local regulations.

17. SERVICES RENDERED

DATE	DIAGNOSIS--TREATMENT	CLASS	OPERATOR AND DENTAL FACILITY	INITIAL
1988			DC #3, Ft. Elsewhere	
5 Jan	Pnt on Flight Status - pnt has hx of pecor #17, 32 requiring removal.			
	Preop instructions given to pnt and pnt consents to procedure.			
	LA (3 x 1.8 cc 2% Lidocaine c̄ 1:100,000 epi) top			
	#17, 32 imp, surgical rem, 2BSS			
	postop instructions to pnt.			
	Rx Tylenol #3 x 12, 1 or 2 q 4 h prn pain			
	qrtrs until 0730 h 7 Jan. RTC then.			
	pnt grounded with DA Form 4186. Copies to flight surgeon and unit			
	commander.			
	Projected grounding period-10days	3	C. Frets, MAJ, DC	CF
7 Jan	OS POT, pnt doing fine, mild discomfort			
	and edema. RTC in AM for su rem	2	C. Frets, MAJ, DC	CF
8 Jan	OS POT, su rem, healing WNL.			
	Pnt not taking medication. RTC in			
	7 d for F/U	2	C. Frets, MAJ, DC	CF
15 Jan	OS POT, pnt healing well.			
	Consult to flight surgeon recommending			
	return to flying duty.	1	C. Frets, MAJ, DC	CF

SAMPLE

Figure 5–12. Aviation personnel (sample).

CHAPTER 6
APPOINTMENT CONTROL

6–1. General information

Appointment control and documentation of time utilization is increasingly becoming a matter of interest for outside agencies evaluating the efficiency of military dental care delivery. Appointment records are also often involved in QA programs, resource management, and legal issues.

6–2. Recommendations

a. The following recommendations are made to give standard guidance to the field concerning this important topic.

(1) Appointment control will be centralized within clinics to the greatest extent possible. Individual control of personal appointment books is generally less efficient, and causes more disruption to clinical care, than a central system.

(2) In some cases certain parts of a provider's day may yield themselves to centralized control, while others should be controlled by the individual. For example, prosthodontists may elect to allow evaluation appointments to be centrally controlled, while keeping personal control of appointments for tooth preparation and appliance insertion.

(3) With the possible exceptions of examinations and oral hygiene appointments, the use of standard length appointments should be discouraged. The length of an appointment should be tailored to the procedure to be accomplished and the skill of the provider.

(4) A system should be used to allow appointments to be scheduled in multiple blocks of time, each block 10 to 15 minutes in length depending on clinic or provider requirements.

(5) Appointment books should be used which will allow for this kind of flexible appointment scheduling.

b. All dental officers should be offered the opportunity, if experience and capabilities are sufficient, to schedule multiple operatories for patient care.

c. Appointments for which patients do not present themselves should be noted on the appointment book.

d. Each clinic should have a program to fill broken appointment time.

(1) A list of patients who can come to the clinic upon short notice should be maintained in order to provide a pool of patients to fill broken appointments.

(2) Each clinic should also have a program to allow patients to standby for care in case of open appointment time.

(3) Alternate methods of filling broken appointment time are extending care on the patient presently in the chair, treating sick call, performing examinations, or treating standby patients.

APPENDIX A
REFERENCES

Section I. RELATED PUBLICATIONS

AR 40–8
Temporary Flying Restrictions due to Exogenous Factors.
AR 40–15
Medical Warning Tag and Emergency Medical Identification Symbol.
AR 40–35
Preventive Dentistry.
AR 40–66
Quality Assurance Administration.
AR 40–501
Standards of Medical Fitness.
AR 50–5
Nuclear and Chemical Weapons and Material—Nuclear Surety.
AR 600–6
Individual Sick Slip (DD Form 689).
AR 600–20
Army Command Policy.
AR 755–3
Recovery and Utilization of Precious Metals.

Section II. REFERENCED FORMS

DA Form 3365
Authorization for Medical Warning Tag.
DA Form 3444
Terminal Digit File for Treatment Record.
DA Form 3984
Dental Treatment Plan.
DA Form 4515
Personnel Reliability Program Record Identifier.
DA Form 5570
Health Questionnaire for Dental Treatment.
DA Label 162
Emergency Medical Identification Symbol.
DD Form 2005
Privacy Act Statement—Health Care Records.
SF 88
Report of Medical Examination.
SF 513
Medical Record—Consultation Sheet.
SF 519B
Radiologic Consultation Request/Report.
SF 521
Clinical Record—Dental (obsolete).
SF 522
Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures.

