INSTRUCTIONS
DD FORM X678-2 TEST, DENTAL HEALTH INFORMATION

(This User Guide provides clarifying descriptions and notes on the DD Form X678-2 TEST, Dental Health Information.)

GENERAL

The DD Form X678-2 TEST, Dental Health Summary, documents dependent (“patient”) dental health in preparation for a move to a location where the patient may have limited access to dental care. It is not intended to address the patient’s comprehensive dental needs.

One (1) form is completed for each dependent. This form is completed and signed by a dentist prior to the Family Member Travel Screening (FMTS) face-to-face interview¬.

NOTE: BLOCK 5 determines Service Affiliation and requirements for this form. Dependent requirements for completion of this form are as follows:

For Airmen: This form must be completed if the dependent is two (2) years of age and older.

For Soldier, Sailors, and Marines: This form must be completed if the dependent is six (6) months of age and older.

PART A: PATIENT INFORMATION

Completed by the dependent at age of majority or parent / guardian.

BLOCKS 1-3: Provides patient information.

BLOCKS 4-6: Provides Sponsor information.

NOTE: The Sponsor is usually the active duty Service member.

PART B: DENTAL EXAMINATION

Completed by a dentist.

BLOCK 7a-b: Indicates if a radiograph has been completed for the patient.

NOTE: A radiograph is considered current if it was taken within the last twelve (12) months.

DENTAL EXAMINATION RESULTS

The dentist records the patient’s dental health. The suggested minimum for this examination is a clinical examination with mirror and probe and bite-wing radiographs.

NOTE: If box (1) or (2) is checked “YES”, there are NO dental needs that require coordination with the gaining FMTS Office. If box(es) (3) and / or (4) is checked “YES”, there ARE dental needs that require this form to be sent forward to the gaining FMTS Office, and the DD Form X678 TEST, Screening Verification, PART C BLOCK 18d must be checked.

BLOCK 8: If box(es) (3) and / or (4) is checked “YES”, the dentist should identify or briefly describe the condition(s), and include recommended treatment(s).

BLOCKS 9-13: Provides dentist information and the date the form is signed.

NOTE: The Appointed FMTS Medical Screener reviews the DD Form X678-2 TEST, Dental Health Information, during the screening to determine if there are dental needs that require coordination with the gaining FMTS Office. The Appointed FMTS Medical Screener annotates the DD Form X678-1 TEST, Medical and Educational Information, PART E BLOCK 31e and indicates any identified needs on the DD Form X678 TEST, Screening Verification, PART C BLOCK 18d.

DENTAL HEALTH INFORMATION FAMILY MEMBER TRAVEL SCREENING *(Completed by a dentist. For a dependent of an Air Force Sponsor, complete this form if the dependent is two (2) years of age and older. For a dependent of an Army, Navy, or Marine Corps Sponsor, complete this form if the dependent is six (6) months of age and older. One (1) form per dependent.)*	OMB No. OMB approval expires

The public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, iincluding suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Directives Division, 4800 Mark Center Drive, Alexandria, VA 22350-3100 (07XX-XXXX). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. **PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THIS ADDRESS. RETURN FORM AS DIRECTED BELOW.**

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136; 20 U.S.C. 927; DoDI 1315.19: DoDI 1342.12; and E.O. 9397 (SSN) as amended.

PRINCIPAL PURPOSE(S): Information will be used by DoD Personnel to document the dental needs of dependents. This information will enable Military Assignment Personnel to match the special needs of dependents against the availability of services. The personally identifiable information collected on this form is covered by a number of system of records notices (SORNs) pertaining to Official Military Personnel Files, Exceptional Family Member Program (EFMP). The SORNs may be found at http://dpcld.defense.gov/Privacy/SORNsIndex .

ROUTINE USE(S): The DoD "Blanket Routine Uses" found at http://dpcld.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx apply.

