How to submit dental form 2813 from a phone

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1. SERV	/ICE MEMBER'S NAME (Last, F	irst, Middle Initial)	2. SOCIAL SECURITY NUMBER	3. BRANCH OF SI	ERVICE
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6. EXAN Dear Do The in of his/her examinat	IINATION RESULTS botor, dividual you are examining is an. r dental health for worldwide duty ion with mirror and probe, and bi rebensive dented nearbother.	Active Duty/Guard/ . Please mark (X) t lewing radiographs	Reserve/Civilian member of the United he block that best describes the cond determine fitness for prolonged do	I States Armed Forces. Ti lition of the member, usin uty without ready access	his member needs your assessmer g as a suggested minimum a clinic s to dental care and is <u>not intend</u>
to comp	 Patient has good oral health a 	nd is not expected	to require dental treatment or reevalua	ation for 12 months	
(Patient has some oral condition rophylaxis, asymptomatic caries 	ns, but you do not with minimal extens	expect these conditions to result in de ion into dentin, edentulous areas not	ental emergencies within 1 requiring immediate prost	2 months if not treated (i.e., require hetic treatment).
(E	 Patient has oral conditions that xamples of such conditions are 	t you do expect to	result in dental emergencies within 12	months if not treated.	
	(a) Infections: Acute oral	infections, pulpal or	periapical pathology, chronic oral infe	ections, or other pathologi	clesions and lesions requiring biops
	(b) Caries/Restorations:	Dental caries or fra	ctures with moderate or advanced ext	ension into dentin; defecti	ve restorations or temporary
	(c) Missing Teeth: Edenti	lous areas requirin	g immediate prosthodontic treatment	for adequate mastication,	communication, or acceptable
	(d) Periodontal Condition	s: Acute gingivitis	or pericoronitis, active moderate to ad	vanced periodontitis,perio	dontal abscess, progressive
	(e) Oral Surgery: Unerup	ed, partially erupted	ibgingival calculus, or periodontal mar d, or malposed teeth with historical, cli	nifestations of systemic dis inical, or radiographic sign	sease or hormonal disturbances. Is or symptoms of pathosis that are
	(f) Other: Temporomandit	ular disorders or m	vofascial pain dysfunction requiring ad	clive treatment.	
(4) If you	u selected Block (3) above, pleas	e indicate the condi	tion(s) you identified in this patient if the	hey appear above, or brie	fly describe the condition(s) below:
		1 1 1 1	VED DATE V DATING THE	0000000	-
	re X-rays consulted?	IF	YES, DATE X-RAY WAS TAKEN (Y	YYYMMDD)	
(5) Wei			DENTISTIC TEL EQUINE NUMBER	(Include Area Code)	
(5) Wei	IST'S NAME (Last, First, Middle	Initial) 8	DENTIST'S TELEPHONE NUMBER	(include roled code)	
(5) Wer 7. DENT	IST'S NAME (Last, First, Middle	NUMBER 1	D. DATE OF EXAMINATION (YYYYM	IMDD)	

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Ar Force: FO44 AF SG E, Medical Record System, http://dp.dd.ddmma.pl DISCLOSURE: Voluntary, However, failure to provide the information re elegioment. 1. SERVICE MEMBER'S NAME (<i>Last, First, Middle Initial)</i> 4. UNIT OF ASSIGNMENT 6. EXAMINATION RESULTS Dear Doctor, The individual you are examining is an Active Duty/GuardRes of his/her dental health for worldwide duty, Please mark (X) the comprohensive dental media. (1) Patient has good oral health and is not expected to re- propylydax, sarynotamic carles with minima extension (3) Patient has good and lendith and is not expected to re- actionary and the formation of the same extension. But you do not expec- propylydax, sarynotamic carles with minima extension (3) Patient has good oral infections, but you do expect to re- st Examples of such conditions that you do expect to re- bamples of such conditions that you do expect to re- tion of the same conditions that you do expect to re- bamples of such conditions that you do expect to re- tion of the same conditions that you do expect to re- care availing biopsy report. (3) Patient has cold conditions: Acute oral infections, Joughal or per or availing biopsy report. (4) Profedontal Conditions: Acute graphitis or pro- mucoging/aul condition, moderate to heavy subgi- (0) Oral Surgery: Unergueted, patielly expected. (5) Were X-rays consulted? 7. DENTIST'S NAME (Last, First, Middle Initial) 8. DI 9. DENTIST'S SIGNATURE'S LICENSE NUMBER 10. D	SuffmanySORMstandex/DOCWsteels SORM-Andex/Server/Index/Server/Index/Server/Index/Server/Index/Sormalitary service and/or for possible assed may result in delays in assessing your dental headth needs for military service and/or for possible assessment and the sort of the United States Armed Forces. This member needs your assessment block that best describes the condition of the member, using as a suggested main run a clinical termine fitness for prolonged duty without ready access to dental care and is not intended equire dental treatment or reevaluation for 12 months beet these conditions to reault in dental emergencies within 12 months if not treated (i.e., requires indicate prosthetic treatment). If in dental emergencies within 12 months if not treated (i.e., requires indicate prosthetic treatment). If a dental emergencies within 12 months if not treated (i.e., requires indicate prosthetic treatment). If in dental emergencies within 12 months if not treated (i.e., requires indicate prosthetic treatment). If a dental emergencies within 12 months if not treated (i.e., requires indicate and the pace provided) respect heat pace provided respect to advanced extension into dentin, defective restorations or temporary months. If in dental, enterprints of systemic disease or hormonal disturbances. If malposed testive with historical, clinical, or radiographic signs or symptoms of pathosis that are reacial pain dysfunction requiring active treatment. If you identified in this patient if they appear above, or briefly describe the condition(s) below: IS, DATE X-RAY WAS TAKEN (YYYYMMDD) ENTIST'S TELEPHONE NUMBER (include Area Code) TATE OF EXAMINATION (YYYYMMDD)

Enter an email address you wish to send the form to. (For example, your dentist)



Once your dentist fills out the form, you have a few courses of actions (COAs)

- COA 1 Hand deliver the form to medical or your unit health monitor
- COA 2 Email the form to medial <u>usaf.mo.139-</u> <u>aw.mbx.medical-helpdesk@mail.mil</u> or your unit health monitor
 - COA 2A scan the form and email it
 - COA 2B take a picture of the form and email it
- COA 3 Fax to medical @ 816-236-3564