SF 603
Health Record—Dental.
SF 603A
Health Record—Dental—Continuation.

APPENDIX B
COMMON DENTAL CORPS ABBREVIATIONS

General

The use of standardized abbreviations is encouraged as long as clarity of the information in the dental record is not compromised. Below is a list of commonly accepted dental abbreviations. This list is not meant to be all inclusive. Any standard Army, medical, or dental abbreviation may be used. If there is any doubt as to the meaning of what needs to be recorded, as in difficult or problem cases, do not abbreviate any more than absolutely necessary. Avoid making up abbreviations for your particular practice since they are not commonly known, can compromise treatment, and cause medicolegal problems.

abrasion	abr
abscess	abs
abutment	abut
acid etch	etch
acrylic	acr
adjust(ed (ment)	adj
alveolar	alv
alveolectomy	alvy
amalgam	am
anesthesia	anes
anterior	ant
apicoectomy	apico
appointment	appt
archwire adjustment	aw adj
acidulated phosphate fluoride	APF
auscultation	ausc
base	b
biopsy	BX
bite-wing x-rays	BWX
Black	Bl
blood pressure	BP
black silk suture	BSS
bridge	br
calculus	cal
Caucasian	Cau
caries (carious)	car
caries preventive treatment	Car Prev TX
carpules	carp
cement	cem
central panograph storage facility	CPSF
cephalometric x ray	ceph
chief complaint	CC
citric acid	cit acid
cleansing and shaping	CL & SH
complete	comp
composite resin	com res
concentration	conc
consultant/consultation	conslt
craniofacial analysis	CFA
crown	cr
culture and sensitivity test	C&S

curettage	cur
deciduous	Dec
defective	def
dental health record	DHR
denture	dtr
diagnosis (diagnostic)	Dx
direct pulp cap	DPC
drain	drn
dressing	drs
duplicate(d)	dup
edentulous	eden
electric pulp test	EPT
extra oral x ray	EX
anteroposterior	EX(AP)
lateral	EX(LAT)
temporomandibular joint	EX(TMJ)
endodontics	endo
equilibration	equil
extraction	ext
eugenol	eug
examination	exam
oral examination	oral exam
other examination	other exam
screening examination	sc exam
facing	fac
family member prefix	FMP
female	F
fixed	fxd
fixed partial denture	FPD
followup	F/U
formocresol	fc
fracture(d)	fx
framework	fmwk
free gingival margin	FGM
frenectomy	frenmy
full mouth x ray	FMX
general(ized)	gen
gingiva(l)	ging
gingivectomy	gtmy
gingivoplasy	gplasy
gingivities	gitis
glass ionomer cement	ion
group oral health counseling	GOHC
gutta-percha	gp
headache	HA
hemorrhage	hemo
history	hx
hard acrylic occlusal splint	HAOS
identification	ID
immediate	imm
impacted	imp
implant	impl
impression	impr
in accordance with	IAW
indirect pulp cap	IPC

incise(d)	inc
incision and drainage	I&D
initial dental examination	Init Den Exam
inlay	inl
inserted	ins
instruction	instr
intermediate restorative material	IRM
intracanal medication	ic med
intravenous	IV
irrigation	Irrig
left	L
local	Local
local anesthesia	LA
localized juvenile periodontitis	LJP
lower lingual arch	LLA
male	M
malocclusion	malocc
mandible(ular)	mand
material	mat
maxilla(ry)	max
medical history	med hx
milliliters	ml
missing	msg
millimeters	mm
mucogingival junction	MGJ
myofacial pain dysfunction	MPD
necrotizing ulcerative gingivitis	NUG
negative	neg
next visit	nv
nitrous oxide	N2O
nonrestorable caries	NRC
number	# or No.
occlusion	occ
operative	oper
oral hygiene	OH
oral hygiene instructions	OHI
oral surgery	OS
orthodontic postoperative instructions	Ortho POT
other	oth
palpation	palp
panographic x rays	PANX
partial	pr
patient	pnt
pedodontic	pedo
periapical	PA
pericornitis	pecor
periodontal	perio
periodontitis	pedon
permanent	perm
pit and fissure occlusal sealant	PFS
plaque and tissue indexes	PTI
porcelain	porc
porcelain fused to metal	PFM
posterior	post
postoperative instructions	POI

