MANUAL FOR
PREVENTIVE DENTISTRY
I-II
&
CLINICAL
PERIODONTICS
I - II

DEPARTMENT OF
PERIODONTICS

2013- 2014
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JNP-rev-9-2013
PERIODONTAL CHARTING

The following clinical findings are included in the periodontal charting:

- **Pocket Depths** – Three markings are recorded for the buccal (distal, mid-buccal and mesial) and three markings for the lingual (distal, mid-lingual and mesial) surfaces of all teeth. The markings are dated at the time of the probings.

- **Bleeding on probing** – Pocket recordings, which bleed are recorded.

- **Mobility** – Mobility patterns are recorded as 0, 1, 2, or 3.
  (Classification - Linde; Modified by Genco)
  - Class 1 – any mobility of the crown up to, but less than 1 mm in a horizontal direction
  - Class 2 – any mobility of the crown from 1 mm to less than 2 mm in a horizontal direction
  - Class 3 – any mobility of the crown 2 mm or more in a horizontal direction or vertical displacement in the socket.

- **Furcation Involvement** (Classification - Hamp) – Furcation involvement is recorded as Class 1, 2, or 3.
  - Class I – Horizontal loss of periodontal tissue support that is less than 3 mm.
  - Class II – Horizontal loss of periodontal tissue support that is greater than 3 mm but does not encompass the width of the furcation.
  - Class III – “Through and through” destruction of the periodontal supporting tissues in the furcation.

- **Gingival Lines** – Free Gingival Margin (FGM) – The position of the free gingival margins are recorded for each tooth relative to the CEJ.

- **Muco-Gingival Defects** – are recorded in Axium.

- **Indices** – The following two indices are recorded at any periodontal exam, re-evaluations, case completes and maintenance visits:
  - **Axium Plaque Index** – (Modified from Podshadley Index)
    a. Teeth - # 3, # 8, # 14, #19, # 25 and # 30
    b. If a tooth is missing, proceed to the next tooth and adjust the denominator of the total score %.
    c. The buccal and lingual surfaces in the maxillary arch are scored.
    d. The buccal and lingual surfaces in the mandible are scored.
    e. Plaque scores range from 0 to 6 – the tooth surface is divided into three horizontal sections on the buccal and on the lingual.
    f. Disclosing solution must be used.
    g. The score of 1 is assigned for every section where plaque is present. There are 6 teeth and 6 maximum surfaces per tooth, for a maximum total of 36.
    h. A percentage for the Axium Plaque Index is based on the amount of plaque present is calculated.
An ideal is 0%.

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<td># 8</td>
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<td># 14</td>
<td># 30</td>
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</tbody>
</table>

Total Score = __

\[
\text{API} = \frac{\text{Total Score}}{36} \%
\]

- Bleeding Index – Modified Muhleman/Carranza Text
  - **Bleeding Index**
  a. All bleeding points are circled on the charting
  b. The number of bleeding points per tooth are calculated – maximum of 6 per tooth (6 probings)
  c. A percentage is calculated:
     \[
     \frac{\text{# of bleeding points}}{\text{# of teeth times 6 areas per tooth}}
     \]
  d. 0 is ideal, but 10% or less is desirable.

**PERIODONTAL NON-SURGICAL PHASE I PROCEDURES & PARAMETERS**

- Periodontal Exam & Diagnosis
- Implant Parameters
- Esthetic Considerations
- Plaque Control Procedures
- Periodontal Scaling & Root Planing
- Occlusal Adjustment
- Fabrication of a Night Guard
- Minor Orthodontic Treatment
- Intra & Extra-coronal Splinting
- Desensitization

**CLASSIFICATION OF PERIODONTAL DISEASE**

**PERIODONTAL EXAM & DIAGNOSIS - 14001**

Prior to starting any periodontal therapy, the dental student will examine the patient and complete the Department’s worksheet to determine a periodontal diagnosis, prognosis and treatment plan for patients who are ADA Class II or III cases. These categories are listed under the following classification:

**ADA CLASSIFICATION OF PERIODONTAL DISEASE**

<table>
<thead>
<tr>
<th>ADA CLASS</th>
<th>Description</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>(No Loss of Attachment)</td>
<td>Prevention</td>
</tr>
<tr>
<td>II</td>
<td>(1-2 mm Loss of Attachment)</td>
<td>Undergraduate</td>
</tr>
<tr>
<td>III</td>
<td>(3-4 mm Loss of Attachment)</td>
<td>Phase I (Undergraduate)</td>
</tr>
<tr>
<td>IV</td>
<td>(≥ 5 mm Loss of Attachment)</td>
<td>Phase II (Postgraduate)</td>
</tr>
</tbody>
</table>

ADA Class IV (≥ 5 mm Loss of Attachment) | Postgraduate
CLASSIFICATION OF DISEASES AFFECTING THE PERIODONTIUM (Armitage)

GINGIVAL DISEASES

- Dental plaque-induced
  1. Gingivitis associated with plaque
     A. Without local contributing factors
     B. With local contributing factors
        • Tooth anatomic factors
        • Dental restorations
        • Root fractures
        • Cervical root resorption
  2. Gingival Disease modified by systemic factors
  3. Gingival Disease modified by medications
  4. Gingival Disease modified by malnutrition

- Non-plaque-induced
  1. Gingival Disease of specific bacterial origin
  2. Gingival Disease of viral origin
  3. Gingival Disease of fungal origin
  4. Gingival Disease of genetic origin
  5. Gingival manifestations of systemic conditions
  6. Traumatic lesions
  7. Foreign body reactions
  8. Not otherwise specified

PERIODONTAL DISEASE

- Chronic Periodontitis
- Aggressive Periodontitis
- Manifestation of a systemic disorder
- Necrotizing Periodontal Disease
- Abscesses of the Periodontium
- Associated with Endodontic lesions
- Developmental or Acquired Deformities and Conditions
INSTRUCTIONS ON USING THE WORKSHEET

TREATMENT PLANNING

Treatment planning is a process that involves a custom plan based on the patient’s needs and desires, the practitioner’s philosophy, skills, objectives, experiences, and evidence based dental procedures. It is a process that:

a. Recognizes a patient’s concerns  
b. Identifies medical, social, radiographic, clinical & occlusal problems  
c. Determines a diagnosis (Periodontal first)  
d. Determines a prognosis for individual teeth and the entire case  
e. Uses specific treatment procedures  
f. Sequences those procedures  
g. Assesses treatment results  
h. Manages time  
i. Brings the plan to completion & completes the objectives

METHOD OF TREATMENT PLANNING

a. Make a Proper Diagnosis First - Construct individual problem lists based on the patient’s chief complaint, medical issues, social history and habits, past dental history, dental wishes, radiographic findings, clinical findings, and occlusal findings as you do the four exams: initial interview, radiographic, clinical and occlusal. Evaluate each listed item for the different exams and check them off as you do the exams on the worksheet. If an item has relevance, then make a note of it in the space below the listings. After analyzing the findings and problems, make a diagnosis.

b. In constructing the treatment plan, do the following in the order listed below:
   • Decide on a definitive restorative plan and develop the Phase III portion of the plan first  
   • After you decide on the Phase III plan, work backwards and develop the Phase II procedures (such as pre-prosthetic surgery, periodontal surgery, socket preservation surgery, bone grafting procedures (GBR), and implant surgery).  
   • Develop the Phase I procedures, including any necessary temporization.

c. Arrange the anticipated procedures of the three phases in numerical order to follow proper treatment sequencing throughout the plan.

d. During treatment constantly review your plan and monitor patient’s compliance to insure your anticipated results are achieved; otherwise, a change in your plan or sequence may be required.
PERIODONTAL DIAGNOSIS & TP WORKSHEET
(2-24-2013)

Patient Name - ____________________ Age - _____ Chart # - __________
Date - ___________________________ Dental Student - ________________

I. INITIAL INTERVIEW

A. CHIEF COMPLAINT

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

B. MEDICAL HISTORY, MEDICATIONS & MEDICAL RISK ASSESSMENT
   - ASA CLASSIFICATION

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

C. VITAL SIGNS
   Blood Pressure = ________    Pulse = ________

D. PAST DENTAL HISTORY

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

E. SOCIAL HISTORY & ORAL HEALTH HABITS

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
II. RADIOGRAPHIC EXAM – Review the following parameters on the radiographs, check each item off as you do your evaluation, and all findings numerically.

|----------------------------------|----------------|-----------|
III. CLINICAL EXAM – Review your clinical charting along with the following parameters, check each item off as you do your evaluation, and list all findings numerically.

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>3. Clinical Charting Review (pockets, attachment levels, etc.)</td>
<td>13. Fractured teeth and/or restorations</td>
<td>23. Evaluation of ridges (undercuts, tori, tuberosity areas)</td>
</tr>
<tr>
<td>5. Gingival bio-type</td>
<td>15. Pathologic migration</td>
<td>25. Inter-arch spacing</td>
</tr>
<tr>
<td>7. Muco-gingival defects</td>
<td>17. Mobility – Fremitus</td>
<td>27. Parameters for implants</td>
</tr>
<tr>
<td>8. Gingival recession</td>
<td>18. Violation of biologic width</td>
<td>28. Smile Parameters- Gingival Symmetry, Lip line, tooth proportions, etc.</td>
</tr>
<tr>
<td>10. Periodontal or dental abscess</td>
<td>20. Root trunks</td>
<td></td>
</tr>
</tbody>
</table>
IV. OCCLUSAL EXAM – Review your mounted models along with the following parameters, check each item off as you do your evaluation, and list all findings numerically.

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>2. Wear facets &amp; patterns</td>
<td>10. Tooth positions – extrusion, drifting, etc.</td>
<td>18. Positive occlusal sense</td>
</tr>
<tr>
<td>8. Prematurities in centric &amp; excursions</td>
<td>16. Inter-arch spacing</td>
<td></td>
</tr>
</tbody>
</table>

__________________________________________________________________________________________
__________________________________________________________________________________________
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__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
V. CLINICAL INDICES

A. Axium Plaque Index - (Modified from Podshadley Index)
   1. Use Teeth - # Teeth - # 3, # 8, # 14, #19, # 25 and # 30
   2. If a tooth is missing, proceed to the next tooth and adjust the denominator of the total score %.
   3. Score buccal and lingual surfaces for max. & mand.
   4. Plaque scores range from 0 to 6 areas per tooth – the tooth surface is divided into three horizontal sections on the buccal and on the lingual – Disclosing solution must be closed.
   5. The score of 1 is assigned for every section where plaque is present. There are 6 teeth and 6 maximum sections per tooth for a maximum total of 36. Formulate a percentage for the Modified Plaque Index based on the amount of plaque present.

