

**USER INFORMATION PACKAGE FOR THE  
INDIAN HEALTH SERVICE DENTAL  
EXAMINATION RECORD, FORM IHS 42-1  
PAGE 1 AND PAGE 2**

**(FOR RELEASE JULY 1, 1993)**

**DISTRIBUTED BY  
THE INDIAN HEALTH SERVICE (IHS)  
DENTAL FIELD SUPPORT & PROGRAM DEVELOPMENT  
SECTION**

**300 SAN MATEO NE, SUITE 600**

**ALBUQUERQUE, NM 87108**

# APPENDIX A.1

## DENTAL EXAMINATION RECORD

IHS 42-1, Page 1 (Rev. 9-92)

### PART III. ORAL DIAGNOSIS

Denture Possession:

Upper \_\_\_\_\_

Lower \_\_\_\_\_

A	B	C	D	E	F	G	H	I	J
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

T	S	R	Q	P	O	N	M	L	K
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Periodontal Diagnosis: \_\_\_\_\_

CPITN Scores:

Date	Date	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

X-rays Reviewed: \_\_\_\_\_

Enamel Defects: \_\_\_\_\_

Soft Tissue/TMJ: \_\_\_\_\_

Orthodontics:  No Need  Tx. in Progress  Completed

Therapy or Eval. Needed: \_\_\_\_\_

### PART V. TREATMENT PLAN

---



---



---



---



---



---



---



---

Referral/Followup: \_\_\_\_\_ Interval: \_\_\_\_\_

This treatment plan has been explained and I accept it.

Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Dentist \_\_\_\_\_ Date \_\_\_\_\_

### IV. PREVENTION ASSESSMENT

Status of:

Water Fluoride \_\_\_\_\_ ppm

Use of Fluoride Toothpaste \_\_\_\_\_

Other Fluoride Supplements \_\_\_\_\_

Oral Hygiene \_\_\_\_\_

Tobacco Use \_\_\_\_\_

Need for:

Topical Fluoride \_\_\_\_\_

Fluoride Tablets/Drops \_\_\_\_\_

Sealants \_\_\_\_\_

Hygiene Instruction \_\_\_\_\_

Other Education \_\_\_\_\_

Target Group: \_\_\_\_\_

### VI. DEFERRED DENTAL NEEDS

Basic Care (Level I - III Svcs) \_\_\_\_\_

Anterior/Bicuspid Endo \_\_\_\_\_ / \_\_\_\_\_

Molar Endodontics \_\_\_\_\_

Perio Pocket Therapy \_\_\_\_\_

Crowns/Complex Restor. \_\_\_\_\_ / \_\_\_\_\_

Removable Dentures \_\_\_\_\_ / \_\_\_\_\_

Fixed Bridge: Ant. \_\_\_\_\_ Post. \_\_\_\_\_

Surgery: 3rd Molars \_\_\_\_\_ Other \_\_\_\_\_

Ortho: Limited \_\_\_\_\_ Comp \_\_\_\_\_

### PART I. DEMOGRAPHICS

HRN	SSN
NAME	TRIC
B DATE	SEX
RESIDENCE	DATE
FACILITY	

### PART II. MEDICAL ALERT/UPDATE

---



---



---



---



---



---



---



---



**PATIENT CONSENT FOR ORAL SURGERY**  
**EXPLANATION OF RISKS AND TREATMENT ALTERNATIVES**

THIS FORM XXX (1993)

Surgical Procedure: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Possible complications that have been explained to me include, but are not limited to:

Check applicable items.

- \_\_\_ *Dry socket or incomplete healing of an extraction site*
- \_\_\_ *Bleeding and/or bruising that may be prolonged*
- \_\_\_ *Infection*
- \_\_\_ *Injury to nerves in or around the mouth that could be permanent*
- \_\_\_ *Decision to leave a small piece of root in the jaw when its removal would require extensive surgery and an increased risk of complications*
- \_\_\_ *Involvement of sinus near tooth structures*
- \_\_\_ *Injury to nearby teeth or fillings*
- \_\_\_ *Restriction of mouth opening*
- \_\_\_ *Unusual reaction to medications given or prescribed*
- \_\_\_ **You can expect bleeding, swelling, and/or pain following this procedure.**
- \_\_\_ *Other: \_\_\_\_\_*

Alternatives to surgery: Risks to my health if this procedure is not performed include, but are not limited to:

- \_\_\_ *Pain*
- \_\_\_ *Infection*
- \_\_\_ *Cyst or tumor formation*
- \_\_\_ *Loss of bone around the teeth causing their loss*
- \_\_\_ *Increased risk of complications if surgery is postponed to a later date.*

**Medications:** Drugs given at the time of surgery for sedative purposes, or medications prescribed for pain following the surgery, may cause drowsiness and lack of awareness or coordination. I have been instructed not to drive or perform hazardous chores until fully recovered from the effects of these medications.

I have been told that a perfect result from this treatment cannot be guaranteed. If unexpected conditions arise during the procedure, I request and authorize the doctor to do whatever is deemed necessary to correct the condition.

**PATIENT IDENTIFICATION:**

NAME \_\_\_\_\_ HRN \_\_\_\_\_

**PATIENT CONSENT:**

I agree to cooperate with Dr. \_\_\_\_\_ and I will follow post-operative instructions to the best of my ability for my own comfort and safety. I have had an opportunity to ask questions concerning these procedures.

\_\_\_\_\_  
 Patient, Parent or Guardian

\_\_\_\_\_  
 Date:

\_\_\_\_\_  
 Doctor

\_\_\_\_\_  
 Witness



## APPENDIX B.1

### COMPLETING THE DENTAL PATIENT MEDICAL HISTORY, IHS 42-1, Page 2.

The Dental Patient Medical History form (IHS 42-1, Page 2) should be completed for all patients at their initial (routine or emergency) visit to the clinic and at least annually thereafter. This questionnaire should be completed or updated prior to the initiation of any diagnostic or treatment procedures. It provides an essential source for information which may be entered in the Medical Alert/Update (Part II of the IHS 42-1, Page 1). Additional demographic and billing data (address, telephone number, Medicaid eligibility, water source, etc.) can be added to the questionnaire at the discretion of the local program to serve a variety of clinical and administrative applications.

It is imperative that the provider be confident that the patient, parent, or guardian fully understand the questions, and is providing truthful answers to the best of their ability. Any uncertainty expressed by the patient, parent or guardian when answering a specific question should be more thoroughly investigated through further questioning, referring to the medical record, or seeking a medical consultation. An interpreter is required for those patients who either do not speak English or who do not understand English well enough to be able to answer the health questions accurately.

The patient, parent or guardian should sign the bottom of the form. Minors must have a parent or legal guardian sign for them. This signature indicates the health questions have been answered to the best of the patient's ability, and that consent is given for routine dental procedures, except for tooth extraction and other procedures requiring a separate consent. The examining dentist then signs the form indicating that he/she has reviewed the information provided and it is accurate and complete to the best of his/her knowledge.