postoperative treatment	POT
postsurgical treatment	PST
power chain	pow ch
prepare(d) (ation)	prep
prevention	prev
preventive dentistry counseling	PDC
prognosis	prog
prophylaxis	pro
prosthodontics	pros
(fixed)	fx pros
(removable)	rem pros
pulp capping	pc
pulpitis	pitis
pulpotomy	pulpo
quadrant	quad
quarters	qrtrs
range of motion	ROM
rapid palatal expander	RPE
reappointment	reappt
rebase(d)	reb
recommend	rec
recement(ed)	recem
reconstruct(ed)	recon
reduce(d) (tion)	red
regional	reg
reline	rel
removable	rmbl
removable partial denture	RPD
remove(d)	rem
repair(ed)	rep
replace(d) (ing)	repl
resin	res
restoration	rest
respiration	resp
retained	ret
return to clinic	RTC
right	R
root canal	RC
root canal filling	RCF
root planing	RP
rubber dam	RD
scale(d) (ing)	scal
sedative	sed
sextant	sxt
shade	sh
social security number	SSN
sodium fluoride	NAF
soft vinyl occlusal splint	SVOS
stainless steel crown	SSC
stannous fluoride	SNF
subgingival	subging
supernumerary	spnmry
surface	sur
surgical	surg
suture	su

temperature	Temp
temporomandibular joint	TMJ
temporary	Tem
temporary treatment	TT
thermal pulp test	TPT
toothbrush	TB
tooth surface	
distal	D
facial	F
incisal	I
lingual	L
mesial	M
occlusal	O
topical anesthetic	top
topical fluoride application	TFA
treatment(s)	Tx
unerupted	Uner
unknown	Unk
upper lingual arch	ULA
unservicable	Unsvc
varnish	V
vasoconstrictor	Vasoc
within normal limits	WNL
zinc oxide and eugenol	ZNOE
zinc phosphate cement	ZNOP

APPENDIX C

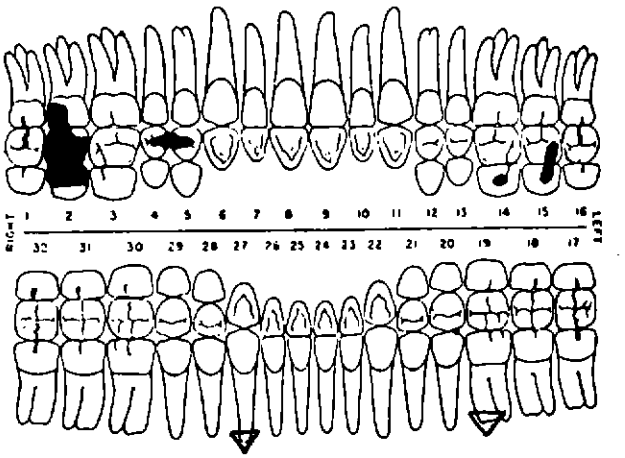
COMMON PHARMACEUTICAL ABBREVIATIONS

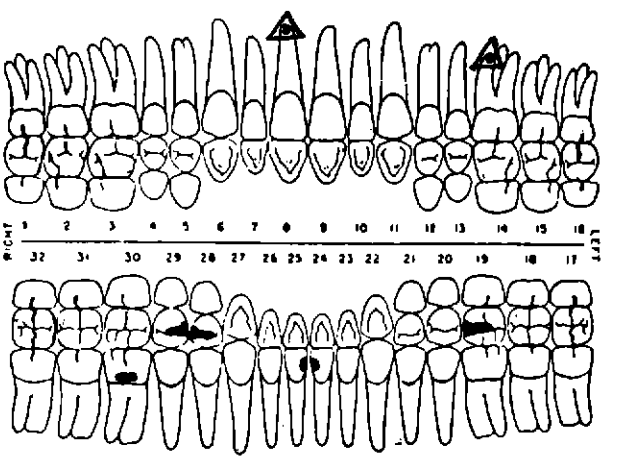
bid	twice daily
CAPS	capsules
Disp	dispense
h	hour(s)
hs	at bedtime
NPO	nothing by mouth
PO	by mouth
PRN	if needed
q	every (i.e. q4h)
qid	four times a day
Tabs	tablets
tid	three times a day

