SENSEITIVE TEETH STUDY

Symptomatic Exam (3rd Line Treatment Visit)

Visit Date: ______/_____/______ / ______/_____/______
m       m       d       d       y       y       y       y

Dentist-assessed signs of dentin hypersensitivity

1. Fill in the boxes below: (1) Circle the number of each tooth/teeth judged sensitive in the upper arch. (2) Mark the restoration(s) present on the sensitive tooth/teeth only.

   2   3   4   5   6   7   8   9   10   11   12   13   14   15
   ☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐

2. Check: (1) Whether visible dentin and (2) gingival recession is present and (3) the type of the restoration only on the hypersensitive upper tooth/teeth chosen above. Mark all that apply:

   2   3   4   5   6   7   8   9   10   11   12   13   14   15

   Visible Dentin
   Gingival Recession
   No Restoration
   Amalgam
   Resin
   PFM Restoration
   All Porcelain
   Cast Metal
   Other Restoration
3. Fill in the boxes below: (1) Circle the number of each tooth/teeth judged sensitive in the lower arch. (2) Mark restoration(s) present on sensitive tooth/teeth only.

☐ 31 ☐ 30 ☐ 29 ☐ 28 ☐ 27 ☐ 26 ☐ 25 ☐ 24 ☐ 23 ☐ 22 ☐ 21 ☐ 20 ☐ 19 ☐ 18

4. Check: (1) Whether visible dentin and (2) gingival recession is present and (3) the type of the restoration only on the hypersensitive lower tooth/teeth chose above. Mark all that apply:

☐ 31 ☐ 30 ☐ 29 ☐ 28 ☐ 27 ☐ 26 ☐ 25 ☐ 24 ☐ 23 ☐ 22 ☐ 21 ☐ 20 ☐ 19 ☐ 18

Visible Dentin
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Gingival Recession
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

No Restoration
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Amalgam
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Resin
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

PFM Restoration
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

All Porcelain
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Cast Metal
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Other Restoration
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

5. Patient out of pocket expense for the preventive visit and/or problem focused exam will be: (Check one)
☐ Both visit types will be covered 100% by the insurance
☐ Patient will pay a co-payment for both visit types
☐ Patient will pay 100% out of the pocket for both visit types
6. Treatment recommended and/or prescribed: **(Check and complete all that apply)**

<table>
<thead>
<tr>
<th>Treatment recommended and/or prescribed</th>
<th>Duration</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Fluoride (if checked, specify duration and frequency):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Fluoride Gel (if checked, specify duration and frequency):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Fluoride Varnish (if checked, specify duration and frequency):</td>
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<tr>
<td>☐ Fluoride Paste (if checked, specify duration and frequency):</td>
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<tr>
<td>☐ Fluoride Rinse (if checked, specify duration and frequency):</td>
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<tr>
<td>☐ Desensitizing OTC Potassium nitrate toothpastes (if checked, specify duration and frequency):</td>
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<tr>
<td>☐ Glutaraldehyde/HEMA products</td>
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<td>☐ Bonding agents</td>
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<tr>
<td>☐ Sealants</td>
<td></td>
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<tr>
<td>☐ Restorative treatments</td>
<td></td>
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<tr>
<td>☐ Lasers</td>
<td></td>
<td></td>
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<tr>
<td>☐ Oxalates</td>
<td></td>
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<tr>
<td>☐ No treatment</td>
<td></td>
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<tr>
<td>☐ Advice (If checked, specify below. Check all that apply):</td>
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<tr>
<td>☐ To stop product, habit and/or behavior. If yes, what product/habit/behavior?</td>
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<tr>
<td>☐ To decrease product, habit and/or behavior. If yes, what product/habit/behavior?</td>
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<tr>
<td>☐ To start or increase behavior. If yes, what behavior?</td>
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<tr>
<td>☐ Other (please specify):</td>
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</tbody>
</table>

7. Recommended follow-up time for this patient’s sensitive tooth/teeth: **(Check one)**
   ☐ More than 4 weeks
   ☐ 2-4 weeks
   ☐ 2 weeks
   ☐ No follow-up is needed
   ☐ Other, (Please specify :) __________________________

Practitioner Signature __________________________________________ Date: __________/____/____ 2011

PLEASE REVIEW THIS FORM FOR COMPLETION AND ACCURACY. THANK YOU.
Questions? Contact your Regional Coordinator.