The Dental Patient Medical History **must be reviewed at each visit**. The patient should be queried as to whether there have been changes in his or her medical status since the last dental visit. Such changes may include a visit to the physician, a change in medication, or a recent illness. If there have been no changes since the last dental visit, the dentist can document this by dating, initialing, and indicating "No Changes" (NC) in the Provider Review section (upper right hand corner) of the IHS 42-1, Page 2 form. If the dentist notes changes which may affect the proposed dental treatment or the manner in which it is provided, additional questioning of the patient, review of the medical progress notes, or a medical consultation may be needed. The Provider Review section of the IHS 42-1, Page 2 should be dated and initialed. Summary documentation of the change in health status should be entered on the IHS 42-1, Page 1 or the Dental Progress Notes, Form IHS 42-2. If a review and update of the Dental Patient Medical History cannot be accomplished, such as in the case of a minor with no parent or guardian present, it should be documented as well.

## USE OF THE IHS PERIODONTAL EXAMINATION RECORD

An adequate record of the patient's periodontal status over time is essential to providing effective care. Therefore, the IHS Periodontal Examination Record should be used, in addition to the IHS 42-1, Page 1, for periodontal treatment planning and recall or maintenance therapy of all high risk periodontal patients. The form is used in conjunction with the 4110 Periodontal Case Workup dental procedure code which is reported only for patients when periodontal pocket therapy will be provided.

The IHS Periodontal Examination Record is designed primarily to provide a record of probing pocket depths, furcation involvement and tooth mobility scores. However, it may be used to document any specific periodontal diagnostic activity beyond the CPITN screening and ADA Case Type diagnosis conducted during routine exams (codes 0110 and 0120), such as the use of the periodontal occlusal analysis or micro biological assay.

Three lines of boxes are provided for three separate dates of pocket measurements. Each box should contain three pocket depth measurements (mesial, mid-buccal/mid-lingual and distal) for each tooth included in the periodontal exam. When both the buccal and lingual aspects of the arches are probed and recorded, each tooth will have a total of six sites measured for pocket depth. Although the record form contains spaces for all possible teeth in both arches, pocket depth findings can be recorded for only limited numbers of teeth.

Mobility scores can be placed on the unnumbered crowns of the teeth pictured in the examination form. Likewise, the severity of furcation involvement can be indicated with the various triangular designations in the area of root anatomy where the furcations occur.

The furcation involvement definitions for each grade are as follows:

- Grade I      Pocket depth probed up to 3 mm
- Grade II     Pocket depth probed greater than 3 mm
- Grade III    Through-and-through defect

The IHS Periodontal Examination Form should be retained in the Patient's Primary Health Record along with other dental records.

# APPENDIX C

## CODES FOR RECORDING ORAL CONDITIONS AND NEEDS ON THE IHS 42-1.

### TOOTH STATUS:

Decay is indicated by drawing a line through the involved tooth surface(s)

- ✓ = sound tooth (w/o decay or restoration)
- A = abutment for fixed partial denture
- CR = crown (full cast, porcelain/ metal, ceramic)
- DF = defective filling (requires replacement)
- DS = defective sealant (requires replacement)
- E = enamel defect
- EC = endodontics completed
- F = filled tooth (permanent restoration)
- FS = filled and sealed tooth
- FX = coronal fracture from trauma
- I = impacted tooth
- M = missing (extracted)
- NV = non-vital pulp
- NV? = pulp vitality is doubtful
- P = pontic for fixed partial denture
- PE = partially erupted tooth
- S = sealant on tooth, or tooth needs sealant
- SC = tooth space closed
- SM = space maintainer present
- SSC = stainless steel crown
- T = temporary restorative material
- TC = temporary crown
- TR = trauma w/o coronal fracture
- UE = unerupted tooth

### TOOTH TREATMENT NEED:

- CP = needs cusp protective restoration
- CR = needs crown
- NE = needs endodontic therapy (perm. tooth)
- NT = no treatment indicated at this time
- PT = needs pulp treatment (primary tooth)
- R = needs restoration (amalgam or composite)
- SM = needs extraction mainly due to caries
- XO = needs extraction for ortho purposes
- XP = needs extraction mainly due to periodontitis
- XS = needs extraction, surgical (must lay flap)
- XX = needs extraction for other reasons

### DENTURE POSSESSION OR NEED (per arch):

- (blank) = patient does not possess a removable denture.
- F = patient possesses a full denture for the arch.
- FR = patient possesses a full denture needing replacement, rebase, or reline.
- P = patient possesses a cast base partial denture.
- PR = patient has a partial denture which needs replacement, rebase, or reline.
- PT = patient possesses a temporary (thumbplate) or transitional partial denture.

### TOOTH MOBILITY:

Determined by holding the tooth between a forefinger and an instrument and applying light force.

- 0 = Mobility within the normal range.
- I = Mobility approximately 1mm buccolingually.
- II = Mobility approximately 2mm buccolingually, but with no mobility in an apical direction.
- III = Mobility greater than 2mm buccolingually in addition to mobility in an apical direction.

## CODES FOR THE IHS 42-1. Continued.

### PREVENTION ASSESSMENT:

#### Use of Fluoride Toothpaste:

- N = does not claim to use toothpaste regularly
- O = uses toothpaste less than 1 day/week (on average)
- F = uses toothpaste 4 or more days/week (on average)

#### Other Fluoride

- DFS = dietary fluoride supplement
- HMR = home fluoride mouth rinse
- FMR = fluoride mouth rinse
- TF = topical fluoride treatments

#### Oral Hygiene Levels

- P = poor
- F = fair
- G = good
- E = excellent

#### Type of hygiene instruction needed

- B = basic hygiene instruction
- R = reinforcement instruction
- S = special hygiene instruction

#### Tobacco Use

- 1 = never used tobacco
- 2 = current smoker
- 3 = current smokeless tobacco user
- 4 = previous smoker
- 5 = previous smokeless tobacco user

# APPENDIX E

## THE PREVENTIVE SERVICES ASSESSMENT

Individualized Preventive Planning and Patient Education (IHS Procedure Code 1330) are an integral part of each patient's dental treatment in IHS dental programs. The preventive services assessment is meant to serve both as a mechanical reminder to the dentist to address the preventive aspects of oral health care and as documentation that the full spectrum of individual preventive measures were discussed with the patient or the patient's parent or guardian.

The following information provides guidelines to assess the status and need for clinical preventive services for dental patients. After completing the caries and periodontal diagnosis, the need for clinical preventive services and education should be assessed and documented for patients receiving routine exams. These services will vary based on an individual's oral and medical conditions, age, lifestyle, habits, etc. The results of previous assessments of the patient should be reviewed, if available, before the current assessment is completed.

### **Criteria for the documentation of present status:**

**1. WATER FLUORIDATION:** This information aids in determining the need for fluoride supplements and the specific dosage of dietary supplements for children. From existing water system data and by querying the patient or parent, enter the known (most recent) fluoride level of the patient's home water supply in ppm for all persons under the age of 15. If the fluoride level is unknown, enter "UNK" or "?" for unknown. An unknown fluoride level will necessitate further investigation if the patient is on a community water system, or necessitate that a water sample be obtained by the patient and submitted for testing if the patient is on an individual well. When the results of the test are known, they can be entered in the same space provided.