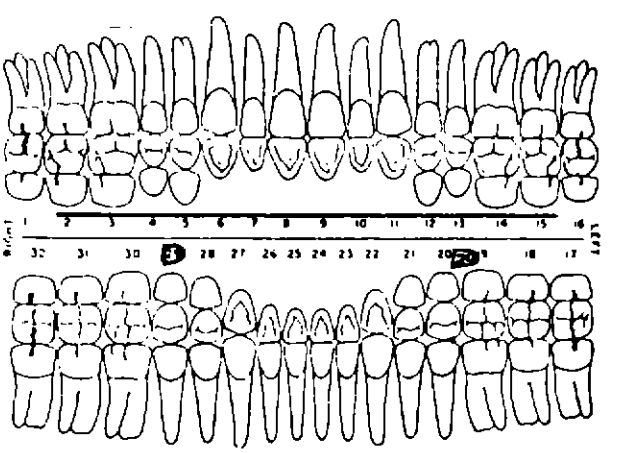
APPENDIX D

QUICK REFERENCE FOR SYMBOLS

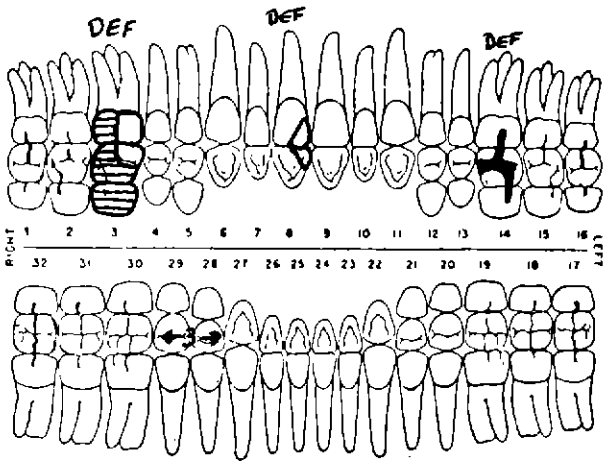
Symbol	Page
Amalgam Restorations	5–3
Apicoectomy	5–6
Apicoectomy with retrofilling	5–6
Caries	4–3
Complete dentures	5–7
Deciduous teeth	4–4