   An Ideal is 0 %

<table>
<thead>
<tr>
<th># 3</th>
<th># 19</th>
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<tbody>
<tr>
<td># 8</td>
<td># 24</td>
</tr>
<tr>
<td># 14</td>
<td># 30</td>
</tr>
</tbody>
</table>
   | Total Score | 36 | API = %

B. Bleeding Index- (Modified from Muhleman/Carranza Text

   Bleeding Index)
   • Circle all bleeding points on your charting
   • Count the number of bleeding points per tooth – maximum of 6 per tooth (6 probings)
   • Formulate a %: # of bleeding points
   # of teeth times 6 areas per tooth
   • 0 is ideal, but 10% or less is desirable

   Bleeding Index = %

VI. RISK FACTORS – exposures that increase the probability that a disease will occur. List all risk factors such as tobacco, smoking, genetics, systemic diseases/issues, medications, familial history, previous periodontal disease & maintenance, etc.
VII. DISEASE CLASSIFICATION – (Armitage)

Refer to your clinical findings, charting & problem lists

Guidelines for Classifying Periodontitis (Chronic / Aggressive)

**Chronic Periodontitis**
- Localized: \(< \text{or } = 30\% \text{ of sites involved}\)
- Generalized: \(> 30\% \text{ of sites involved}\)

- Early (Slight): 1 - 2 mm of Clinical Attachment Loss
- Moderate: 3 or 4 mm of CAL
- Advanced (Severe): \(> \text{or } = 5 \text{ mm of CAL}\)

**DIAGNOSIS** - ____________________________________________

**ETIOLOGY & LOCALIZED FACTORS** – (Plaque, Calculus, Iatrogenic Dentistry, Occlusion, Habits, etc.)

_______________________________________

_______________________________________

VIII. PROGNOSIS


i. **Hopeless**: Tooth needs to be removed – inadequate attachment for health, comfort & function

ii. **Unfavorable**: The periodontal status of the tooth is influenced by local and/or systemic factors that cannot be controlled and continued periodontal breakdown is likely to occur, even with periodontal treatment & maintenance.

iii. **Questionable**: The periodontal status of the tooth is influenced by local and/or systemic factors that may or may not be able to be controlled. If these factors are controlled, then the periodontium can be stabilized; otherwise, future periodontal breakdown may occur.

iv. **Favorable**: The periodontal status of the tooth can be stabilized with comprehensive periodontal treatment and maintenance. Future loss of the periodontal supporting tissues is unlikely, if these conditions are met.

**LIST ALL THE TEETH ACCORDING TO PROGNOSIS**

<table>
<thead>
<tr>
<th>Hopeless</th>
<th>Unfavorable</th>
<th>Questionable</th>
<th>Favorable</th>
</tr>
</thead>
<tbody>
<tr>
<td>________</td>
<td>__________</td>
<td>__________</td>
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</table>
IX. TREATMENT PLAN – PERIODONTAL & RESTORATIVE

**Phase I Therapy – Procedures to be considered:**

<p>| | | |</p>
<table>
<thead>
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</thead>
<tbody>
<tr>
<td>1. Address patient’s chief complaint</td>
<td>7. Endodontic Therapy</td>
<td>13. Temporization</td>
</tr>
<tr>
<td>5. Chemotherapy</td>
<td>11. Night guard fabrication</td>
<td></td>
</tr>
</tbody>
</table>

**Phase II (Surgical) - Procedures to be considered:**

<p>| | | |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>2. Gingival flap</td>
<td>7. Connective tissue graft</td>
<td>12. Revision (Plasty) Procedure - To be done at Phase II Surgical Re-evaluation</td>
</tr>
</tbody>
</table>
Phase III Therapy - Prosthetic
(Fixed - Removable – Implant Dentistry)

a. Ideal Restorative Treatment Plan (Accepted - Not Accepted)
________________________________
________________________________
________________________________
________________________________
________________________________

b. Alternative Restorative Treatment Plan - (Accepted)
________________________________
________________________________
________________________________
________________________________
________________________________

X. PROJECTED TIME INTERVAL FOR PHASE IV (MAINT)
3 months  4 months  6 months  9 months  1 year

INITIAL ASSESSMENT - PERIODONTAL CONDITION

As the primary care dentist for this patient, and based upon your assessment of patient’s periodontal condition and periodontal treatment requirements, and in consideration of your periodontal treatment capabilities, which of the following choices would you make? Circle your choice.

1. Patient will only require Phase I periodontal treatment, and I feel comfortable treating this situation.
2. This case appears borderline for Phase II periodontal treatment. I will reassess treatment results after completion of Phase I, and decide whether this case should be referred to a periodontist.
3. This case will require some Phase II periodontal treatment. I would refer this patient to a periodontist at this time.
4. This case will require implant surgery with possible grafting for site development and/or bone preservation following extraction. I will refer this patient to a periodontist at this time.
1. Minimum distance required between a tooth and an implant is usually 2mm

2. Distance required between two implants in order to obtain a papilla is 3mm from platform shoulder to platform shoulder. It may be reduced to 2 mm, if you use platform switching, whereby the abutment is less than the platform width of the implant.

3. Width of the bony ridge to accommodate an implant is 2 mm wider than the implant diameter. You need at least one mm (ideal is two mm for maxillary anterior tooth) of bone width on the facial and one mm of bone width on the lingual of the osteotomy.

4. Minimum vertical height required from the implant shoulder to the opposing tooth is 7 mm in order to place an abutment and a cemented crown; otherwise, at least 5.5 mm for a screw retained crown. You need a minimum of 4 mm of height for a crown prep to have retention, one mm for the abutment collar, one mm for metal and one mm for porcelain, for a total of 7 mm.

5. JE forms and attaches to a titanium implant similar to the junctional epithelium to a tooth by a hemi-desmosonal attachment; however, the epithelium of the implant doesn’t receive the vascular connections from the vessels of the periodontal ligament.

6. The dense CT found adjacent to implant is similar to scar tissue rich in collagen and poor in cellular elements such as fibroblasts and circulatory elements found around a tooth.

7. The design of the implant with respect to the shape, length, thread design and surface treatments are very important in deciding which implant and implant company to choose.

8. The implant platform should be placed 1 - 2 mm apical to the buccal CEJ’s of the adjacent teeth and 3mm apical to the anticipated gingival margin for a good esthetic result in the anterior zone. For optimum esthetic results between adjacent implants, use the 3X3X3 PIE rule by Dr. George Priest: platforms of the implants should be 3mm apical to the zeniths of the gingival margins, the centers of the implants should at least 3mm palatal to the facial margins, 3 mm spacing should be present between the adjacent implant platforms, and the implants should emerge through the palatal incisal edges (PIE) of the future crown positions.

9. The height of the inter-proximal bone of the adjacent tooth/ teeth to the edentulous space will determine if a papilla can be achieved with implant placement and is an important esthetic consideration before placing the implant.

10. Any anterior maxillary tooth that needs to be removed for an implant, which will not be an immediate implant, should have a socket preservation surgery done at the time of the extraction; otherwise, both esthetic and placement requirements may be compromised. (see #3)

11. Any implant less than 10 mm in length is considered a short implant.
12. If a tooth has a fracture or a failed root canal and there is loss of the facial radicular bone (dehiscence), then a particle graft + a membrane (Guided Bone Regeneration) should be done at the time of extraction or implant placement for socket preservation and bone volume regeneration.

13. Surgical implant placement is classified with the following terminology:

- Two-stage procedure – implant placement with surgical uncovering at a later date, usually 3 to 6 months, at which time a healing abutment is placed or the abutment is placed.
- One-stage procedure – implant placement with the healing abutment or the abutment placed with a temporary crown and no load.

14. There are various surgical and treatment approaches used to place implants depending upon whether a tooth is present, the area is edentulous, bone volume, bone density, and the dimensions and topography of the site. Some of the common approaches are listed in the table below.

<table>
<thead>
<tr>
<th>Tooth Present</th>
<th>Edentulous Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Extract tooth and immediate placement of the implant with bone grafting. It is performed as a two-stage procedure.</td>
<td>● Place an implant and close the site. Wait approximately 3 – 6 months and then uncover the implant. This is a two-stage procedure.</td>
</tr>
<tr>
<td>● Extract the tooth and immediate placement of the implant with minor bone grafting, if needed and a healing abutment or an abutment without load or an abutment and temporary crown with minimal load placed. This is a one-stage procedure.</td>
<td>● Place an implant and a healing abutment or an abutment at the time of the implant placement, without load. This is a one-stage procedure.</td>
</tr>
<tr>
<td>● Extract the tooth with no bone grafting and wait 2 months for soft tissue healing and then place the implant with bone grafting, if needed. This is usually a one-stage procedure where the healing abutment is placed after the implant placement, unless significant bone grafting is done. Then, it becomes a two-stage procedure.</td>
<td>● Place an implant and graft the site, if there is a deficiency. The implant must be stable, before grafting. This is usually a two-stage procedure.</td>
</tr>
<tr>
<td>● Extract the tooth and do a socket preservation procedure with a graft and then wait 4 – 6 months to re-enter and do an implant placement as a one-stage procedure.</td>
<td>● If the site lacks significant bone volume or proper dimensions, then bone grafting must be performed prior to implant placement. After a healing period of approximately 5 – 6 months (will depend upon the materials used and the type of grafting) an implant is placed.</td>
</tr>
</tbody>
</table>
15. After a tooth is extracted, there is bleeding and a blood clot forms. On the 2\textsuperscript{nd} and 3\textsuperscript{rd} days, the granulation tissue begins to form into a clot and on the 4\textsuperscript{th} day, there is a residual clot left, while the epithelium proliferates. On the 7\textsuperscript{th} day, the granulation tissue begins to organize and early connective tissue forms, along with primary osteoid. On the 21\textsuperscript{st} day, the osteoid begins to mineralize, while the epithelialization is almost completed. In about 6 weeks, there is complete soft tissue healing and woven bone trabeculation appears. There is complete osseous healing in about 6 months. Within a year of the extraction, there is usually a reduction of half the ridge width. The majority of this reduction occurs within the first three months of healing.

16. A stent template with a radiopaque marker is usually fabricated on a working model or a diagnostic wax-up to pre-plan the implants’ directions and positions for use during surgical placement of the implants. For the most accurate representation, a stent is fabricated prior to and used during the Cone Beam or the CAT scan imaging. It is also important to plan some type of temporization, preferably a fixed temporary, during the integration period.

17. Staging is a process whereby mini-implants or teeth, which will eventually be removed, are used as abutments for a provisional fixed temporary during implant placement and the period of integration. After the implants are integrated, the teeth and/or mini-implants are removed and abutments are placed on the implants and the case is taken to completion or additional implants are placed in the areas where the previous temporary abutments were removed.

18. If the angulation of the implant is off, then a standard company angled abutment or a custom abutment can be used. A custom abutment is more costly, because it involves more lab time by the technician.

19. In choosing an abutment you must know the measurement from the top of the implant or platform to the free gingival margin.

20. After 1 year, sometimes resorption is seen to the first thread and thereafter, there is an annual bone loss of .1 mm around an implant. Implant companies have developed the concept of platform switching (using an abutment with a smaller diameter than the width of the implant platform) and because of this design; bone resorption at the end of the first year is minimized.