**2. USE of FL TOOTHPASTE:** If the patient claims to use fluoridated toothpaste enter the number of days per week (on average)

N = never uses fluoridated toothpaste regularly

O = occasionally uses fluoridated toothpaste 1-3 days per week, on average

F = frequently uses fluoridated toothpaste 4 or more days per week, on average

If fluoridated toothpaste is not used, query the patient as to whether their beliefs or if economic factors serve as barriers to using dentifrice regularly. Additional patient education may be planned depending on the beliefs and attitudes of the patient/parent.

(continued)

**3. OTHER FLUORIDE SUPPLEMENTS:** These findings may affect the decision of whether to recommend a self-applied fluoride rinse or other supplements. The following codes used to document the type(s) of supplements which the patient claims to use:

**DFS** = for children who have been prescribed a dietary fluoride supplement (drops or tablets) within the past year.

**FMR** = participates in school-based fluoride mouth rinse program. Also query the patient if they are attending a school with a FMR but have elected not to participate. Additional education may be indicated for the patient to encourage participation.

**TFG** = one or more professionally-applied topical fluoride gel applications were received by the patient in the past year.

**TYPE OF OHI NEEDED:** The type of oral hygiene instruction which will be offered should be indicated by using one of the following letter codes:

**B** = **Basic instruction** to develop fundamental hygiene skills. This would be most frequently applied to patients who have poor or fair hygiene and have not received instruction previously at this clinic.

**R** = **Reinforcement of basic skills** with concentration on specific problem areas. This might frequently apply to patients with fair to good hygiene who have previously received instruction or appear to have basic skills.

**S** = **Special instruction** is needed to deal with unusual hygiene problems which need immediate attention. This might apply most frequently to patients who have difficult situations to control, such as prosthetic and orthodontic patients, handicapped individuals and others, as deemed appropriate by the clinician. The treatment plan should specify the type of special OHI recommended.

**NEED FOR OTHER EDUCATION:** Place a check mark if there are other oral health educational needs of the patient or parent. These needs may be met in the dental clinic or referred to other providers. Examples include: counseling for BBTD or other nutritional factors, counseling for periodontal risk factors such as diabetics or glucose intolerance, education in effects of detrimental oral habits, or education for the prevention/cessation of tobacco use.

**TARGET GROUP:** The patient may be placed into a specific target group for special regimens and follow-up if the local dental program focuses disease intervention efforts on such groups. Examples include: Head Start, BBTD, diabetic patients, and others. No codes have been created to designate specific groups at this time. Therefore, the local program should create its own conventions for designating target group.

**ORAL HYGIENE LEVEL:** This information provides a quick general reference for the provider to estimate the effectiveness of home care during therapy and at future oral exams. The findings may be used to recommend specific types of hygiene instruction prior to and during dental therapy. Hygiene levels are documented in the space given using the following codes:

- P = poor hygiene with heavy plaque accumulation and no evidence of routine effective home care.
- F = fair hygiene with moderate plaque accumulation.
- G = good hygiene with isolated areas of plaque accumulation.
- E = excellent hygiene with no evidence of plaque accumulation.

**TOBACCO USE:** The Indian Health Service expects primary care providers (including dentists) to document the use of tobacco in the health records of all patients who receive care. This assessment should be included in the health history, which is updated at each dental visit. The findings should be documented in the space provided on the Dental Patient Medical History form (IHS 42-1, Page 2) and on the patient's "Chronic Problem List" of their medical chart, if available, by using specific terms to designate categories of present or past use. Combinations of the following numeric codes can be entered on the IHS 42-1 form when needed. For example, "5, 2" could be entered to represent a past chewing tobacco user who is a current smoker.

Code definitions of tobacco use patterns:

- 1 = Never Used Tobacco
- 2 = Current Smoker
- 3 = Current Smokeless Tobacco User
- 4 = Previous Smoker
- 5 = Previous Smokeless Tobacco User

**Prevention Assessment documentation of need for services:**

**NEED FOR TOPICAL FLUORIDE:** If the patients meet the criteria for professionally applied topical fluoride (active smooth surface carious lesions on permanent teeth), enter a check mark in this box. The treatment plan should include this procedure and specify the regimen to be used.

**NEED FOR FL TABLETS/DROPS:** Place a check mark if water levels for children less than age 14 (except those whose 2nd molars are fully erupted) to indicate the need for a supplement. The treatment plan should include the specific prescription. Dosage should be in accordance with ADA recommendations concerning age and water fluoride level.

**NEED FOR SEALANTS:** Place a check mark if permanent molars are indicated for sealants. The treatment plan should include this procedure and the tooth treatment lines marked with "S" for the specific teeth. If sealants are not indicated at this time, enter "no".

# DENTAL EXAMINATION RECORD

# EXAMPLE FORM A

### PART III. ORAL DIAGNOSIS

Denture Possession:		A NY	B	C	D	E	F	G	H	I SC	J NY?
Upper	_____										
Lower	_____	PT/SSC		R		XC	XC			SSC	NT?/SSC

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

T	S	R	Q	P	O	N	M	L	K DF
	XC/sm	R			NT			SM	MOB

Periodontal Diagnosis: \_\_\_\_\_

CPITN Scores:

Date	Date	Date

X-rays Reviewed: BWx2, OCC<sup>R</sup>

Enamel Defects: WNL

Soft Tissue/TMJ: WNL

Orthodontics:  No Need  Tx. in Progress  Completed

Therapy or Eval. Need: LLA

### IV. PREVENTION ASSESSMENT

Status of:

Water Fluoride ? ppm

Use of Fluoride Toothpaste F

Other Fluoride Supplements -

Oral Hygiene F

Tobacco Use -

Need for:

Topical Fluoride ✓

Fluoride Tablets/Drops Tablets?

Sealants -

Hygiene Instruction R

Other Education -

Target Group: Head Start

### PART V. TREATMENT PLAN

1. Exam, BWx2, OCC, Prev Plan, H<sub>2</sub>O Sample, BBTQ Counseling, Topical Fluoride, Determine need for fluoride tablets
2. XC #E2#F, XX BS, Retire C
3. OP - ULQ, LLQ
4. OP - URQ, LRQ
5. Space management - lower lingual arch

Referral/Followup: Caries Interval: 6 months

This treatment plan has been explained and I accept it.