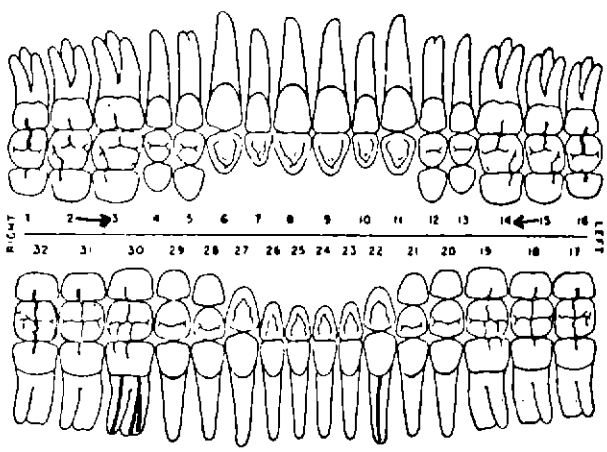


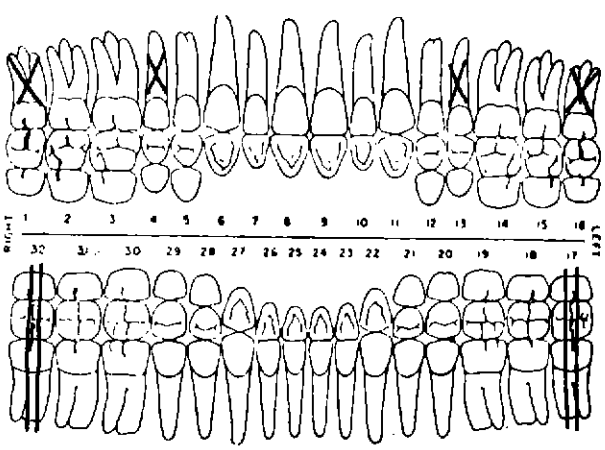




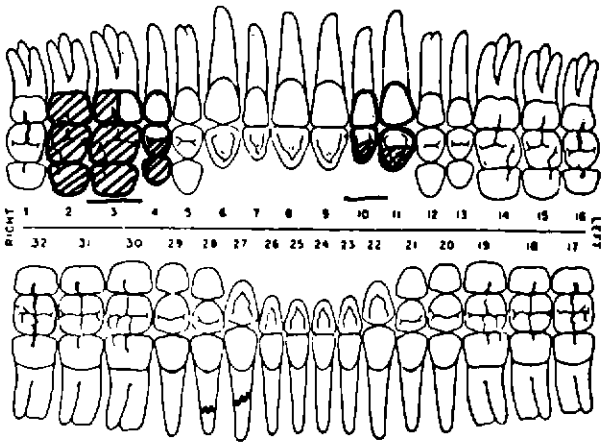
Symbol	Page
Defective restoration	4–3
Diastema	4–4
Drifted tooth	4–5
Endodontic treatment indicated	4–5
Extracted teeth	4–5
Extraction indicated	4–5

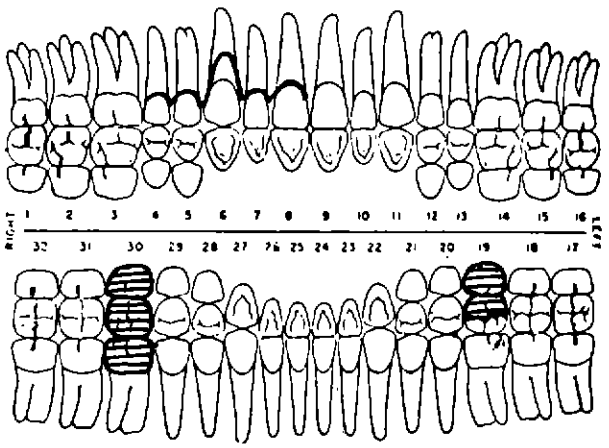


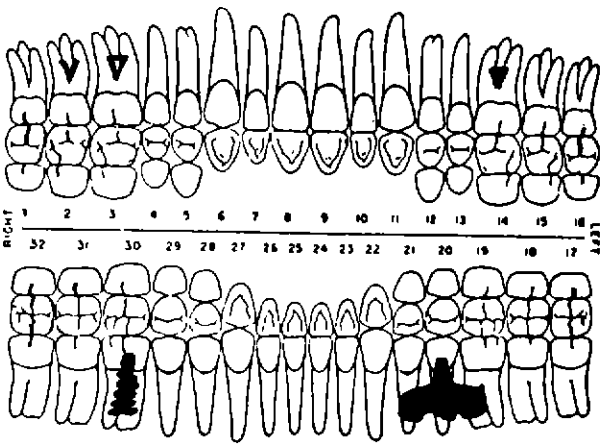




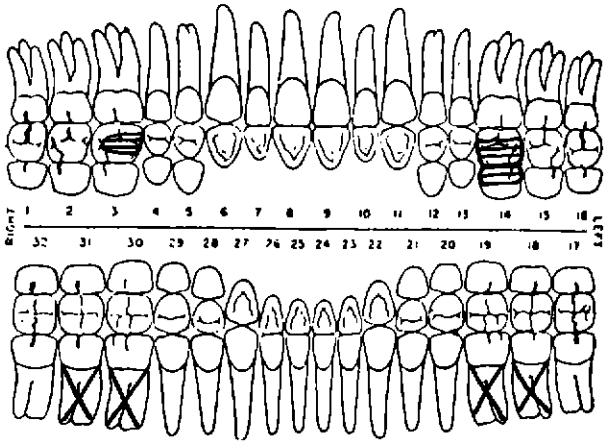
Symbol	Page
Fixed partial dentures with porcelain/veneer facing	5–7
Fractured tooth or root	4–5
Free gingival margin	4–6
Full cast crown	5–7
Furcation involvement	4–6
Implants	5–11

