**DENTAL RECORD VERIFICATION FORM**

**This following requested information is provided (print neatly in black or blue pen):**

**FULL NAME OF INDIVIDUAL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME OF CIVILIAN DENTIST \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**LOCATION (ADDRESS) OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DENTIST**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PHONE NUMBER OF DENTIST \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**“I acknowledge that the above named civilian dentist has dental records on file on myself sufficient to aid in forensic identification which contain either one, or a combination of the following:**

**Descriptive profiles**

**Bite wing x-rays**

**Orthodontic profiles**

**Dental x-rays**

**I understand this information is required for all participants in the Army ROTC program who use government-owned or government-contracted transportation.”**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **(SIGNATURE) (DATE SIGNED)**