Patient/Guardian \_\_\_\_\_ Date 3-8-93

Dentist \_\_\_\_\_ Date 3-8-93

### PART I. DEMOGRAPHICS

HRN 555-524 SSN \_\_\_\_\_

NAME \_\_\_\_\_

B DATE 1-29- SEX \_\_\_\_\_

RESIDENCE \_\_\_\_\_

FACILITY \_\_\_\_\_

### PART II. MEDICAL ALERT/UPDATE

1/91 Hospitalized for Pneumonia

### VI. DEFERRED DENTAL NEEDS

Basic Care (Level I - III Svcs) \_\_\_\_\_

Anterior/Blowup Endo 1

Molar Endodontics \_\_\_\_\_

Perio Pocket Therapy \_\_\_\_\_

Crowns/Complex Restor. 1

Removable Dentures 1

Fixed Bridge: Ant. \_\_\_\_\_ Post. \_\_\_\_\_

Surgery: 3rd Molars \_\_\_\_\_ Other \_\_\_\_\_

Ortho: Limited \_\_\_\_\_ Comp \_\_\_\_\_

# DENTAL EXAMINATION RECORD

# EXAMPLE FORM B

## PART III. ORAL DIAGNOSIS

Denture Possession:

Upper \_\_\_\_\_

Lower \_\_\_\_\_

A	B	C	D	E	F	G	H	I	J
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	PE	DS											S		
		S/L													

32	31	30 DS	29	28	27	26	25	24	23	22	21	20	19	18	17
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	S/OB	R/B		S							S				

T	S	R	Q	P	O	N	M	L	K SC
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

### Periodontal Diagnosis:

Gingivitis (Type I)

### CPITN Scores:

Date 3/20/93

1	0	1
1	1	1

Date


Date


X-rays Reviewed: BWx2, Panorax <sup>ms</sup>

Enamel Defects: Mild Fluorosis #7-10

Soft Tissue/TMJ: WNL

Orthodontics:  No Need  Tx. in Progress  Completed, Spaced Closed

Therapy or Eval. Need: X-bite #14/23 #K  
mom wants ortho consult

## PART V. TREATMENT PLAN

- Exam BWx2, Panorax, Prevention Plan
- Op - ULQ, Sealants
- Op - LRQ Impressions + Arch length analysis
- Ortho consult

Referral/Followup: Sealants Interval: 6 months

This treatment plan has been explained and I accept it.

Patient/Guardian \_\_\_\_\_ Date 3/20/93

Dentist \_\_\_\_\_ Date 3/20/93

## PART I. DEMOGRAPHICS

URN 101-693 SSN \_\_\_\_\_

NAME \_\_\_\_\_

B DATE \_\_\_\_\_ SEX \_\_\_\_\_ TREE \_\_\_\_\_

RESIDENCE \_\_\_\_\_

FACILITY \_\_\_\_\_ DATE \_\_\_\_\_

## PART II. MEDICAL ALERT/UPDATE

Allergy to Pen.

## IV. PREVENTION ASSESSMENT

Status of:

Water Fluoride 1.1 ppm

Use of Fluoride Toothpaste F

Other Fluoride Supplements FMR

Oral Hygiene P

Tobacco Use -

Need for:

Topical Fluoride -

Fluoride Tablets/Drops -

Sealants ✓

Hygiene Instruction B

Other Education -

Target Group: -

## VI. DEFERRED DENTAL NEEDS

Basic Care (Level I - III Svcs) \_\_\_\_\_

Anterior/Akroepid Endo \_\_\_\_\_ / \_\_\_\_\_

Molar Endodontics \_\_\_\_\_

Perio Pocket Therapy \_\_\_\_\_

Crowns/Complex Restor. \_\_\_\_\_ / \_\_\_\_\_

Removable Dentures \_\_\_\_\_ / \_\_\_\_\_

Fixed Bridge: Ant. \_\_\_\_\_ Post. \_\_\_\_\_

Surgery: 3rd Molars \_\_\_\_\_ Other \_\_\_\_\_

Ortho: Limited \_\_\_\_\_ Comp \_\_\_\_\_

# DENTAL EXAMINATION RECORD

# EXAMPLE FORM C

## PART III. ORAL DIAGNOSIS

Denture Possession:

Upper \_\_\_\_\_  
Lower \_\_\_\_\_

A		B		C		D		E		F		G		H		I		J	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16				
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>				
			R	R							DO	MO		S/L					
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17				
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>				
												R							
T		S		R		Q		P		O		N		M		L		K	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	

Periodontal Diagnosis:

Chronic, VITIS

CPITN Scores:

Date <u>1/6/93</u> <sup>HW</sup>	Date <u>3/9/93</u> <sup>MAC</sup>	Date _____
<u>1 1 1</u>	<u>0 0 1</u>	_____
<u>1 2 1</u>	<u>1 0 1</u>	_____

X-rays Reviewed:

BWx4, Panorax <sup>NW\*</sup>

Enamel Defects:

WNL

Soft Tissue/TMJ:

WNL

Orthodontics:  No Need  Tx. in Progress  Completed

Therapy or Eval. Need: Class II crowding - needs consult

## PART V. TREATMENT PLAN

- Exam, BWx4, Panorax, Prev Plan, Prophy, Topical Fluoride
- Op - URQ, Eval oral hygiene, Tobacco counseling
- Op - U-LQ Sealants Op - LLQ Topical Fluoride
- Told parent that child is placed on list for deferred ortho services

Referral/Followup: Caries control Interval: 6 months

This treatment plan has been explained and I accept it.

Patient/Guardian \_\_\_\_\_ Date 1/6/93

Dentist \_\_\_\_\_ Date 1/6/93

## PART I. DEMOGRAPHICS

MRN 101-716 SSN \_\_\_\_\_  
 NAME \_\_\_\_\_  
 B DATE 11/23/77 SEX \_\_\_\_\_  
 RESIDENCE \_\_\_\_\_  
 FACILITY \_\_\_\_\_

## PART II. MEDICAL ALERT/UPDATE

## IV. PREVENTION ASSESSMENT

Status of:  
 Water Fluoride .8 ppm  
 Use of Fluoride Toothpaste 0  
 Other Fluoride Supplements \_\_\_\_\_  
 Oral Hygiene F  
 Tobacco Use 3  
 Need for:  
 Topical Fluoride   
 Fluoride Tablets/Drops \_\_\_\_\_  
 Sealants   
 Hygiene Instruction R  
 Other Education Tobacco  
 Target Group: \_\_\_\_\_

## VI. DEFERRED DENTAL NEED:

Basic Care (Level I - III Svcs) \_\_\_\_\_  
 Anterior/Blowup Endo 1  
 Molar Endodontics \_\_\_\_\_  
 Perno Pocket Therapy \_\_\_\_\_  
 Crowns/Complex Restor. 1  
 Removable Dentures 1  
 Fixed Bridge: Ant. \_\_\_\_\_ Post. \_\_\_\_\_  
 Surgery: 3rd Molars \_\_\_\_\_ Other \_\_\_\_\_  
 Ortho: Limited \_\_\_\_\_ Comp

# DENTAL EXAMINATION RECORD

EXAMPLE FORM D

**PART III. ORAL DIAGNOSIS**

Denture Possession:

Upper FR  
Lower PR

A		B		C		D		E		F		G		H		I		J	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

32	31	30	29	28	27	26	25 <sup>I</sup>	24 <sup>I</sup>	23	22	21	20	19	18	17
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<u>XC</u>	<u>XX</u>	<u>XX</u>	<u>XX</u>	<u>XX</u>	<u>XC</u>					