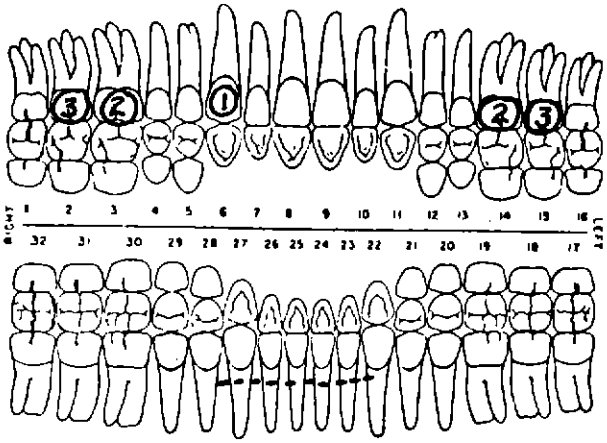


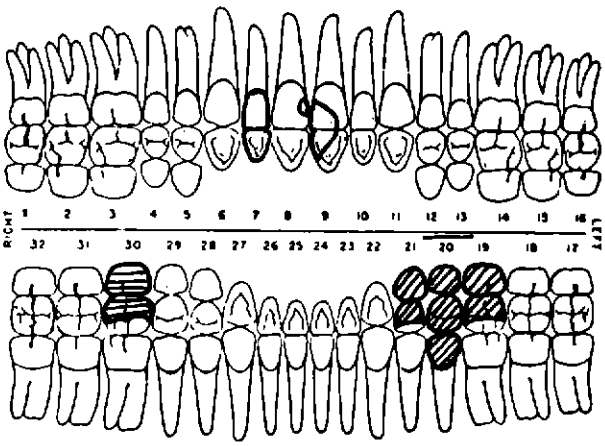




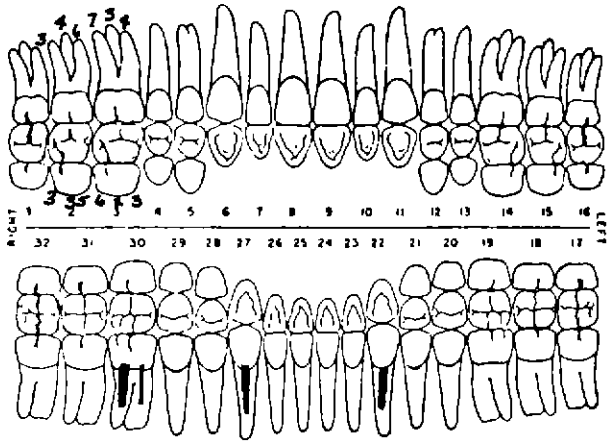
Symbol	Page
Inlay	5–7
Missing teeth	4–5
Mobility	4–6
Mucogingival junction	4–6
Non-metallic permanent restorations	5–3
Partial veneer crown	5–7