21. There is usually gingival recession of .9 mm at the end of one year.

22. Ideally the restorative plan should be to place one implant per missing tooth, but finances may not always permit this. Also, a consideration for the number of implants placed to restore an edentulous area will depend upon the quality of bone, D-I, II, III, IV. If D-IV bone is present, then always use one implant per missing tooth. The worst area of bone density and quality is the maxillary posterior, usually D-IV bone.

23. Ideally implants can be restored individually, splinted or as part of an implant supported bridge and if possible, not splinted with natural teeth or be part of a bridge with natural teeth. However, for some practitioners the jury is still out on this issue, especially with short spans. The controversy over combining natural teeth and implants as abutments for a
fixed bridge or a splint centers on the possibility of intrusion of the natural tooth/teeth that serve as bridge or splinted abutment/s. The consensus is to keep implants by themselves.

24. Some practitioners feel adjacent implants should be splinted; others feel they should be restored as individual units. Considerations for splinting should include the size and width of the implants, the type of bone present (D-I, II, III, IV), the patient’s occlusion and whether bone grafting was required for implant placement.

25. Implant therapy is a restoration driven specialty and therefore, your restorative treatment plan should be completed prior to implant placement.

26. An accurate medical history is important to evaluate before placing implants.

27. Always obtain a proper consent form prior to the surgical implant procedure.

ESTHETIC CONSIDERATIONS & PARAMETERS
(The information listed below is referenced from Anthony G. Sclar’s textbook: “Soft Tissue & Esthetic Considerations in Implant Therapy” – Publisher: Quintessence Books)

1. INFORMATION: Know – facial symmetry, smile esthetics and gingival bio-type (Thin vs. Thick)

2. KEY FACTORS & QUESTIONS:
   a. Facial symmetry – Are the nasal midline, the upper lip philtrum, and chin midline all coincident with the facial midline?
   b. Are the max and mandibular teeth midlines coincident with facial midline or at least parallel?
   c. Are the incisal, occlusal and gingival planes parallel to a line through the pupils?
   d. What is the upper lip line relationship to the teeth? Evaluate the lip position at rest, during conversation, during relaxed smile and highly animated (have the patient enunciate the letter “e”).
   e. The average max incisor display of teeth with lips in relaxed position is 1.91 mm in men and 3.40 mm in women. Younger people show more teeth and people with long upper lips, display less teeth. Older people, 60+ years old tend to show less maxillary teeth and more mandibular teeth as they age.
   f. Display of > 3mm of gingival tissue during a moderate smile is classified as a gummy smile.
   g. Lower lip – incisal plane of maxillary anterior teeth should follow the curvature of lower lip. The sound “f or v” should be produced by the incisal edges inside the vermilion border or at the wet/dry lip line. The incisal edges are also important in establishing anterior guidance.
   h. Incisal plane – should be parallel to the pupil line (if pupil line is slanted, then the incisal plane should be perpendicular to facial midline) and follow the curvature of lower lip. Two good morphologies of incisal edges: gull-wing (laterals slightly
off plane) or slight convexity (youthful) from central to
cuspid. **Always try to avoid a concave form to the incisal
plane (sad smiley face).**

i. Incisal embrasures - They should widen from the distals of the centrals to
the canines.

j. Occlusal plane - The plane should be parallel to the pupil line and
determined by the Frankfort horizontal plane on a
sagital view or from the Camper plane (inferior border
of ala of the nose to the superior border of the tragus).

k. Tooth Proportions:
   1. Max central width should be 75% or 80% of its length.
   2. Max central should be 60% wider than the lateral and
      the lateral should be 60% wider than the mesial aspect
      of canine.
   3. Max anterior teeth should be slightly tipped medially
      towards the midline.
   4. The length of the contact points should be 50% of
      the length for centrals, 40% of the length between
      lateral and central & 30% of the length between the
      lateral and cuspid.

l. Dominance – The maxillary centrals should dominate and
   should be slightly brighter

m. Gingival Plane – Gingival plane should be parallel to the
   pupil line and if canted, then perpendicular to the facial
   midline. It should also be parallel to the incisal plane. It
   is normal to have the gingival margins of the laterals
   slightly coronal. **The right side must mirror the left side
   and this symmetry should be the endpoint and
   objective of treatment.**

n. Gingival Biotypes – Identify as thin scalloped or thick flat
   periodntium. With the thin type, you usually have
   triangular teeth with small contact points at the
   incisal thirds. The thin biotype also has long
   papillae. You must be careful of recession and loss
   of facial bone with this biotype. If the biotype is
   thick you will have plenty of fibrous attached tissue
   and bony architecture with square teeth and long
   contact points with short papillae.

o. Lip Size
   1. Norm for upper male lip is 22mm + or – 2mm
   2. Norm for upper lip female is 20 mm + or – 2mm
   3. Short upper lip for female < 18mm - For male < 20 mm
PLAQUE CONTROL INSTRUCTIONS - 11001

Students will instruct patients in plaque control procedures prior to the start of periodontal and preventive treatments and will re-enforce these techniques throughout periodontal and preventive treatments, as well as, at subsequent treatment visits, re-evaluation and recall visits. Students will record the “Modified Plaque Index” and the “Bleeding Index” at the initial diagnosis visit, Phase I Evaluation visit, case complete visit, and all recall visits.

PERIODONTAL SCALING & ROOT PLANING –
  4341 (4 or more teeth)  4342 (1 to 3 teeth)

Students are to know how to detect and remove calculus, stain, plaque and material alba correctly. The armamentaria is set up prior to seating the patient and all instruments are to be sterile and sharp. The use of the Cavitron is also permitted with faculty approval. The student is to be familiar with the different types of instruments and know how to position them, use them correctly and efficiently and sharpen them. An atraumatic technique with proper anesthesia is to be utilized during this procedure. The procedure is complete when there is complete removal of the calculus and stain. Before starting scaling on any subsequent visit, the student evaluates the previously scaled quadrant/s, re-debride, as necessary, and re-enforce home care instructions.

OCCLUSAL ADJUSTMENT – 9951 (limited)
  9952 (complete)

Students are to know and understand the indications for an occlusal adjustment. Students will perform an occulsal adjustment procedure when indicated by the treatment plan and approved by a faculty member. Mounted models are suggested and a plan will be required before starting this procedure. After completion of the procedure, the teeth are to be highly polished before dismissing the patient. Additional appointments are needed to determine if further adjustments are needed.

FABRICATION of a NIGHT GUARD - 9940

The students are to know and understand the indications for the night guard, whether it is for a para-functional habit, splinting of teeth or as an aid in the correction of an occlusion for prosthetics. Impressions are taken in order to obtain accurate casts and particularly, for the arch the guard will be made to. A face bow and a bite registration are needed in order to mount the casts. After mounting, the guard is waxed up by the lab and a processed acrylic guard is fabricated. The guard is to fitted to the arch passively and adjusted to the occlusion at the insertion visit. After adjustments on subsequent visits, the guard is polished and the checked on future recall visits.
EXTRA-CORONAL SPLINTING – 4321
INTRA-CORONAL SPLINTING – 4320

The students are to know and understand the indications for extra-coronal splinting and intra-coronal splinting. Students will perform extra-coronal splinting and intra-coronal splinting when indicated on the treatment plan. The materials used will vary depending upon the preference of the supervising faculty member. After the splint is fabricated, it is highly polished before dismissing the patient.

DESENSITIZATION - 9910

The students are to know and understand the indications for the desensitizing procedure. Students will perform this procedure in a dry, isolated area and the desensitizing agent used will vary depending upon the preference of the supervising faculty member. The students are to know the mechanism of action of each agent used.

PHASE I EVALUATION
14002 (Case Type II)
14003 (Case Type III)

Students are required to evaluate the tissue response to scaling at each subsequent scaling visit or prior visits. Phase I Evaluation may be scheduled after a minimum of 2 to 4 weeks at the discretion of the faculty member following the last scaling visit. Three (3) Phase I Evaluations are required during the junior year and three (2) for the senior year. Phase I Evaluations must be completed on patients, which students have performed Phase I Therapy procedures. At the Phase I Evaluation visit the following is to be completed:

- Review and update the Medical History & BP
- Probe all remaining teeth and enter the three pocket depths on the periodontal sheet in the chart along with the date. Also, record the mobility on each tooth. Compare this data to the initial charting from the previous evaluation.
- Record the Plaque Index and the Bleeding Index in the chart. The new recordings should be compared to the previous recordings, which were taken at the diagnosis visit for an evaluation.
- Evaluate the tissue response to Phase I therapy.
- Determine whether the case will need surgical procedures that were proposed at the treatment planning session or if additional surgical procedures are needed at this time. If additional procedures are needed, the treatment plan is changed and the surgical referral form is completed on the computer. Upon completion of the referral form, an A-mail will be forwarded to the PG Director for assignment.
- Set a future 9-month recall interval appointment on the computer, at the end of Phase I Evaluation for the active patient. An earlier appointment can be made, if needed.
- If the periodontal therapy is complete at this time, then enter a periodontal final case complete code and note this in your SOPA note.
PERIODONTAL FINAL CASE COMPLETE

(14004 – Non-surgical case)
(14005 – Surgical case)
(14006 – Non-Compliant Patient)

The Final Periodontal Case Complete visit is completed at Phase I evaluation, if no surgery is planned or at Phase II evaluation, if surgery was performed and completed. It includes the following procedures:

- A review of the Medical History & BP
- An oral exam
- A comprehensive periodontal charting, including pocket depths, mobility, etc. and the date performed
- An exam for caries and/or defective restorations
- A recording & evaluation of the Plaque Index & the Bleeding Index
- A review plaque control procedures, if necessary
- An evaluation of the tissue quality & the effectiveness of the periodontal treatment.
- An evaluation, if the disease process has been eliminated or adequately controlled
- An evaluation for the need of any additional treatment or restorative work
- Maintenance Treatment, if due at this time
- A date and time for the next Maintenance Treatment

N.B. This procedure code should be completed in conjunction with the Phase I Evaluation procedure code at the same visit, providing no periodontal surgery is needed. This code is also used in conjunction with the Phase II evaluation procedure code when all the periodontal surgical procedures are completed.

PERIODONTAL MAINTENANCE - 4910
ADULT PROPHY - 1110

The maintenance visit occurs on a time interval schedule, depending upon the particular case; however, during active treatment all patients are placed on an initial 9-month recall interval. If an active patient is in need of a supportive visit prior to the initial 9-month interval, then the procedure is done earlier. At this visit the following procedures are completed:

- A review of the Medical History & Vital Signs (BP & Pulse)
- An intra & extra oral examination
- A comprehensive periodontal charting, including pocket depths, bleeding upon probing, gingival recession, furcation violations, fremitus, mobility, etc. and date performed
- An exam for any caries and/or defective restorations
- Radiographs, and if taken, x-rays are processed immediately and read
- A recording and evaluation of the Plaque Index & the Bleeding Index
- A review of plaque control procedures, if necessary
• An evaluation of the tissue quality & the effectiveness of any previous periodontal treatment.
• An evaluation, if the disease process has been adequately controlled.
• An evaluation for the need of any additional treatment or restorative work due to caries, defective restorations or replacement dentistry.
• Maintenance therapy is completed at this visit
• A date and time for the next Maintenance Treatment – 9 month interval, if the patient is still active. If the active treatment is completed and the patient is to be paced on maintenance, then an appropriate time interval (3mos, 4mos, 5mos, etc.) is chosen.
• Caries Risk Assessment
• Reappointment for a future recall appointment

SURGICAL REFERRAL TO PG PERIODONTAL CLINIC

Whenever an undergraduate's patient requires surgery by a postgraduate student, the undergraduate is required to perform the "surgery assist" and participate with the postgraduate in all the "post-op" visits. The undergraduate student follows the protocol for surgical assist that is listed in this manual. An undergraduate surgical referral form on Axium is completed, which will be A-mailed to the P.G. Director. The P.G. Director will assign the case to a P.G. student for the surgery.