T		S		R		Q		P		O		N		M		L		K	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Periodontal Diagnosis: \_\_\_\_\_

CPITN Scores:

Date <u>2/4/93</u> <sup>DO</sup>	Date	Date
3		

X-rays Reviewed: Panorex<sup>DO</sup>

Enamel Defects: WNV

Soft Tissue/TMJ: Hyperplastic Tissue Palate/TMJ<sup>WNV</sup>

Orthodontics:  No Need  Tx. in Progress  Completed

Therapy or Eval. Need: \_\_\_\_\_

**IV. PREVENTION ASSESSMENT**

Status of:

Water Fluoride \_\_\_\_\_ ppm

Use of Fluoride Toothpaste 1

Other Fluoride Supplements \_\_\_\_\_

Oral Hygiene F

Tobacco Use 2

Need for:

Topical Fluoride \_\_\_\_\_

Fluoride Tablets/Drops \_\_\_\_\_

Sealants \_\_\_\_\_

Hygiene Instruction B

Other Education Tobacco

Target Group: \_\_\_\_\_

**PART V. TREATMENT PLAN**

1. Exam, Panorex, Prevention Plan, Prophyl, Tobacco counseling
2. Tissue Condition Max Denture - Put on waiting list for F/F!
3. XC's & XX's when dentures can be made
4. F/F Construction

**VI. DEFERRED DENTAL NEEDS:**

Basic Care (Level I - III Svcs) \_\_\_\_\_

Anterior/Maxillo Endo 1

Molar Endodontics \_\_\_\_\_

Perio Pocket Therapy \_\_\_\_\_

Crowns/Complex Restor. 1

Removable Dentures F | F

Fixed Bridge: Ant. \_\_\_\_\_ Post. \_\_\_\_\_

Surgery: 3rd Molars \_\_\_\_\_ Other \_\_\_\_\_

Ortho: Limited \_\_\_\_\_ Comp \_\_\_\_\_

Referral/Followup: Denture Recall Interval: 2 year

This treatment plan has been explained and I accept it.

Patient/Guardian \_\_\_\_\_ Date 12/15/92

Dentist \_\_\_\_\_ Date 12/15/92

**PART I. DEMOGRAPHICS**

HRN 100-014 SSN \_\_\_\_\_

NAME \_\_\_\_\_

B DATE 6/13/31 SEX \_\_\_\_\_

RESIDENCE \_\_\_\_\_

FACULTY \_\_\_\_\_ DATE \_\_\_\_\_

**PART II. MEDICAL ALERT/UPDATE**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# DENTAL EXAMINATION RECORD

# EXAMPLE FORM E

### PART III. ORAL DIAGNOSIS

Denture Possession:		A	B	C	D	E	F	G	H	I	J												
Upper	Lower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
1	2	3	4	5	6	7	8	9 Fx	10	11 ↑	12	13	14 EC	15 NV	16								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>								
XC	MOD	P				MI	m	MI	MI			MO	CR	NEKR	XX								
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18 E	17								
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>								
XS													P	NT	XS								
		T	S	R	Q	P	O	N	M	L	K												
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												

### Periodontal Diagnosis:

Gingivitis

CPITN Scores: BT Date 1/24/93 LT Date 3/24/93 Date \_\_\_\_\_

2	1	2	1	0	1	_____	_____	_____
2	2	2	1	0	1	_____	_____	_____

X-rays Reviewed: No X-rays Taken <sup>BT</sup>

Enamel Defects: #19 Hypoplastic

Soft Tissue/TMJ: Fibroma - tongue / TMJ

Orthodontics:  No-Need  Tx. in Progress  Completed

Therapy or Eval. Need: Sever ante. crowding

### IV. PREVENTION ASSESSMENT

Status of:

Water Fluoride \_\_\_\_\_ ppm

Use of Fluoride Toothpaste F

Other Fluoride Supplements \_\_\_\_\_

Oral Hygiene P

Tobacco Use 1

Need for:

Topical Fluoride

Fluoride Tablets/Drops \_\_\_\_\_

Sealants \_\_\_\_\_

Hygiene Instruction B

Other Education Pre-natal

Target Group: \_\_\_\_\_

### PART V. TREATMENT PLAN

1. Exam, Prev Plan, Prophyl, Topical Fluoride, Pre-natal counseling
2. Op # 2, 7, 8
3. Endo # 15
4. Op # 13 & 15 Topical Fluoride
5. Op # 9, 10
6. Told patient put name on deferred list for crown & bridge + ortho. To return after delivery for extractions

Referral/Followup: Caries Interval: 6 months

This treatment plan has been explained and I accept it.

Patient/Guardian \_\_\_\_\_ Date 1/29/93

Dentist \_\_\_\_\_ Date 1/29/93

### VI. DEFERRED DENTAL NEED:

Basic Care (Level I - III Svcs) \_\_\_\_\_

Anterior/Blowup Endo 1

Molar Endodontics \_\_\_\_\_

Perio Pocket Therapy \_\_\_\_\_

Crowns/Complex Restor. 4, 13

Removable Dentures 1

Fixed Bridge: Ant. \_\_\_\_\_ Post. \_\_\_\_\_

Surgery: 3rd Molars \_\_\_\_\_ Other \_\_\_\_\_

Ortho: Limited \_\_\_\_\_ Comp

### PART I. DEMOGRAPHICS

MRN 100-018 SSN \_\_\_\_\_

NAME \_\_\_\_\_

B DATE 7/18/70 SEX \_\_\_\_\_

RESIDENCE \_\_\_\_\_

FACILITY \_\_\_\_\_

DATE \_\_\_\_\_

### PART II. MEDICAL ALERT/UPDATE

4 months pregnant



# DENTAL EXAMINATION RECORD

# EXAMPLE FORM G

## PART III. ORAL DIAGNOSIS

Denture Possession:

Upper PR  
Lower PR

A B C D E F G H I J

1 2 3 NV? 4 5 6 7 8 9 10 11 12 13 14 15 16

m m NE?/CR or XC m m F       m m m m m

XC XC XC

32 31 30 29 28 27 26 II 25 II 24 II 23 II 22 21 NV 20 19 18 17

I F F m m        NE/CR CR m m m

XS XP XP XP XP

T S R Q P O N M L K

Periodontal Diagnosis:

Type IV Perio

CPITN Scores:

Date 2/12/93

2	1	X
4	4	2

Date		

Date		

X-rays Reviewed: Panorex, Apical pathology 1989

Enamel Defects: WNL

Soft Tissue/TMJ: WNL/R TMJ Clicks-Tender

Orthodontics:  No Need  Tx. in Progress  Completed

Therapy or Eval. Need: \_\_\_\_\_

## IV. PREVENTION ASSESSMENT

Status of:

Water Fluoride \_\_\_\_\_ ppm

Use of Fluoride Toothpaste 0

Other Fluoride Supplements -

Oral Hygiene P

Tobacco Use 2

Need for:

Topical Fluoride

Fluoride Tablets/Drops -

Sealants -

Hygiene Instruction B

Other Education \_\_\_\_\_

Target Group: Diabetics

## PART V. TREATMENT PLAN

- Exam Panorex, Prev Plan, Perio & Tobacco Counseling - Discuss going to F/
- XC #3, #8, 9, 10, Prophy, Topical Fluoride
- Endo #21, #21 CP
- XP #23, 24, 25, 26
- Perio Topical Fluoride Reinforce OHI
- Deferred for F/P

Referral/Followup: Perio Interval: \_\_\_\_\_

This treatment plan has been explained and I accept it.