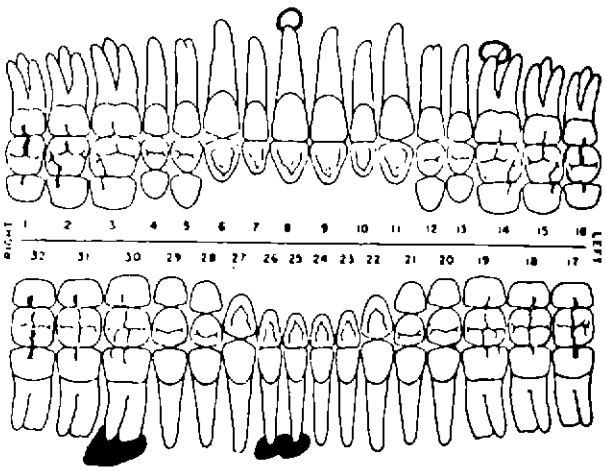


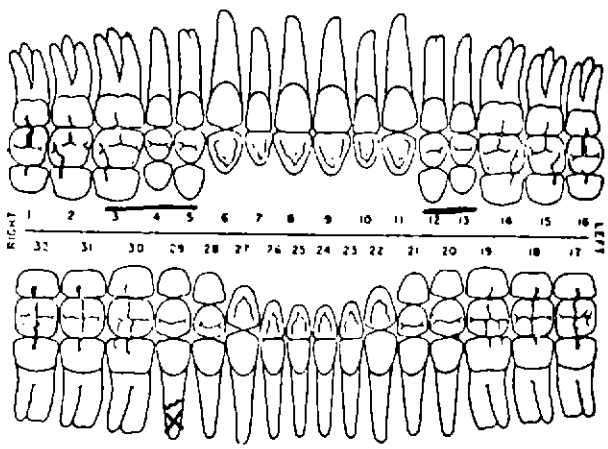




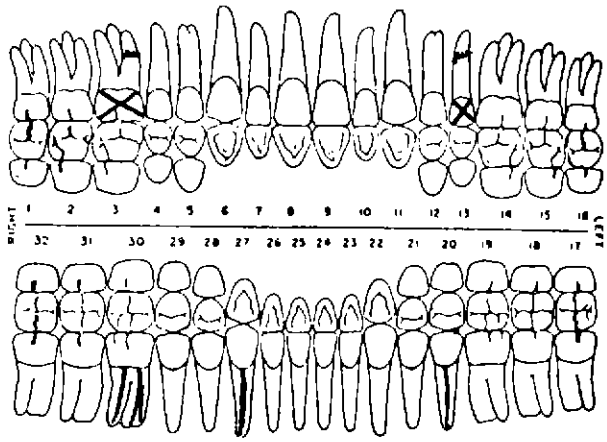
Symbol	Page
Periodontal pocket charting	4–6
Post and core	5–7
Radiolucent lesions	4–5
Radiopaque lesions	4–5
Removable partial dentures	5–7
Resorption of root	4–5

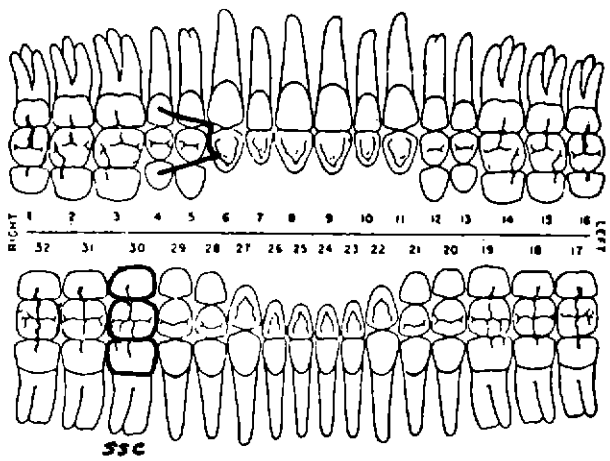


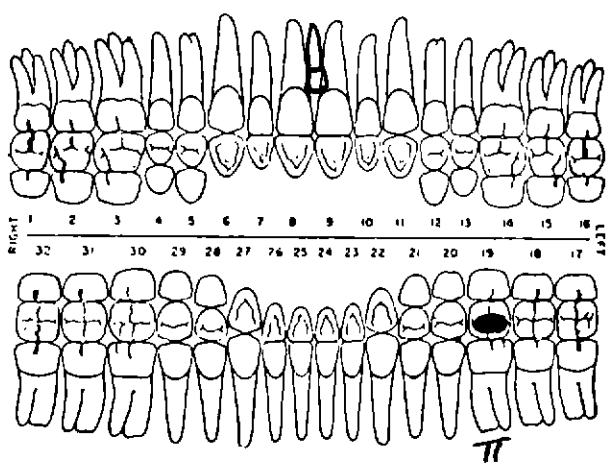




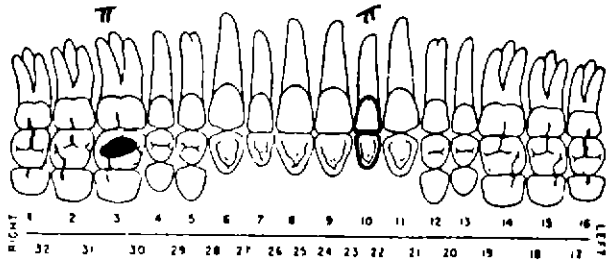
Symbol	Page
Retained root	4–5
Root canal filling	5–6
Space maintainer, simple fixed	5–12
Stainless steel crown	5–12
Supernumerary teeth	4–4
Temporary or sedative treatment	5–6