If the patient is not the undergraduate student’s patient, then the undergraduate student must follow the “Surgical Assist” protocol listed in this syllabus.

Phase I Therapy must be completed prior to surgery and approved by a periodontal faculty member. Poor plaque control, remaining calculus, improper temporization, etc. may result in a postponement of the surgical procedure. In addition, the Phase II (surgical) treatment plan is entered in Axium, if it has not previously been entered.

PERIODONTAL SURGICAL PROCEDURES

Senior students may make a request to the Director of the Undergraduate Periodontal program or the Chairperson to perform periodontal surgical procedures such as clinical crown lengthening surgery, gingival flap surgery, sextant pocket elimination surgery, gingival grafting except lower premolar and 1st molar areas, muco-gingival surgery, etc. providing all of the senior periodontal requirements with respect to competencies and surgical assists are completed or if a senior has completed the selective/elective course in “Advanced Topics in Clinical Periodontics” given in the fall semester of the senior year.
1. **Mucogingival Defects**
   - Lack of attached keratinized tissue
     a. Probe passes the muco-gingival junction – there is keratinized tissue but it is unattached.
     b. There is no keratinized tissue present
   - Aberrant frenum is present & is pulling on the gingival margin
   - Shallow vestibule is present
   **Surgical Treatment** – Free Gingival Graft, Connective Tissue Graft or Split Flap repositioned apically or laterally – (Frenum issue only – Frenectomy)

2. **Gingival Recession** - Root coverage is needed for esthetics or control root sensitivity
   **Surgical Treatment** – Connective Tissue Graft or Coronal Repositioned Gingival Flap with a biologic product for tissue engineering

3. **Gingival Pockets (Pseudopockets)** – No attachment loss and usually caused by gingival hyperplasia
   **Surgical Treatment** – Gingival Flap or Gingivectomy/Gingivoplasty

4. **Chronic Periodontitis – Moderate destruction**
   - Periodontal Pockets of 5 – 6 mm with attachment loss up to 4 mm
   - Horizontal & Minimal Vertical Attachment Loss
   **If Surgical Treatment** – Osseous Surgery with Apically Repositioned Flaps or Gingival Flap

5. **Chronic Periodontitis – Severe destruction**
   - Periodontal Pockets of 6 mm or > with attachment loss > 4 mm
   - Horizontal & Vertical Attachment Loss
   **Surgical Treatment** – Osseous Surgery with Apically Repositioned Flaps

6. **Periodontal Pockets of the Infrabony Type, Class I & II Furcations – Vertical Attachment Loss**
   **Surgical Treatment** – Guided Tissue Regeneration (GTR) using collagen membranes and some type of bone or bone substitute graft material, growth factor or biologic product for tissue engineering or osseous.

7. **Uneven Gingival Margins** – Esthetic considerations for smile design
   **Surgical Treatment** – Gingival flap or Osseous surgery with apically repositioned flap

8. **Inadequate Crown Length for Restorative Dentistry – Prosthetic Consideration**
   - Short clinical crown height
   - Tooth fracture that is sub-osseous or at the crest of bone
   - Decay that is sub-osseous or at the crest of bone
   - Tooth preparation that is sub-osseous or at the crest of bone
   **Surgical Treatment** – Osseous Crown Lengthening Surgery with apically repositioned flaps

   **Surgical Treatment** – Gingival Flap or Osseous Surgery with apically repositioned flaps

10. **Ridge Augmentation or Ridge Preservation**
    **Surgical Treatment** – Bone Augmentation – Guided Bone Regeneration
        Socket Preservation – Guided Bone Regeneration
        Soft Tissue Augmentation- Connective Tissue Graft or Free Gingival Graft

6-6-2012
CLINICAL CROWN LENGTHENING - D4249

Clinical crown lengthening procedure is indicated when:

- The biologic width is violated by either crestal/sub-osseous decay or crestal/sub-osseous fracture.
- The clinical crown height is too short for adequate tooth preparation, or for esthetic reasons or if there is an inter-arch spacing problem for prosthetic purposes.

The following policies are followed in order to insure optimal therapy and satisfactory results:

- A current periapical x-ray of the tooth must be available.
- The procedure must be approved by a periodontal faculty member and recorded on Axium’s Surgical Referral Form.
- All decay must be excavated prior to the surgical procedure and a new x-ray taken.
- If the tooth is to receive a crown, then a temporary crown with proper tooth form and proximal contacts must be in place prior to the surgery. \textbf{This does not apply to the cases where the clinical crown height is too short.}
- The undergraduate student must assist at his/her patient’s surgery.
- Any deviation from these criteria must be approved by the Undergraduate Director.

IMPLANT – SURGICAL PLACEMENT - D6010

This includes the surgical placement of the fixture and the post operative visits. If a tooth is present, \textbf{then the code D4265- (Biologic material) should also be included}, since grafting usually occurs during this procedure.

PERIODONTAL SURGICAL ASSIST PROTOCOL

30021 – Periodontal Surgery Assist
16010 – Implant Surgery Assist

Twelve (12) Surgery Assists (5 junior year/7 senior year) are requirements of the Department of Periodontics. If a student observes the surgery for the entire procedure, then credit for ½ of an assist will be given. To receive credit for your assists the following protocol \textbf{must} be followed:

- It is required that the undergraduate student, whose patient is to receive surgery, will read about the surgical technique prior to the treatment and be knowledgeable about the procedure. The undergraduate student must meet with the PG student one week prior to the procedure to discuss the diagnosis, treatment plan, surgical technique and post-operative care. The outcome of the procedure should also be discussed with the
supervising faculty. If possible, the student should come prior to the appointment time to help set up. The undergraduate must also be present for the follow-up care visits.

• If the patient is not the student’s patient, then the undergraduate student meets with the PG student prior to the procedure or immediately after to discuss the diagnosis, treatment plan, surgical technique and post-operative care. The outcome of the procedure should also be discussed with the supervising faculty. If possible, the student should come prior to the appointment time to help set up. The undergraduate must also be present for the first follow-up care visit.

- Preparation for procedure
  a. All materials for surgery (gauze, irrigation, Coepak, etc.)
  b. Blades on handles
  c. Syringes together

- Clean-up after procedure
  a. Wash all instruments removing all signs of blood
  b. Clean and spray all instruments
  c. Clean unit and spray area
  d. Remove all blades from instruments before bringing to dispensary

CLOSED CLINIC ROTATION

In the Junior year, there is a closed rotation in the Periodontal PG clinic for surgical assisting every Monday (AM) session during the Fall trimester.

In the Senior year, there is a closed rotation in the Periodontal PG clinic for surgical assisting every Tuesday (PM), Wednesday (PM), Thursday (PM) and Friday (PM) during all three trimesters.
COMPETENCIES

PERIODONTAL DIAGNOSIS COMPETENCY - 20021

A minimum of one (1) Diagnosis Competency must be completed by the first trimester of each academic year, a total of two (2) by the end of the 2nd trimester and three (3) by the third trimester. This requirement applies for both junior and senior years. A Diagnosis Competency may be scheduled anytime during the year once two (2) diagnoses have been successfully completed. A Diagnosis Competency performed without adherence to this criterion will be classified as a Diagnosis and an “F” grade will be recorded for the attempted competency. The student must declare the Competency prior to the start of the procedure. Failure to complete the minimal trimester requirement/s will result in a competency failure per applicable trimester, which will influence the final grade for the course. A “U” – Unsatisfactory will be submitted to the Registrar’s office for the interim trimester grade.

A Scaling Competency may be scheduled anytime during the academic year once at least three (3) quadrants of scalings have been successfully completed. A Scaling Competency performed without adherence to this criterion will be classified as a Scaling and an “F” grade will be recorded for the attempted competency. The use of a cavitron is permitted with faculty approval. Routine Scaling/Root Planing or Scaling/Root Planing Competencies may not be undertaken without a Periodontal Diagnosis and Periodontal Treatment Plan.

The Scaling Competency Packet must be completed prior to the procedure, before challenging the competency. It consists of:

1. Instruction sheet
2. Worksheet
3. Medical history form
4. Progress form
5. Grade sheet
PERIODONTAL SCALING COMPETENCY INSTRUCTIONS  (1-12-2012)

a. This format mimics the ADEX/NERB periodontal exam with respect to paperwork, patient selection (minor variation), blood pressure, radiographs, and format

b. The competency exam is performed mainly on a quadrant, rather than, pre-selected teeth in different quadrants. The time allotted is 1 hour.

c. The scaling procedure for the entire quadrant must be completed, even though some teeth are not used during the exam. The scaling procedure can be completed after the competency is completed and evaluated.

d. Patient selection will include:
   1. 4 to 6 teeth are to be selected in one quadrant and each tooth needs at least one surface of calculus present. A total of 6 surfaces of calculus are required. If there are not enough surfaces in the quadrant, another tooth may be selected in another quadrant to qualify.
   2. Quadrant must have at least 2 posterior teeth: bicuspsids and/or molars. A minimum 4 surfaces of detectable subgingival calculus must be present on the posterior teeth, with at least two surfaces on interproximal areas. There is no longer an approximating tooth requirement. No more than 2 surfaces may be selected on incisors.
   3. Three of the 4 – 6 selected teeth for calculus removal need pocket depths of 4mm or more and the teeth along with the surfaces must be recorded on the competency worksheet
   4. An anterior tooth and a posterior outside of the teeth selected must be present for pocket measurements assignment by the examiner.
   5. FMS within three years. (ADEX/NERB board exam also requires 4 bitewings within 6 months)

e. Paperwork includes:
   1. Medical History must be completed. (On NERB/ADEX EXAM, the Informed Consent Form is also required.)
   2. BP must be recorded on the medical history prior to the competency.
   3. Periodontal Scaling Competency Worksheet should be completed prior to taking the exam and the information transferred to the Junior and Senior Scaling Competency Grading Form. The worksheet process consists of:
      a. Recording 3 of the selected teeth indicating the teeth and the surfaces with pocket depths of 4 mm or more under “Pocket Depth Qualifications” (Ascending order)
      b. Recording the 4 – 6 teeth selected and indicating the surfaces on the selected teeth for calculus removal under “Subgingival Calculus Detection” (Ascending order)
      c. Recording the 4 -6 teeth under the “Plaque/Stain Removal”. (Ascending order)
      d. The examiner will fill in the start and finish times and mark the two teeth for pocket measurements.
   4. Progress Form must be completed and will include:
      a. Anesthetic Record – Request the use of local anesthesia: type, quantity and concentration.
      b. Pre-Treatment Medication – List the antibiotic and the dosage if pre-medication is being used.
      c. An anterior and posterior tooth, outside of the selected teeth, will be chosen by the examiner and listed on the progress form. You must record the six pocket markings for each tooth as part of the exam on this form.
d. A start and finish time will be indicated on the Progress form by the examiner. For this competency format you are allowed one hour.