Patient/Guardian \_\_\_\_\_ Date 2/12/93

Dentist \_\_\_\_\_ Date 2/12/93

## PART I. DEMOGRAPHICS

HRN 101-104 SSN \_\_\_\_\_

NAME \_\_\_\_\_

B DATE 10/12/45 SEX \_\_\_\_\_

RESIDENCE \_\_\_\_\_ TREE \_\_\_\_\_

FACILITY \_\_\_\_\_ DATE \_\_\_\_\_

## PART II. MEDICAL ALERT/UPDATE

Hypertension  
Diabetes

## VI. DEFERRED DENTAL NEED

Basic Care (Level I - III Svcs) \_\_\_\_\_

Anterior/Blowup Endo 1

Molar Endodontics \_\_\_\_\_

Perio Pocket Therapy \_\_\_\_\_

Crowns/Complex Restor. 1

Removable Dentures F / F

Fixed Bridge: Ant. \_\_\_\_\_ Post. \_\_\_\_\_

Surgery: 3rd Molars \_\_\_\_\_ Other \_\_\_\_\_

Ortho: Limited \_\_\_\_\_ Comp \_\_\_\_\_

# DENTAL EXAMINATION RECORD

# EXAMPLE FORM H

## PART III. ORAL DIAGNOSIS

Denture Possession:

Upper FR  
Lower \_\_\_\_\_

A	B	C	D	E	F	G	H	I	J
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

32	31	30	29	28	27	26	25	24	23	22	21	20	19 F	18	17
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<i>9 mm</i>	<i>DO</i>		<i>R</i>	<i>R</i>	<i>R</i>		<i>R</i>	<i>R</i>			<i>R</i>		

T	S	R	Q	P	O	N	M	L	K
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Periodontal Diagnosis:

Type IV perio

CPITN Scores:

Date <u>1/14/93</u>	Date	Date
<u>4</u> <u>4</u> <u>4</u>		

X-rays Reviewed:

Panorex <sup>mf</sup> sec 42-2

Enamel Defects: WNL

Soft Tissue/TMJ: WNL/WNL

Orthodontics:  No Need  Tx. In Progress  Completed

Therapy or Eval. Need: \_\_\_\_\_

## IV. PREVENTION ASSESSMENT

Status of:

Water Fluoride \_\_\_\_\_ ppm

Use of Fluoride Toothpaste F

Other Fluoride Supplements \_\_\_\_\_

Oral Hygiene F

Tobacco Use 4

Need for:

Topical Fluoride

Fluoride Tablets/Drops \_\_\_\_\_

Sealants \_\_\_\_\_

Hygiene Instruction B

Other Education \_\_\_\_\_

Target Group: \_\_\_\_\_

## PART V. TREATMENT PLAN

- Exam, Panorex, Prev Plan, Prophy, Topical Fluoride
- Op - LLQ, Perio
- Op - LRQ, Topical Fluoride
- Rebase Max denture

Referral/Followup: \_\_\_\_\_ Interval: \_\_\_\_\_

This treatment plan has been explained and I accept it.

Patient/Guardian \_\_\_\_\_

Date 1/14/93

Date 1/14/93

Dentist \_\_\_\_\_

## PART I. DEMOGRAPHICS

HRN 100-690 SSN \_\_\_\_\_

NAME \_\_\_\_\_

B DATE 10/10/25 SEX \_\_\_\_\_ TREE \_\_\_\_\_

RESIDENCE \_\_\_\_\_

FACULTY \_\_\_\_\_ DATE \_\_\_\_\_

## PART II. MEDICAL ALERT/UPDATE

## VI. DEFERRED DENTAL NEEDS

Basic Care (Level I - III Svcs) \_\_\_\_\_

Anterior/Etiologic Endo \_\_\_\_\_

Molar Endodontics \_\_\_\_\_

Perio Pocket Therapy 3

Crowns/Complex Restor. \_\_\_\_\_

Removable Dentures \_\_\_\_\_

Fixed Bridge: Ant. \_\_\_\_\_ Post. \_\_\_\_\_

Surgery: 3rd Molars \_\_\_\_\_ Other 1

Ortho: Limited \_\_\_\_\_ Comp \_\_\_\_\_

# DENTAL EXAMINATION RECORD

EXAMPLE FORM J

## PART III. ORAL DIAGNOSIS

Denture Possession:

Upper \_\_\_\_\_

Lower \_\_\_\_\_

A	B	C	D	E	F	G	H	I	J						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T	S	R	Q	P	O	N	M	L	K						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						

*Handwritten:* Furcation 14  
12mm  
XP

Periodontal Diagnosis:

Type IV perio

CPTN Scores:

Date 2/12/93

4	3	4
4	4	4

Date		

Date		

X-rays Reviewed: PA #14, sever bone loss #14

Enamel Defects: \_\_\_\_\_

Soft Tissue/TMJ: Sinus tract buccal #14

Orthodontics:  No Need  Tx. in Progress  Completed

Therapy or Eval. Need: \_\_\_\_\_

## IV. PREVENTION ASSESSMENT

Status of:

Water Fluoride \_\_\_\_\_ ppm

Use of Fluoride Toothpaste \_\_\_\_\_

Other Fluoride Supplements \_\_\_\_\_

Oral Hygiene \_\_\_\_\_

Tobacco Use \_\_\_\_\_

Need for:

Topical Fluoride \_\_\_\_\_

Fluoride Tablets/Drops \_\_\_\_\_

Sealants \_\_\_\_\_

Hygiene Instruction \_\_\_\_\_

Other Education \_\_\_\_\_

Target Group: \_\_\_\_\_

## PART V. TREATMENT PLAN

- Emergency exam #14 PA #14
- Emergency Treatment #14-XP, Pt informed that no replacement available from IHS. Pt told he has sever periodontal disease and told about its relationship to diabetes (see progress notes)
- Pt given appt. for complete exam

Referral/Followup: \_\_\_\_\_ Interval: \_\_\_\_\_

This treatment plan has been explained and I accept it.