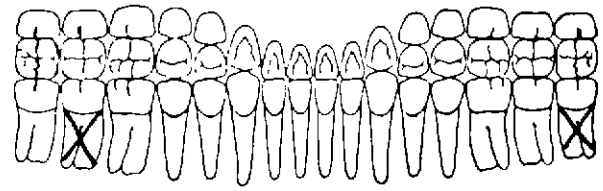


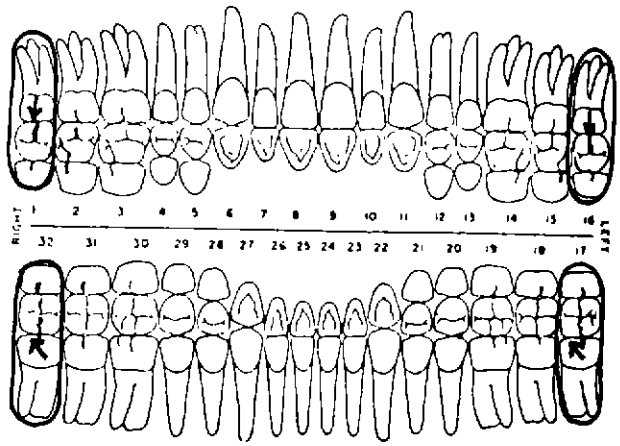




Symbol	Page
Temporary restoration	4–4
Tooth removal or extraction	5–9
Unerupted or impacted teeth	4–5







GLOSSARY

Section I. ABBREVIATIONS

A (in SOAP)
  appraisal
ARNG
  Army National Guard
CAPMI
  computer assisted postmortum identification
CDA
  Certified Dental Assistant
CPSF
  Central Panograph Storage Facility
DA
  Department of the Army
DC
  Dental Corps
DD
  Department of Defense
DDM
  Doctor of Dental Medicine
DDS
  Doctor of Dental Surgery
DEERS
  Defense Enrollment/Eligibility Reporting System
dent asst
  dental assistant
DEROS
  date eligible to return from overseas
DH
  dental hygienist
DOD
  Department of Defense
DTA
  dental therapy assistant
ETS
  expiration term of service
FMP
  family member prefix
ID
  identification
mm
  millimeter(s)
NOAA
  National Oceanic and Atmospheric Administration
O (in SOAP)
  objective findings
P (in SOAP)
  plan
PCS
  permanent change of station

PDS
preventive dentistry specialist
PHS
Public Health Service
POR
preparation of replacements for oversea movement
PRP
Personnel Reliability Program
QA
quality assurance
REFRAD
relief from active duty
REFRADT
relief from active duty for training
RDH
Registered Dental Hygienist
RET
retire
ROTC
Reserve Officers' Training Corps
S (in SOAP)
subjective findings
SF
standard form
SSN
social security number
TDFS
Terminal Digit Filing System
USAF
U.S. Air Force
USAFA
U.S. Air Force Academy Cadet
USAR
U.S. Army Reserve
USCG
U.S. Coast Guard
USMA
U.S. Military Academy Cadet
USMC
U.S. Marine Corps
USN
U.S. Navy
USNA
U.S. Navy Academy Midshipman

Section II. TERMS

Dental health record

A properly marked DA Form 3444 and all enclosed forms and radiographs. It must contain, as a minimum, SF 603 with Section II completed and a properly identified panographic radiograph of diagnostic quality. In situations where a record is made and it is impossible to include a panograph, Section I, part 4, must be completed. A panograph must be added to the record at the earliest convenience.

Duplicate identification panographic radiograph

All soldiers are required to have a duplicate panograph on file. The duplicate panograph will be forwarded, per current directives, to the CPSF and held there as a backup source of forensic identification dental

information. A new duplicate will be submitted for storage only when, in the opinion of the treating dentist, a new panograph is required for diagnostic purposes and enough change to the dentition has been caused by restorative, prosthodontic, orthodontic, or oral surgical procedures, or trauma, to make a new panograph a requirement for identification purposes. The dental health record will be checked for the completion and filing of the duplicate panograph at each record audit, and during inprocessing and outprocessing of the dental record.

Dental screening examination

A dental screening examination is a survey of the oral cavity to detect gross pathological conditions and identify patients requiring early treatment of potential emergency conditions.

Initial dental processing

Initial dental processing consists of—

a. Exposing and developing an original and duplicate panographic radiograph, and

b. A dental screening examination.

Initial dental examination

The initial dental examination is performed after the initial dental processing at a time when definitive care is contemplated, or as part of the Dental Fitness Program.

Computer assisted postmortem identification (CAPMI)

The CAPMI is a computer program that uses an electronic dental profile of an individual to rapidly sort for possible identification matches in the event of mass casualty situations. It relies on accurate dental examination data to improve both the speed and accuracy of the forensic identification process.

By Order of the Secretary of the Army:

CARL E. VUONO
General, United States Army
Chief of Staff

Official:
WILLIAM J. MEEHAN II
Brigadier General, United States Army
The Adjutant General

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