e. Option - Make any notes or comments that are relevant to the case prior to the start of the procedure under “Notes & Comments” section.

f. Presentation of patient to examiner – FMS, Progress Form, Medical History Form & Junior and Senior Scaling Competency Grade form

g. Grading parameters – The student is given 1 hour for the actual exam and the scaling must be completed for the main quadrant after the grading is completed. The grading parameters for the scaling competency are:

1. Patient selection and radiographs
2. Plaque/stain/calculus detection/calculus removal
3. Pocket measurements
4. Unauthorized anesthesia/treatment management

Note: The grading scheme for these four areas would be: 1=failure, 4=pass

h. The criteria for grading is:
1. Failure to remove plaque/stain on two teeth or more = FAILURE
2. Failure to detect calculus on two or more surfaces = FAILURE
3. Failure to remove calculus on two or more surfaces = FAILURE
4. Pocket measurements off by two or more mm in two or more areas = FAILURE
5. Unpreparedness (failure to understand and/or be prepared for the competency protocol)
PERIO SCALING COMPETENCY (PDSCAL)

General Questions:

Review of Patient History ○ Pass ○ Fail
Comment if Fail: ____________________________

Preparedness ○ Pass ○ Fail
Comment if Fail: ____________________________

Infection Control ○ Pass ○ Fail
Comment if Fail: ____________________________

Communication with Faculty/Staff ○ Pass ○ Fail
Comment if Fail: ____________________________

Professionalism ○ Pass ○ Fail
Comment if Fail: ____________________________

Patient Management ○ Pass ○ Fail
Comment if Fail: ____________________________

Chart Completion/Documentation ○ Pass ○ Fail
Comment if Fail: ____________________________

Faculty Intervention
○ 1-Major Intervention
○ 2-Minor Intervention
○ 3-No Intervention
Comment if Major Intervention: ____________________________

How did the Student Self-Assess?
○ 1-Critical Error
○ 2-Multiple Minor Errors
○ 3-Minor Error
○ 4-No Error
○ 99-Non Applicable
Comment if Critical Error: ____________________________

Treatment Specific Questions:

Patient Selection/Radiographs
○ 1-Critical Error
○ 2-Multiple Minor Errors
○ 3-Minor Error
○ 4-No Error
○ 99-Non Applicable

Comment if Critical Error: ____________________________

Plaque/Stain/Calculus Detection/Removal
○ 1-Critical Error
○ 2-Multiple Minor Errors
○ 3-Minor Error
○ 4-No Error
○ 99-Non Applicable

Comment if Critical Error: ____________________________

Pocket Measurements
○ 1-Critical Error
○ 2-Multiple Minor Errors
○ 3-Minor Error
○ 4-No Error
○ 99-Non Applicable

Comment if Critical Error: ____________________________

Unauthorized Anesthesia/Treatment Management
○ 1-Critical Error
○ 2-Multiple Minor Errors
○ 3-Minor Error
○ 4-No Error
○ 99-Non Applicable

Comment if Critical Error: ____________________________

** One Critical Error equals a failure
# Periodontal Scaling Competency Worksheet

On the day of the examination all information on this Form must be accurately transferred to the Periodontal Examination Evaluation Form provided at that time.

## Pocket Depth Qualification
Enter the numbers of the 3 teeth (from the list of teeth below selected for Subgingival Calculus Detection) with 4 mm or deeper pockets in the large boxes to the left and indicate the surface where the pocket selected on each tooth is located in the smaller adjacent box (M = Mesial, F = Facial, D = Distal, L = Lingual). It is not necessary to select one of these surfaces to scale.

## Subgingival Calculus Detection
Select 6 surfaces on four to six teeth for subgingival calculus detection / removal. At least two of the teeth must be posterior teeth (incisors and / or molars). At least 2 surfaces must be on interproximal surfaces of molars and / or premolars. A cusp is neither an anterior nor posterior tooth. No more than 2 surfaces may be on incisors.

Enter the numbers of the teeth selected in the large boxes. In the smaller adjacent box, enter the surface on that tooth that is selected for removal (M=Mesial, F=Facial, D=Distal, L=Lingual). If more than one surface is selected on the same tooth, enter the tooth number each time a new surface is listed.

Record the tooth numbers in ascending order. Each tooth selected must have at least one surface of calculus indicated for removal.

## Plaque / Stain Removal
Enter the numbers of the 4 to 6 teeth (from the list of teeth above selected for Subgingival Calculus Detection). These teeth will be evaluated for the removal of plaque, stain, and supragingival calculus on the crowns of the teeth.

The two teeth assigned for "Pocket Measurements" will be indicated on the Periodontal Progress Form. Your pocket measurements should also be recorded on the Periodontal Progress Form.

Each time the patient is sent to the Evaluation Station, the Periodontal Progress Form, the Evaluation Form*, Medical History, Informed Consent and radiographs must accompany the patient.

The assigning examiner will insert Start and Finish times on the Periodontal Progress Form and return it to you. The assigning examiner will also give permission to administer the anesthetic solution.

It is the candidate’s responsibility to accurately transfer the information from this Treatment Selection Worksheet to the Evaluation Form prior to presenting the patient for assignment.

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*Maintained in the Evaluation Station
Patient's name ___________________________ Date Form Completed __/__/____

Birthdate __/__/____ Weight __________________________

Blood Pressure __________ Date/Time Taken __________

INSTRUCTIONS TO THE PATIENT:
Answer the following questions as completely and accurately as possible. All information is CONFIDENTIAL.
Please circle "yes" or "no" to all questions, and write in your answers as appropriate.

1. Are you under the care of a physician at this time? YES NO

If yes, for what condition?

2. The name and address of my physician is __________________________

3. My last physical examination was on __________________________

4. Has a physician treated you in the past six months? YES NO

If yes, for what condition?

5. Have you been hospitalized or have a serious illness within the last five years? YES NO

If yes, please specify __________________________

6. Are you allergic or have you had any adverse reaction to any medicines, drugs, local anesthetics, LATEX or other substances? YES NO

If yes, please specify __________________________

7. Do you have or have you had any of the following diseases/problems? Please explain "YES" answers on the back.

| A. Abnormal bleeding, bruise easily or require blood transfusion | YES NO | Q. Artificial/Prosthetic heart valves | YES NO |
| B. Angina/Chest pain | YES NO | R. Valve damage following heart transplant | YES NO |
| C. Asthma/Lung/Respiratory condition | YES NO | S. Congenital heart disease | YES NO |
| D. Diabetes | YES NO | T. Infective endocarditis | YES NO |
| E. Emotional/Mental health disorder | YES NO | U. Heart murmurs | YES NO |
| F. Epilepsy/Seizures/Convulsions | YES NO | V. Mitral valve prolapse | YES NO |
| G. Hepatitis/Infections/Cirrhosis, Liver disease | YES NO | W. Rheumatic heart disease | YES NO |
| H. High blood pressure | YES NO | X. Congestive heart failure | YES NO |
| I. HIV positive/AIDS | YES NO | Y. Pacemaker | YES NO |
| J. HIV or skin rash | YES NO | Z. Cardiovascular (heart) disease | YES NO |
| K. Kidney/Renal disease | YES NO | Arteriosclerosis/Coronary occlusion | YES NO |
| L. Sexually Transmitted Disease(s) | YES NO | AA. Cancer/Chemo/Radiation therapy | YES NO |
| M. Stomatitis ulcers | YES NO | BB. Immune suppression or deficiency | YES NO |
| N. Thyroid disease | YES NO | CC. Heart attack | YES NO |
| O. Tuberculosis | YES NO | DD. Heart surgery Date | YES NO |
| P. Artificial/Prosthetic joint replacement | YES NO | EE. Stroke Date | YES NO |

8. Have you had surgery or x-ray treatment for a tumor, growth or other condition of your head or neck? YES NO

If yes, please list __________________________

Turn Over ✓
Please explain all “YES” answers to Question #7

9. Do you have any other diseases, conditions, or problems not listed above? If yes, please explain: .................................... YES NO

Any item on the Medical History with a “YES” response, in questions #4-9 could require a Medical Clearance from a licensed physician if the explanation section indicated the possibility of a significant systemic condition that could affect the patient’s suitability for elective dental treatment during the examination. The Medical Clearance must include the physician’s name, address, and phone number.

10. Are you taking or have you ever taken any of the following medications for any type of cancer, osteoporosis or bone loss due to aging, Paget’s Disease, or multiple myeloma? .......................................................... YES NO
   If yes, please check the appropriate medication below:

   - Non-Nitrogen Containing (less potent) Bisphosphonates – Oral
     □ Etidronate (Didronel®, Didrocal®)
     □ Thudronate (Skelid®)

   - Nitrogen Containing Bisphosphonates – Oral
     □ Pamidronate (Aredia®, Rhoax®)
     □ Zoledronate (Zometa®, Aclasta®, Reclast®)
     □ Clodronate (Bonefos®)
     □ Neridronate

   - Nitrogen Containing Bisphosphonates – IV
     □ Alendronate (Fosamax®, Fosamax+D, Fosavance®)
     □ Ibandronate (Boniva®, Bondronat®)
     □ Risedronate (Actonel®)
     □ Olpadronate

   (This list of Bisphosphonate medications should not be considered complete as new drugs are continually being developed)

11. Please list any premedication, medications, pills, or drugs with dosage which you are taking both prescription and nonprescription (Must be completed the DAY OF THE EXAMINATION):

12. WOMEN ONLY: Are you pregnant? .......................................................... YES NO
   If yes, when is your expected due date?

I certify that I have read and understand the above. I acknowledge that I have answered these questions accurately and completely. I will not hold the testing agency responsible for any action taken or not taken because of errors I may have made when completing this form.

PATIENT SIGNATURE: __________________ DATE SIGNED: ____________

CANDIDATE INITIALS: _____ DATE INITIALED: __________ CANDIDATE SIGNATURE: __________________ (Added at end of exam)
PERIODONTAL
Progress Form

MEDICAL HISTORY
Reviewed by Evaluation Station Examiner
Examiner #: □ □ □ □ □ □

ANESTHETIC RECORD
If a local anesthetic were to be used on this patient you would provide:

Type(s) of Injection (Infiltration/Block):
Anesthetic(s) (Brand/Generic Name):
Quantity of Anesthetic (cc) Expected to use:
Vasoconstrictor (Concentration):

Has the patient previously received anesthetic same day? □ Yes □ No

Evaluation Station Examiner Approval for Initial Anesthetic
Examiner #: □ □ □ □ □ □

Clinic Floor Examiner Approval for Additional Anesthetic
Examiner #: □ □ □ □ □ □

Quantity of Anesthetic (cc) Actually used:

PRETREATMENT MEDICATION (if required)
Medication(s) (Brand/Generic Name):
Dosage/When Taken:

PERIODONTAL MEASUREMENTS
INSTRUCTIONS: The teeth identified in the box grids below, one posterior and one anterior, are assigned for Periodontal Charting. Measure and record the depth of each sulcus/pocket on six aspects (DF, F, MF, DL, L, ML) of each assigned tooth. Record each measurement to the nearest mm.