Patient/Guardian \_\_\_\_\_ Date 2/12/93

Dentist \_\_\_\_\_ Date 2/12/93

## PART I. DEMOGRAPHICS

HRN 100-318 SSN \_\_\_\_\_

NAME \_\_\_\_\_ TREE \_\_\_\_\_

B DATE 6/15/36 SEX \_\_\_\_\_ DATE \_\_\_\_\_

RESIDENCE \_\_\_\_\_

FACILITY \_\_\_\_\_

## PART II. MEDICAL ALERT/UPDATE

Diabetes  
BP 125/85

## VI. DEFERRED DENTAL NEED:

Basic Care (Level I - III Svcs) \_\_\_\_\_

Anterior/Bicuspid Endo \_\_\_\_\_ / \_\_\_\_\_

Molar Endodontics \_\_\_\_\_

Perio Pocket Therapy \_\_\_\_\_

Crowns/Complex Restor. \_\_\_\_\_ / \_\_\_\_\_

Removable Dentures \_\_\_\_\_ / \_\_\_\_\_

Fixed Bridge: Ant. \_\_\_\_\_ Post. \_\_\_\_\_

Surgery: 3rd Molars \_\_\_\_\_ Other \_\_\_\_\_

Ortho: Limited \_\_\_\_\_ Comp \_\_\_\_\_

# DENTAL EXAMINATION RECORD

# EXAMPLE FORM I

## PART III. ORAL DIAGNOSIS

Denture Possession:

Upper \_\_\_\_\_  
Lower \_\_\_\_\_

A	B	C	D	E	F	G	H	<i>pulp</i>	<i>pulp</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>SSC</i>	<i>SSC</i>		<i>XC</i>	<i>XC</i>	<i>XC</i>	<i>XC</i>		<i>SSS</i>	<i>SSC</i>

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T	<i>pulp</i> S	R	Q	P	O	N	M	L	K						
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
<i>XC</i>	<i>SSC</i>							<i>SSC</i>	<i>SSC</i>						

Periodontal Diagnosis: \_\_\_\_\_

X-rays Reviewed: *PA #T* <sup>BW</sup> (see 42-2)

CPITN Scores:

Date	Date	Date

Enamel Defects: \_\_\_\_\_  
Soft Tissue/TMJ: \_\_\_\_\_  
Orthodontics:  No Need  Tx. in Progress  Completed  
Therapy or Eval. Need: \_\_\_\_\_

## IV. PREVENTION ASSESSMENT

Status of:

Water Fluoride \_\_\_\_\_ ppm  
Use of Fluoride Toothpaste \_\_\_\_\_  
Other Fluoride Supplements \_\_\_\_\_  
Oral Hygiene \_\_\_\_\_  
Tobacco Use \_\_\_\_\_

Need for:

Topical Fluoride \_\_\_\_\_  
Fluoride Tablets/Crops \_\_\_\_\_  
Sealants \_\_\_\_\_  
Hygiene Instruction \_\_\_\_\_  
Other Education \_\_\_\_\_  
Target Group: \_\_\_\_\_

## PART V. TREATMENT PLAN

- Emergency exam #T, PA #T
- Emergency Treatment - XC #T, Parent informed of widespread decay present & that PT requires complete exam & possible space management.
- Parent gives appt for child's exam.

Referral/Followup: \_\_\_\_\_ Interval: \_\_\_\_\_

This treatment plan has been explained and I accept it.

Patient/Guardian \_\_\_\_\_ Date *1/6/93*  
Dentist \_\_\_\_\_ Date *1/6/93*

## VI. DEFERRED DENTAL NEED

Basic Care (Level I - III Svcs) \_\_\_\_\_  
Antero-Biocupid Endo *1* \_\_\_\_\_  
Molar Endodontics \_\_\_\_\_  
Perio Pocket Therapy \_\_\_\_\_  
Crowns/Complex Restor. *1* \_\_\_\_\_  
Removable Dentures *1* \_\_\_\_\_  
Fixed Bridge: Ant. \_\_\_\_\_ Post. \_\_\_\_\_  
Surgery: 3rd Molars \_\_\_\_\_ Other \_\_\_\_\_  
Ortho: Limited \_\_\_\_\_ Comp \_\_\_\_\_

## PART I. DEMOGRAPHICS

HRN ~~8-515~~ *8-515* SSN \_\_\_\_\_  
NAME \_\_\_\_\_  
B DATE *2/16/05* SEX \_\_\_\_\_ TRIC \_\_\_\_\_  
RESIDENCE \_\_\_\_\_  
FACILITY \_\_\_\_\_ DATE \_\_\_\_\_

## PART II. MEDICAL ALERT/UPDATE

# USE OF THE COMMUNITY PERIODONTAL INDEX OF TREATMENT NEEDS IN INDIAN HEALTH PROGRAMS

## POLICY

Initial (0110) and periodic (0120) oral examinations should include an assessment of periodontal status based upon the COMMUNITY PERIODONTAL INDEX OF TREATMENT NEEDS (CPITN). Findings are entered on the Dental Examination Record (IHS 42-1, Page 1) to include a CPITN score for each sextant of the mouth. The definition of sextant is 2nd molar to 1st bicuspid and cuspid to cuspid. The teeth included in each sextant are listed by tooth number in FIGURE ONE.

**FIGURE ONE**

UR	UA	UL
2-5	6-11	12-15
31-28	27-22	21-18
LR	LA	LL

**FIGURE TWO**

UR	UA	UL
3	8	14
30	24	19
LR	LA	LL

## THE EXAMINATION

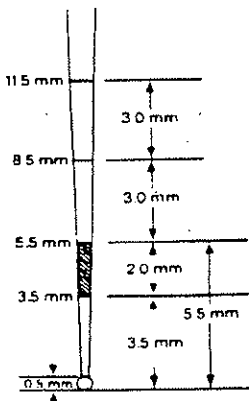
For patients age 7 to 19 years: False pockets associated with normal tooth eruption frequently yield unreliable CPITN scores. Thus, probing to determine pocket depth is not recommended for patients under 12 years of age. For patients age 12 to 19 years, probing can be limited to the six index teeth listed in FIGURE TWO. If an index tooth is missing, the sextant can be assessed only for gingival bleeding, coronal calculus, and overhangs of restorations. The documentation of periodontal status using the CPITN is not necessary for patients under 7 years of age.

For patients age 20 years or older: All teeth should be examined on adults. Third molars are not included in CPITN assessments unless they function in the place of missing second molars. A sextant must have at least two functioning teeth to be scored. If only one tooth remains in the sextant, the findings for that tooth should be included with the score for the nearest adjacent sextant. The criterion for a functioning tooth is that it is not indicated for extraction.

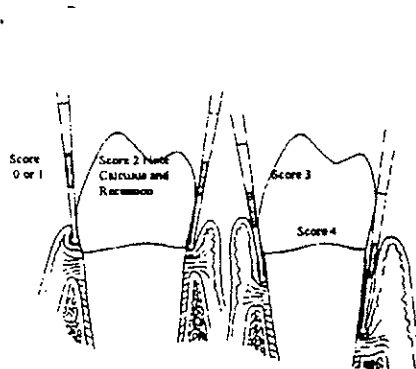
## USE OF A PERIODONTAL PROBE

The use of a graduated periodontal probe is necessary. The recommended instrument is the CPITN probe. The working end of this probe is shown in FIGURE THREE. Two important characteristics of the probe are its ball-tip and the color-coded segment between the 3.5 and 5.5 mm marks. The small spherical tip aids in the detection of calculus from any angle, and it reduces the risk of over-measurement in pocket depth, particularly when the base of the pocket is inflamed. The color-coded segment allows direct reading of pocket depth to correspond with CPITN scoring as shown in FIGURE FOUR. Note that pocket depth is measured from the gingival crest and not from the cemento-enamel junction (CEJ), even when gingival recession has occurred. Thus, the treatment need (and the CPITN score) is determined by pocket depth rather than by loss of tissue attachment.

