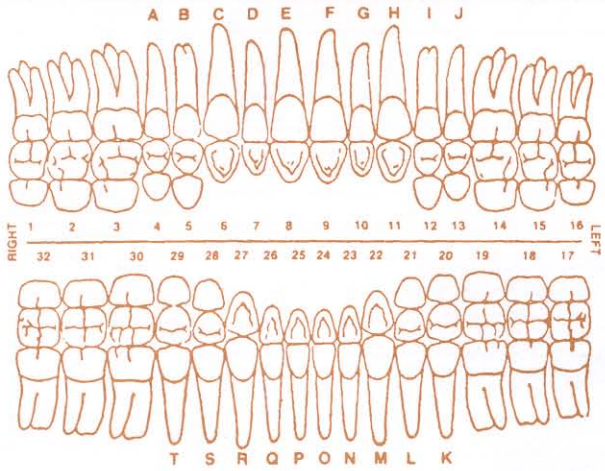
HEALTH RECORD | **DENTAL – Continuation**

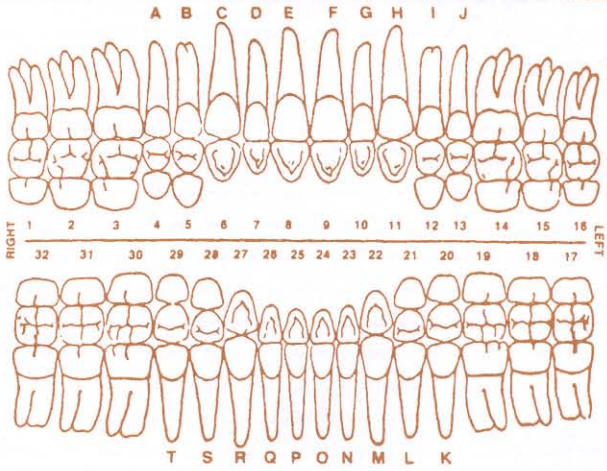
SECTION II. CHRONOLOGICAL RECORD OF DENTAL CARE PAGE:

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



REMARKS

9. SUBSEQUENT DISEASES AND ABNORMALITIES



REMARKS

10. SERVICES PROVIDED

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, PROVIDER, TREATMENT FACILITY *(Sign each entry)*	CLASS

PERIODIC ORAL EVALUATION

BP_____/_____

BWX____ PAX____ PANX____

SOFT TISSUE WNL : Yes / No

CARIES RISK: Low Mod High

TOBACCO: No Smoke Chew Both

PSR

PATIENT'S IDENTIFICATION *(Use this Space for Mechanical Imprint)*

PATIENT'S NAME *(Last, First, Middle Initial)*			SEX
DATE OF BIRTH	RELATIONSHIP TO SPONSOR	COMPONENT/STATUS	DEPART/SERVICE
SPONSOR'S NAME			RANK/GRADE
SSN OR IDENTIFICATION NO.		ORGANIZATION	

EXCEPTION TO SF 603A
APPROVED BY GSA/IRMS 1-91