ASSIGNED TEETH:
For Measurement of Pocket Depths:

Anterior
Tooth #  DF  F  MF  DL  L  ML

Posterior
Tooth #  DF  F  MF  DL  L  ML

Assignment Procedure Completed: □ □ □ □ □ □
E. S. – Examiner(s): □ □ □ □ □ □

Treatment Evaluation Completed: □ □ □ □ □ □
E. S. – Examiner(s): □ □ □ □ □ □

On or before the Finish Time, send the patient to the Evaluation Station with an instrument tray containing the radiographs, mirror, #11/12 explorer, periodontal probe with markings at 1, 2, 3, 5, 7, 8, 9, 10, Medical History, color coded cubicle ID card, and this Progress form (with periodontal measurements).

NOTES and COMMENTS
□ See other side for more comments
SENIOR MOCK BOARD - 20023
MOCK BOARD (Participation required)
All seniors must participate in the Periodontal Mock Board. **Failure to participate without permission from Course Director will result in the requirement of passing an additional scaling competency for the senior year.** Successful completion of the Mock Board will be credited as a Scaling Competency, if challenged. The criteria for Patient Selection, exam guidelines and grading are identical to the Department’s scaling competency.

**REQUIREMENTS FOR CLINICAL PERIODONTICS I - JUNIOR YEAR**

- 3 Diagnosis Competencies *
- 3 Scaling Competencies**
- 2 Phase I Evaluations***
- 4 Maintenance Visits****
- 5 Surgical Assists
- 150 points*****

* - requires successful completion of 2 diagnoses prior to taking a competency and a minimum total number of competencies at the end of each trimester
** - requires successful completion of 3 scalings prior to taking a competency and a minimum total number of competencies at the end of each trimester
*** - must be a patient that the student treated with Phase I Therapy
**** - requires a minimum of 1 maintenance visit per trimester
***** - requires a minimum of 50 clinic points per trimester during the junior year

N.B. - A minimum of one (1) Diagnosis Competency must be completed in the first trimester of the junior year, a total of two (2) by the end of the 2nd trimester and three (3) by the completion of the junior course. A Diagnosis Competency may be scheduled anytime during the year, once two (2) diagnoses have been successfully completed. **Failure to complete the minimal trimester requirement/s will result in a competency failure per applicable trimester, which will influence the final grade for the course. A Diagnosis Competency performed without adherence to this criterion will be classified as a Diagnosis and an “F” grade will be recorded for the attempted competency.**

A “U” grade (Unsatisfactory) will be submitted to the Registrar’s office for the interim trimester grade.

A minimum of one (1) Scaling Competency must be completed in the first trimester of the junior year, a total of two (2) by the end of the 2nd trimester and three (3) by the completion of the junior course. A “U” grade (Unsatisfactory) will be submitted to the Registrar’s office for the interim trimester grade. A Scaling Competency may be scheduled anytime during the academic year, once at least three (3) quadrants of scalings have been successfully completed and graded. A **Scaling Competency performed without adherence to this criterion will be classified as a Scaling and an “F” grade will be recorded for the attempted competency.**

Any Diagnosis and/or Scaling Competencies and Phase I Evaluations in excess of the junior requirements, may be applied towards Clinical Periodontics II requirements.
The final grade for the junior course will be reported to the Registrar as either a Pass or Fail. The course grade will be an A, B+, B, C+, C, D or F based on the criteria listed below. **The D or F grade must be remediated or the course repeated.** Remediation will be determined by the Course Director and may occur during the month of August in the PG clinic. The remediation will consist of one on one instruction with a faculty member. The parameters from the Departmental Periodontal Diagnosis Worksheet will be reviewed and discussed for the Periodontal Diagnosis Competency. Calculus detection and instrumentation for calculus removal will be emphasized for the Scaling Competency. The grade will be computed as follows:

Competencies (3 Periodontal Diagnoses and 3 Scaling Competencies)

- 40% of the grade
  - No failure in obtaining each of the 3 competencies – A
  - One failure in obtaining each of the 3 competencies – B
  - Two failures in obtaining each of the 3 competencies – C
  - Three failures in obtaining each of the 3 competencies – D
  - Four failures or more in obtaining each of the 3 competencies – F
  - All D & F grades will require remediation before attempting another competency. After completion of the remediation and successful completion of the competency requirement, a C grade will be given.

Points (150 points)

- 60% of the grade
  - Minimum completion of 5 Phase I Evaluations, 2 Maintenance Visits, and 7 Surgical Assists must be included in the total point aggregate.
  - 210 points or greater – A
    - 195 to 209 points – B +
    - 180 to 194 points - B
    - 165 to 179 points – C +
    - 150 to 164 points – C
    - 135 to 149 points - D
    - Less than 135 points – F

Daily Grades

- Daily grades are graded as Pass or Fail based on the number of minor errors and/or critical errors. A critical error is an error that compromises and/or impacts negatively on patient safety and/or treatment results. It can be a result of lack of knowledge, substandard treatment, inappropriate method of care, or incorrect execution of proper care. In addition, there can be misdiagnosis, the use of unacceptable techniques, incorrect or flawed diagnostic methods, and/or major damage to soft tissues or hard tissues during procedures. A minor error is an error in the diagnosis and/or treatment of a patient, which does not result in the consequences listed above for a critical error and does not compromise a patient’s safety and/or treatment results.

  - Any student who receives 4 or more failures on the daily grades in a trimester must be remediated.
  - A minimum of 50 points per trimester is required during junior year.
**REQUIREMENTS FOR**

CLINICAL PERIODONTICS II SENIOR YEAR

3 - Diagnosis Competencies *
3 - Scaling Competencies *
1 - Mock Board Participation
3 - Phase I Evaluations**
4 - Maintenance Visits*
7 - Surgical Assists

110 Points*

* - requires successful completion of a minimum total number of competencies, a minimum of 35 points per trimester and at least 1 maintenance visit at the end of each trimester.

** - must be a patient that the student treated with Phase I Therapy

A minimum of one (1) Diagnosis Competency must be completed in the first trimester of the senior year, a total of two (2) by the end of the 2nd trimester and three (3) by the completion of the senior course. **Failure to complete the minimal trimester requirement/s will result in a competency failure per applicable trimester, which will influence the final grade for the course.** A “U” grade (Unsatisfactory) will be submitted to the Registrar’s office for the interim trimester grade.

A minimum of one (1) Scaling Competency must be completed in the first trimester of the senior year, a total of two (2) by the end of the 2nd trimester and three (3) by the completion of the senior course. Failure to complete the minimal trimester requirement/s will result in a competency failure per applicable semester, which will in influence the final grade of the course.

The final grade for the senior course will be a letter grade A to F and based on the criteria listed below. The final course grade reported to the Registrar will be either an A, B+, B, C+, C, D or F and will represent the average between the sum of the two letter course grades from the junior and senior years, since the junior course grade is reported as a Pass/Fail. The D or F grade in the senior course must be remediated or the course repeated. Remediation will be determined by the Course Director and will occur after the official graduation of the class and possibly, if needed, up to and during the month of August in the PG clinic. The remediation will consist of one on one instruction with a faculty member. The parameters from the Departmental Periodontal Diagnosis Worksheet will be reviewed and discussed for the Periodontal Diagnosis Competency. Calculus detection and instrumentation for calculus removal will be emphasized for the Scaling Competency. The grade will be computed as follows:

If remediation occurs, a grade of no higher than a C will be awarded. If a senior student is deficient in requirements, which are required by graduation date, due to patient availability, then an “INC” (Incomplete) grade will be issued and additional time will be granted to the student. The final grade for the senior course will be computed as follows:

Competencies (3 Periodontal Diagnoses and 2 Scaling Competencies + 1 Mock Board/additional scaling competency)

- 40% of the grade
- No failure in obtaining each of the necessary competencies – A
- One failure in obtaining each of the necessary competencies – B
- Two failures in obtaining each of the necessary competencies – C
• Three failures in obtaining each of the necessary competencies – D
• Four failures or more in obtaining each of the necessary competencies – F
• All D & F grades will require remediation before attempting another competency. After completion of the remediation and successful completion of the competency requirement, a C grade will be given

Points (110 points)
• 60% of the grade
• Minimum completion of 3 Phase I Evaluations, 2 Maintenance Visits, and 5 Surgical Assists must be included in the total point aggregate.
• 150 points or greater – A
  140 to 149 points – B +
  130 to 139 points - B
  120 to 129 points – C +
  110 to 119 points – C
  100 to 109 points - D
  Less than 100 points – F

Daily Grades
• Daily grades are graded as Pass or Fail based on the number of minor errors and/or critical errors. A critical error is an error that compromises and/or impacts negatively on patient safety and/or treatment results. It can be a result of lack of knowledge, substandard treatment, inappropriate method of care, or incorrect execution of proper care. In addition, there can be misdiagnosis, the use of unacceptable techniques, incorrect or flawed diagnostic methods, and/or major damage to soft tissues or hard tissues during procedures. A minor error is an error in the diagnosis and/or treatment of a patient, which does not result in the consequences listed above for a critical error and do not compromise a patient’s safety and/or treatment results.
• Any student with 3+ failures on the daily grades in a trimester must be remediated.
• A minimum of 35 points per trimester is required in the senior year.

TOTAL CLINICAL REQUIREMENTS - 2 YEARS

<table>
<thead>
<tr>
<th>REQUIREMENTS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 Diagnosis Competencies*</td>
</tr>
<tr>
<td>6 Scaling Competencies*</td>
</tr>
<tr>
<td>1 Mock Board Participation</td>
</tr>
<tr>
<td>5 Phase I Evaluations</td>
</tr>
<tr>
<td>8 Maintenance Visits*</td>
</tr>
<tr>
<td>12 Surgical Assists</td>
</tr>
<tr>
<td>260 Clinic Points</td>
</tr>
</tbody>
</table>

* - Requires a minimum number of competencies, clinic points and maintenance visits per trimester for the junior and senior years.

GRADE CARDS

There are three grade cards in the Department of Periodontics on Axium. Each grade card consists of core questions and procedure specific questions.
1. Periodontal Diagnosis Competency
2. Periodontal Scaling Competency
3. Tobacco Cessation

Note: The 1st grade card is used for all procedures that are done in the Department of
Periodontics, except Periodontal Scaling Competency and Tobacco Cessation procedures.