**FIGURE THREE**



**FIGURE FOUR**



## Probing should be conducted in the following manner:

- Hold the probe gently, so that it could be removed easily from the examiner's hand by another person.
- Use a hand or finger rest which is distant from the tooth/teeth being examined.
- Use a 45-60 degree angulation of the probe from the long axis of the tooth during insertion into the pocket. Then move the probe parallel to the long axis of the tooth to measure pocket depth.
- Maintain the tip of the probe in contact with the tooth surface during probing.
- Use tactile sense only and avoid "scraping" of the tooth surfaces.
- Detect "solid" resistance from subgingival calculus and "soft" resistance at the base of the pocket.
- When necessary, probe around supra - or subgingival calculus to reach the base of the pocket.
- When gently retracting the probe, the apical ledge of subgingival calculus can be detected with the ball tip of the probe.

Probing should not cause discomfort to the patient. (No more than 25gm pressure should be placed on the tip of the probe.) The light probing pressure required should be practiced in front of a mirror using an examiner's own teeth before examinations are conducted on dental patients. Assistance is available from the Indian Health Service in obtaining and learning to use the CPITN probe. Contact the Area Dental Office which serves your local program.

## SCORING BY SEXTANT

The CPITN classifies the need for therapy by using the "most severe" finding (or highest score) observed among all teeth in the sextant. Thus, only one score is recorded for every sextant examined. The CPITN codes, diagnostic features, and the recommended therapies are given in the following table:

CPITN SCORE	DIAGNOSTIC FEATURES	RECOMMENDED THERAPY
0	Healthy tissues	None
1	Bleeding upon gentle probing	Education to promote effective "self-care"
2	Presence of calculus or overhangs and no pockets deeper than 3.5 mm	Education + prophylaxis (Includes ultrasonic scaling)
3	At least one pocket which is 3.5 to 5.5 mm deep	Education + prophylaxis + root scaling/planning
4	At least one pocket greater than 5.5 mm deep	Education + prophylaxis + deep scaling or surgery
X	Less than two teeth are functioning in the sextant	Excluded from separate needs assessment

A general rule for scoring is: If doubt exists, assign the lesser score. When heavy extrinsic staining is present in the absence of calculus or pockets, the sextant may be scored as 2, if professional care is needed to remove the stains.

The use of the CPITN does not replace the need for a thorough charting of pockets when periodontal therapy is planned for patients who have pathologic pockets (4mm or greater). Examiners should also bear in mind that some sextants which are scored as a 3 or 4 upon an initial examination may be found to have a CPITN score of 0 or 1 after prophylaxis/deep scaling are completed.

## USES OF THE CPITN DATA

The recording of CPITN scores on a periodic basis provides a general guide for treatment planning and the evaluation of therapy. The scores also can be used to make patients aware of disease and the effectiveness of their "self-care" practices. The data also can be aggregated among patients on a computer to estimate the type and amount of resources needed to support periodontal therapy as well as to monitor trends in the periodontal health of a given population.

# GUIDELINES FOR REPORTING PERIODONTAL SERVICES BASED UPON C.P.I.T.N. SCORING AND THE A.D.A. CASE TYPES

<u>C.P.I.T.N. SCORE</u>	<u>ADA CASE TYPE</u>	<u>CLINICAL DESCRIPTION</u>	<u>RECOMMENDED THERAPY</u>
0	Periodontal Health	Periodontal Health	No treatment
1	Gingivitis	Inflamed gingiva, bleeding upon probing	Education (1330) with a documented preventive plan to promote "self-care".
2	Gingivitis (with calculus)	CPTN Calculus present and/or restoration overhangs ADA No classification for local etiology.	Education (1330) with a self-care plan. Prophylaxis (1110, 1120 or 1130) to remove calculus, stains and/or overhangs.
3	Early Periodontitis	CPTN Probing pocket depths 3-5.5 mm (dark segment) ADA Probing pocket depth of 4-5mm, up to 30% horizontal bone loss. Can be generalized or localized.	Education (1330) with self-care plan. Non surgical care, which includes prophylaxis (1110, 1120 or 1130) and subgingival root cleaning (Root Planing, 4341)
4	Moderate Periodontitis	CPTN Probing pocket depths > 5.5mm. ADA Probing pocket depths of 5-7mm, with 30-50% horizontal bone loss. Can be localized or generalized.	<b>Non-surgical:</b> Education (1330) with self-care plan. Prophylaxis (1110, 1120 or 1130) and root planing (4341). <b>Surgical:</b> Conservative surgical procedures such as Gingival Surgery (4210), Gingival Flap (4240) or Osseous Surgery (4260). <b>Note:</b> For extensive root planing or surgical treatment, a case workup (4110) is required prior to therapy. The case workup includes probing, pocket measurements as a minimum for documentation of disease and treatment success.
4, 5, 6	Advanced Periodontitis	CPTN Probing pocket depths of > 5.5mm. Optional scoring for deep pockets: 4 = 5.5-8.5mm, 5 = 8.5-11.5mm, 6 > 11.5mm ADA Probing pocket depths > 7mm and > 50% bone loss. These conditions may be localized or generalized.	<b>Non-surgical:</b> Education (1330) with self-care plan. Prophylaxis (1110, 1120 or 1130) and root planing (4341) <b>Surgical:</b> Conservative surgical procedures such as Gingival Surgery (4210), Gingival Flap (4240) or Osseous Surgery (4260). <b>Note:</b> A case workup (4110) is required prior to advanced periodontal therapy.
			<b>RECALL OR MAINTENANCE CARE:</b> Following the initial prophylaxis (1110, 1120 or 1130), recall prophylaxis which occur more frequently than every 12 months must be coded as perio recall (4910).

**LIMITATIONS OR REPORTING:**

- The limitations below provide general guidelines for reporting and reimbursement policies in direct or contract programs. Some of the limitations may not apply to patients at high risk of disease (e.g. diabetics) and those with advanced or rapidly progressive disease, when more frequent and intensive therapy may be required.
- Self-care Education (1330) once per 12 month period.
- Prophylaxis (111) or 1120) once per 6-month period. Difficult prophylaxis (1130) may be reported once per 36-month period and only if 1110 or 1120 has not been reported within 12 months.
- Case Workup/Retained Perio Exam (4110) once per 12-month period.
- Root planing (4341) reported by sextant, once per 12-month period.
- Surgical Procedures (4210, 4240 or 4260) once per quadrant per 24-month period
- Perio Maintenance or Recall (4910) once per each 6-month period following prophylaxis, root planing and/or surgical treatment