1. LAST NAME, FIRST NAME, MIDDLE INITIAL

2. REGISTER No. | 3. ARMY SERIAL No. | 4. GRADE

5. ORGANIZATION AND ARM OR SERVICE

6. AGE | 7. RACE | 8. LENGTH OF SERV. | 9. DATE OF ADM.

10. SOURCE OF ADMISSION*

*Required only when stencil procedure is used.

REGISTER OF DENTAL PATIENTS

11. DISEASE OR INJURY WITH LOCATION, COMPLICATIONS, SEQUELAE, ETC.

12. DATES AND NATURE OF TREATMENTS AND OPERATIONS

13. RESULTS AND REMARKS

SIGNATURE OF DENTAL OFFICER

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REPORT OF DENTAL SURVEY

UPPER TEETH*

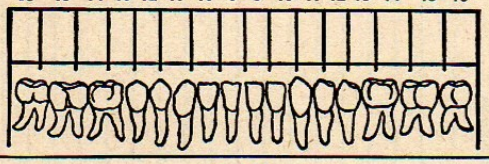
RIGHT LEFT

8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8

LOWER TEETH*

RIGHT LEFT

16 15 14 13 12 11 10 9 9 10 11 12 13 14 15 16



CLASS

OCCLUSION

PERIODONTOCLASIA

DENTAL FOCI SUSPECTED ☐ YES ☐ NO

OTHER CONDITIONS

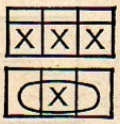
CALCULUS: SLIGHT, MEDIUM, HEAVY

DATE | SIGNATURE OF DENTAL OFFICER

* RESTORABLE CARIOUS TEETH BY O
NONRESTORABLE CARIOUS TEETH BY /
MISSING NATURAL TEETH BY X

TEETH REPLACED BY DENTURE
(Horizontal line)

TEETH REPLACED BY FIXED BRIDGE
(Oval to include abutments)



WD AGO FORM 15 MAR 1945 **8-116**

This form supersedes WD AGO Form 8-116, 31 May 1944 (formerly WD MD Form 79) which will not be used upon receipt of this revision.

16—20622-2 ☆ GPO