<table>
<thead>
<tr>
<th>Student Provider</th>
<th>Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instructor:</td>
<td></td>
</tr>
<tr>
<td>Date Completed:</td>
<td></td>
</tr>
<tr>
<td>Chart #:</td>
<td></td>
</tr>
<tr>
<td>Patient Name:</td>
<td></td>
</tr>
<tr>
<td>Site: Procedure Code:</td>
<td></td>
</tr>
<tr>
<td>Facility:</td>
<td></td>
</tr>
</tbody>
</table>

- **Competency** (Check if this is a competency grade)

### Period & Prevention Evaluation (PDPREV)

#### General Questions:
- Review of Patient History: Pass/Fail
- Preparedness: Pass/Fail
- Infection Control: Pass/Fail
- Communication with Faculty/Staff: Pass/Fail
- Professionalism: Pass/Fail
- Patient Management: Pass/Fail
- Chart Completion/Documentation: Pass/Fail

#### Faculty Intervention:
- 1-Major Intervention
- 2-Minor Intervention
- 3-Non Intervention

### How did the Student Self-Assess?
- 0-Critical Error
- 0-Major Error
- 0-Minor Error
- 0-Non Error

### Treatment Specific Questions:

#### Accuracy of Periodontal Charting:
- 0-Critical Error
- 0-Major Error
- 0-Minor Error
- 0-Non Error

#### Interpretation of Clinical and Radiographic Data:
- 0-Critical Error
- 0-Major Error
- 0-Minor Error
- 0-Non Error

#### Oral Hygiene Assessment:
- 0-Critical Error
- 0-Major Error
- 0-Minor Error
- 0-Non Error

#### Oral Hygiene Instruction:
- 0-Critical Error
- 0-Major Error
- 0-Minor Error
- 0-Non Error

#### Detection of Subgingival Calculus:
- 0-Critical Error
- 0-Major Error
- 0-Minor Error
- 0-Non Error

### Please add additional comments to the reverse side of the Grade Card.
PERIO SCALING COMPETENCY (PDSCAL)

General Questions:

Review of Patient History
Comment if Fail:

Preparedness
Comment if Fail:

Infection Control
Comment if Fail:

Communication with Faculty/Staff
Comment if Fail:

Professionalism
Comment if Fail:

Patient Management
Comment if Fail:

Chart Completion/Documentation
Comment if Fail:

Faculty Intervention

1-Major Intervention
2-Minor Intervention
3-No Intervention
Comment if Major Intervention:

How did the Student Self-Assess?

1-Critical Error
2-Multiple Minor Errors
3-Minor Error
4-No Error
99-Non Applicable
Comment if Critical Error:

Treatment Specific Questions:

Patient Selection/Radiographs

1-Critical Error
2-Multiple Minor Errors
3-Minor Error
4-No Error
99-Non Applicable
Comment if Critical Error:

Plaque/Stain/Calculus Detection Removal

1-Critical Error
2-Multiple Minor Errors
3-Minor Error
4-No Error
99-Non Applicable
Comment if Critical Error:

Pocket Measurements

1-Critical Error
2-Multiple Minor Errors
3-Minor Error
4-No Error
99-Non Applicable
Comment if Critical Error:

Unauthorized Anesthesia/Treatment Management

1-Critical Error
2-Multiple Minor Errors
3-Minor Error
4-No Error
99-Non Applicable
Comment if Critical Error:

** One Critical Error equals a failure
PERIO TOBACCO CESSATION (PDTOBA)

General Questions:

Review of Patient History
Comment if Fail:

Preparedness
Comment if Fail:

Infection Control
Comment if Fail:

Communication with Faculty/Staff
Comment if Fail:

Professionalism
Comment if Fail:

Patient Management
Comment if Fail:

Chart Completion/Documentation
Comment if Fail:

Faculty Intervention

1-Major Intervention
2-Minor Intervention
3-No Intervention
Comment if Major Intervention:

How did the Student Self-Assess?

1-Critical Error
2-Multiple Minor Errors
3-Minor Error
4-No Error
99-Non Applicable
Comment if Critical Error:

Treatment Specific Questions:

Assess/Evaluate Smoking History

1-Critical Error
2-Multiple Minor Errors
3-Minor Error
4-No Error
99-Non Applicable
Comment if Critical Error:

Advise Patient on Effects of Oral Health

1-Critical Error
2-Multiple Minor Errors
3-Minor Error
4-No Error
99-Non Applicable
Comment if Critical Error:

Assist Patient Commitment to Cessation

1-Critical Error
2-Multiple Minor Errors
3-Minor Error
4-No Error
99-Non Applicable
Comment if Critical Error:

Support Patient through Cessation Pgm

1-Critical Error
2-Multiple Minor Errors
3-Minor Error
4-No Error
99-Non Applicable
Comment if Critical Error:

** One Critical Error equals a failure
<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1110</td>
<td>Adult Prophylaxis</td>
</tr>
<tr>
<td>11331</td>
<td>Rx Flouride Therapy</td>
</tr>
<tr>
<td>11332</td>
<td>Chlorohexidine Therapy</td>
</tr>
<tr>
<td>4910</td>
<td>Periodontal Maintenance</td>
</tr>
<tr>
<td>20131</td>
<td>Oral Hygiene Competency</td>
</tr>
<tr>
<td>20132</td>
<td>Preventive Therapy Plan Competency</td>
</tr>
<tr>
<td>20133</td>
<td>Preventive Chemotherapeutic Competency</td>
</tr>
<tr>
<td>1320</td>
<td>Tobacco Cessation</td>
</tr>
<tr>
<td>14001</td>
<td>Periodontal Exam &amp; Diagnosis</td>
</tr>
<tr>
<td>20021</td>
<td>Periodontal Exam &amp; Diagnosis Competency Exam</td>
</tr>
<tr>
<td>4341</td>
<td>Periodontal Scaling &amp; Root Planing – 4 or more teeth</td>
</tr>
<tr>
<td>4342</td>
<td>Periodontal Scaling &amp; Root Planing – 1 to 3 teeth</td>
</tr>
<tr>
<td>20022</td>
<td>Periodontal Scaling &amp; Root Planing Competency Exam</td>
</tr>
<tr>
<td>4381</td>
<td>Local Delivery of Antimicrobial agents</td>
</tr>
<tr>
<td>4320</td>
<td>Provisional Splinting - Intracoronal</td>
</tr>
<tr>
<td>4321</td>
<td>Provisional Splinting - Extracoronal</td>
</tr>
<tr>
<td>9951</td>
<td>Occlusal Adjustment – Limited</td>
</tr>
<tr>
<td>9952</td>
<td>Occlusal Adjustment – Complete</td>
</tr>
<tr>
<td>9940</td>
<td>Occlusal Guard</td>
</tr>
<tr>
<td>14420</td>
<td>Minor Tooth Movement</td>
</tr>
<tr>
<td>14421</td>
<td>Appliance Adjustment</td>
</tr>
<tr>
<td>14002</td>
<td>Case Type II Phase I Re-evaluation</td>
</tr>
<tr>
<td>14003</td>
<td>Case Type III Phase I Re-evaluation</td>
</tr>
<tr>
<td>14013</td>
<td>Case Type IV Phase I Re-evaluation</td>
</tr>
<tr>
<td>14004</td>
<td>Periodontal Final Case Complete – non-surgical case</td>
</tr>
<tr>
<td>14005</td>
<td>Periodontal Final Case Complete – surgical case</td>
</tr>
<tr>
<td>14006</td>
<td>Periodontal Final Case Complete – non-compliant patient</td>
</tr>
<tr>
<td>D4210</td>
<td>Gingivectomy – 4 or more teeth</td>
</tr>
<tr>
<td>D4211</td>
<td>Gingivectomy – 1 to 3 teeth</td>
</tr>
<tr>
<td>D4240</td>
<td>Gingival Flap – 4 or more teeth</td>
</tr>
<tr>
<td>D4241</td>
<td>Gingival Flap – 1 to 3 teeth</td>
</tr>
<tr>
<td>D4245</td>
<td>Apically Positioned Flap</td>
</tr>
<tr>
<td>D4249</td>
<td>Clinical Crown Lengthening – hard tissue</td>
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<td>Code</td>
<td>Description</td>
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<td>---------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>D4260</td>
<td>Osseous Surgery – 4 or more teeth</td>
</tr>
<tr>
<td>D4261</td>
<td>Osseous Surgery – 1 to 3 teeth</td>
</tr>
<tr>
<td>D4263</td>
<td>Bone Graft – 1st site</td>
</tr>
<tr>
<td>D4264</td>
<td>Bone Graft – each additional site</td>
</tr>
<tr>
<td>D4265</td>
<td>Biologic Material – soft &amp; hard tissue</td>
</tr>
<tr>
<td>D4266</td>
<td>GTR – resorbable membrane per site</td>
</tr>
<tr>
<td>D4267</td>
<td>GTR – non-resorbable membrane per site</td>
</tr>
<tr>
<td>D4268</td>
<td>Surgical Revision Procedure – per tooth</td>
</tr>
<tr>
<td>D4270</td>
<td>Pedicle Soft Tissue Graft</td>
</tr>
<tr>
<td>D4271</td>
<td>Free Gingival Graft</td>
</tr>
<tr>
<td>D4273</td>
<td>Connective Tissue Graft</td>
</tr>
<tr>
<td>D4274</td>
<td>Distal or Proximal Wedge</td>
</tr>
<tr>
<td>D4275</td>
<td>Soft Tissue Allograft</td>
</tr>
<tr>
<td>D4276</td>
<td>Combined CT &amp; Double Pedicle Graft</td>
</tr>
<tr>
<td>14441</td>
<td>Sinus Lift in association with implant placement</td>
</tr>
<tr>
<td>D6010</td>
<td>Surgical Placement of Implant</td>
</tr>
<tr>
<td>D6100</td>
<td>Implant Removal</td>
</tr>
<tr>
<td>D7285</td>
<td>Biopsy of Hard Tissue</td>
</tr>
<tr>
<td>D7286</td>
<td>Biopsy of Soft Tissue</td>
</tr>
<tr>
<td>14298</td>
<td>Periodontics Surgical Post-operative evaluation</td>
</tr>
<tr>
<td>14299</td>
<td>Periodontal Phase II Evaluation (Post Surgical)</td>
</tr>
<tr>
<td>30021</td>
<td>Periodontal Surgical Assist</td>
</tr>
<tr>
<td>16010</td>
<td>Implant Surgical Assist</td>
</tr>
<tr>
<td>20023</td>
<td>Periodontal Mock Board Participation</td>
</tr>
</tbody>
</table>
1. Minimum distance between a tooth and an implant is 1.5 to 2mm.

2. Distance between implants 3mm, may be reduced to 2mm with platform switching.

3. Width needed 6mm (7mm or max ant) when placing 4mm wide implant. 1mm facial and lingual bone to osteotomy (ideally 2mm facial).

4. Minimum vertical height from opposing tooth is 7mm for abutment and cemented crown; otherwise 5.5mm for screw retained. (7 = 4mm for crown prep retention + 1mm abut collar +1mm metal + 1mm porcelain).