PART A: PATIENT INFORMATION

(Completed by dependent at age of majority or parent/guardian.)

1. PATIENT NAME *(LAST, FIRST, MI)*	2. BIRTHDATE *(YYYY/MM/DD)*	3. AGE
4. SPONSOR NAME *(LAST, FIRST, MI)*	5. SERVICE AFFILIATION	6. SPONSOR LAST 4 SSN

PART B: DENTAL EXAMINATION

(Completed by a dentist.)

(The patient you are examining is a dependent of a DoD employee or a member of the US Armed Forces who may be assigned to a location with limited dental support. The suggested minimum for this examination is a clinical examination with mirror and probe and bite-wing radiographs. Check the box(es) below that correspond to the dental health of the patient.)	CHECK YES	CHECK NO
7. Has a radiograph been completed? *(NOTE: Radiographs are considered current if taken within the last twelve (12) months.)* a. If "YES", indicate the date the radiograph was taken *(YYYY/MM/DD)* __________________________	☐	☐
b. If "NO", explain:		

DENTAL EXAMINATION RESULTS

D R A F T

Does the patient have:	YES	NO
(1) Good dental health (not expected to require dental treatment or reevaluation for twelve (12) months)?	☐	☐
(2) Oral conditions that are not expected to result in dental emergencies within twelve (12) months if not treated (e.g., requires prophylaxis, asymptomatic caries with minimal extension into dentin, edentulous areas not requiring immediate prosthetic treatment, etc.)?	☐	☐
(3) Oral conditions that are expected to result in dental emergencies within twelve (12) months if not treated? *(If "YES", "X" the applicable box below, and specify the condition in the space provided in BLOCK 8.)*	☐	☐
a. **Infections:** Acute oral infections; pulpal or periapical pathology; chronic oral infections; or other pathologic lesions and lesions requiring biopsy or awaiting biopsy report.	☐	☐
b. **Caries/Restorations:** Dental caries or fractures with moderate or advanced extension into dentin; baby bottle tooth decay/early childhood caries; defective restorations or temporary restorations that patients cannot maintain for twelve (12) months.	☐	☐
c. **Missing Teeth:** Edentulous areas requiring immediate prosthodontic treatment for adequate mastication, communications, or acceptable esthetics.	☐	☐
d. **Periodontal Conditions:** Acute gingivitis or pericoronitis; active moderate to advanced periodontitis; periodontal abscess; progressive mucogingival conditions; moderate to heavy subgingival calculus; or periodontal manifestations of systemic disease or hormonal disturbances.	☐	☐
e. **Oral Surgery:** Unerupted, partially erupted, or malposed teeth with historical clinical or radiographic signs, or symptoms of pathosis that are recommended for removal.	☐	☐
f. **Other:** Temporamandibular disorders or myofascial pain dysfunction requiring active treatment.	☐	☐
(4) Active orthodontics treatment?	☐	☐

8. COMMENTS *(If you selected YES for (3) and/or (4) above, circle the condition(s) or briefly describe the condition(s). Include recommended treatment(s) here. Attach additional documentation as needed.)*

9. PRACTICE/GROUP NAME		10. OFFICE PHONE
11. EXAMINING DENTIST NAME *(LAST, FIRST, MI)*	12. EXAMINING DENTIST SIGNATURE	13. DATE *(YYYY/MM/DD)*

APPOINTED FMTS MEDICAL SCREENER USE ONLY

The losing Appointed FMTS Medical Screener reviews this form for any dental needs that require coordination. Annotate the DD Form X67Ì ËÁ/ÒÙV Medical and Òå˘ &æ[} æÁnformation BLOCK 31e. If (3) and/or (4) on this form are checked "YES", annotate the DD Form X678 VÒÙV Screening Verification PART C BLOCK 18d æ) åÁ[¦¸ æ åÁ@ÁÖÖÁForm X6Ï Ì ËGÁ/ÒÙV to the gaining FMTS Office.