5. JE forms and attaches to a titanium implant similar to JE of tooth by a hemidesmosomal attachment; however epithelium of implant doesn’t receive vascular supply from PDL.
   b. Gould et al 1983

6. Dense CT found adjacent to implant similar to scar tissue rich in collagen and poor in cellular elements such as fibroblasts and circulatory elements found around a tooth.
   a. Berglundh T, Lindhe J, Ericsson I, Marinello CP, Liljenberg B, Thomsen P. The soft

b. Buser 1992

7. Importance of implant design in regard to shape, length, threads and surface treatments
   a. Kohn DH. Overview of factors important in implant design. JOI 1992;18:204-219

8. Implant platform should be placed 1-2mm apical to the CEJ’s of the adjacent teeth and 3mm apical to the anticipated gingival margin for an esthetic result in the anterior zone. For adjacent implants us Dr. George Priest’s 3X3X3 Pie rule.

9. Height of interproximal bone of adjacent teeth to edentulous space will determine presence of papilla.

10. Socket preservation to preserve facial plate of bone

11. Any implant less than 10mm has a greater failure rate.
    c. van Steenberghe D, Lekholm U, Boldender C, et al. The applicability of osseointegrated oral implants in the reha- bilitation of partial edentulism: A


12. If dehiscence at time of extraction, graft and membrane should be performed

13. One stage and two stage procedure:

14. Immediate, early, late, delayed

15. Extraction of a tooth

16. Radiographic Stent
17. Staging is a process whereby mini-implants or teeth which will eventually be removed, are used as abutments for a provisional fixed temporary during implant placement and the period of integration. After the implants are integrated, the teeth and/or mini-implants are removed and abutments are placed on the implants and the case is taken to completion or additional implants are placed in the areas where the previous temporary abutments were removed.

18. If the angulation of the implant is off, then a standard company angled abutment or a laboratory custom abutment can be used. A custom abutment is more costly, because it involves more lab time by the technician
   a. Reid PE, Burke, TM. Customized implant abutments: technical notes: Implant Dent. 1994:3-243-246

19. Choosing an abutment: know the measurement from the top of the implant or platform to the free gingival margin

20. After I year, it is common to have resorption to the first thread and thereafter, there is an annual bone loss of .1 mm around an implant. An implant company has developed the concept of platform switching (using an abutment with a smaller diameter than the width of the implant platform) and because of this design; the bone resorption at the end of the first year is minimized.
a. A new implant design for crestal bone preservation: initial observations and case report. Harold Baumgarten; Roberto Cocchetto; Tiziano Testori; Alan Meltzer; Stephan Porter. Pract Proced Aesthet Dent 2005;17(10):735-740


21. There is usually gingival recession of .9 mm at the end of one year.

22. One implant per missing space ideally. Also have to consider finances and quality of bone.
   a. Bahat IJOMI 1993;8:151-161
   c. Truhalar JOMS 1997

23. Single units or splinting implants
ADULT PROPHY – 1110

On all adult prophylaxis or periodontal maintenance visits the following clinical evaluations will be included in the patient’s record (chart).

1. Medical History Update: Identify patient’s chief complaint and health needs.

Charting Includes:
Extra oral examination will include the following:
• Palpate the salivary glands and lymph nodes
• Observation head, face, eyes and neck
   Note all findings in the regional exam area of recall sheet.
Intraoral soft tissue examination will include the following:
• Visually inspect and palpate lips, buccal mucosa, vestibules, tongue and floor of mouth.
• Evaluate the hard and soft palates and pharynx for any changes.
   Note all findings in the soft tissue area of recall sheet. There is adequate space (problems/comments) for a complete description of lesions observed. **If there is a positive finding** do not merely put a check mark in the box. A complete description of each finding includes the location, extent size, color surface texture or configurations, consistency, morphology and history. Also note in the comment section the consistency of saliva and any evidence of xerostomia. **If there is negative findings note in (problem/comments) section oral tissues within normal limits.**
• Record modified plaque and bleeding point index.
• Identify any predisposing and etiology factors. Monitor and record recall clinical charting findings:
  - Indices – The following three indices should be recorded at all adult prophylaxis, periodontal exam, patient re-evaluations and all case completes.

  - Modified Plaque Index – (Modified from Podshadley Index)
    (See Page 11)

  - Bleeding Index – Modified Muhleman/Carranza Text
    (See Page 11)

4. Reappointment for a future recall
   3,4,5, or 6, months recall as per patient’s needs. During active treatment adult
prophylaxis a 9 month recall time period is used.

5. **Intraoral hard tissue examination** should include the following:
   - Evaluate for dental and root caries
   - Defective restorations
   Note any changes on the odontogram section of the recall sheet.

6. **Evaluation of periodontium** should include the following:
   - **Pocket Depths**
     - Record six marking (Three markings for the buccal; Three markings for the lingual)
   - **Bleeding on probing**
     - Circle the pocket recording where there is bleeding on probing.
   - **Non-functional Mobility**
     - Scale 0-3
   - **Functional Mobility**
     - Fremitus
   - **Gingival Recession**
     - Measure from free gingiva margin to the cemento-enamel junction
   All negative and positive finding must be recorded in the appropriate area in the chart (ie. Mobility of 0 must be recorded).

7. **Radiographic Assessment**:
   - Review the date of the last radiographs and determine the need for new radiographs based on intra oral observations of new caries/ faulty restorations and changes in the periodontium.
   - Bitewings and/or full mouth series will be based on an individualized plan as per A.D.A guidelines.

8. **Preventive Therapy Treatment Plan**: Is a written plan that is noted in the proposed preventive therapy plan section of the preventive therapy/ periodontal evaluation sheet of the patient’s chart. It is formulated from your clinical evaluation /risk assessment and tailored to the patient’s needs. The treatment plan should include the following but not limited to:
   - Tooth brushing methods, techniques as well as any denture care
   - Flossing and floss aids and/or interdental aids
   - Toothpaste and adjunctive fluoride (OTC or RX) as well as other chemotherapeutic agents
   - Mouth guard
   - Sealants
   The preventive therapy treatment plan should explain the rational and philosophy for its approach. The patient’s oral hygiene knowledge, current oral hygiene habits and their oral hygiene motivation needs to be noted in the appropriate section of the preventive therapy/ periodontal evaluation sheet of the patient’s chart. This will be based on the table below

**Patient’s knowledge/habits/motivation:**


Good- Brush 2x a day/ Floss once a day/ 6 month check- ups
Fair –Brushing 2x a day but does not know how to floss and is not on regular check- ups
Poor- Brushing less than once a day and hasn’t seen a dentist in the last year.

**Oral Hygiene Instructions: D1330**

It is the verbal implementation of the preventive therapy treatment plan. This code will be used only on patient’s initial visit for oral hygiene instructions.

**Oral Hygiene Reinforcement (indexes, OHI): 11001**

This code will be used on all recall appointments.

**Tobacco Cessation: D1320**

In Clinical Prevention Dentistry I or II a tobacco cessation counseling (4 phases) is required and can only be completed with designated faculty. This requirement must be completed by February 28 of the senior year.

**Reappointment for future recall:** 3, 4, 5, or 6, months recall as per patient’s needs.

**COMPETENCIES**

**PREVENTIVE THERAPY PLAN – 20132**

The student will write a plan that is noted in the proposed preventive therapy/ periodontal evaluation sheet section of the patient’s chart. It is formulated from your clinical evaluation /risk assessment and tailored to the patient’s needs. The treatment plan should include the following but not limited to:

- Tooth brushing methods, technique as well as any denture care
- Flossing and floss aids and/or interdental aids
- Toothpaste and adjunctive fluoride, as well as, other chemotherapeutic agents
- Mouth guard
- Sealants

The preventive therapy treatment plan should explain the rational and philosophy for its approach. The patient’s oral hygiene knowledge, current oral hygiene habits and their oral hygiene motivation needs to be noted in appropriate section of the preventive therapy/ periodontal evaluation sheet. This will be based on the table below:

**Patient’s knowledge/habits/motivation:**
- Good- Brushing 2x a day/ Floss once a day/ 6 month check- ups
- Fair –Brushing 2x a day but does not know how to floss and is not on regular check- ups
- Poor- Brushing less than once a day and hasn’t seen a dentist in the last year

**ORAL HYGIENE COMPETENCY – 20131**
Students will verbally implement preventive therapy treatment plan with a faculty member. Student will instruct the patient in the proposed plan and implement strategies that will benefit treatment outcomes. Student will be graded upon their ability to convey the preventive therapy treatment plan to their patient. Faculty will use patient feedback information to determine the effectiveness of student’s communication skills.

CHEMO-THERAPEUTIC - 20133
Student will first identify the need for any chemotherapeutic agents and explain the rational for the recommendation. The student will first write the proposed prescription on a piece of paper and once approved by the faculty member will obtain a prescription from the GPA and write a chemotherapeutic prescription for the patient.

REQUIREMENTS
A minimum of one (1) Oral Hygiene Instruction Competency must be completed by the end of your junior year, and (1) by the end of your senior year. A total of (2) are required by the end of your senior year. A Competency may be scheduled anytime during the year. The student must declare the Competency prior to the start of the procedure. Failure to complete the minimal requirements will result in a failure of the course.

A minimum of one (1) Preventive Therapy Plan Competency must be completed by end of your junior year, and (1) by the end of your senior year. A total of (2) are required by the end of your senior year. A Competency may be scheduled anytime during the year. The student must declare the Competency prior to the start of the procedure. Failure to complete the minimal requirement will result in a failure of the course.

A minimum of one (1) Chemotherapeutic Competency must be completed by end of your junior year, and (1) by the end of your senior year. A total of (2) are required by the end of your senior year. A Competency may be scheduled anytime during the year. The student must declare the Competency prior to the start of the procedure. Failure to complete the minimal requirements will result in a failure of the course.

A minimum of one (1) Tobacco Cessation counseling (4 phases) must be completed by February 28 of the senior year. Failure to complete the minimal requirements will result in a failure of the course.

A minimum of six (6) Adult Prophylaxis and (6) Oral Hygiene Instructions must be completed by the end of your junior year. A minimum of six (6) Adult Prophylaxis and (6) Oral Hygiene Instructions must be completed by the end of your senior year. Failure to complete the minimal requirements will result in a failure of the course.

REQUIREMENTS - CLINICAL PREVENTION I (JUNIOR YEAR)
Competencies:
1 Oral Hygiene Instruction
1 Preventive Therapy Plan
Requirements: A Tobacco Cessation counseling which includes 4 phases on one patient must be completed by February of the senior year. Four community service credits and all forms completed (approval form, contact form, reflection paper and summary form)

PASS/FAIL FOR COMPETENCIES
Failure to complete or pass a competency will result in a failing grade for the course.
- All failing grades will require remediation before attempting another competency. Remediation will consist of one on one instruction with a faculty member. After completion of the remediation and successful completion of the competency a pass grade will be given.

Points
- Minimum of 33 points required for passing
- 4 points per adult prophylaxis (minimum of 6 patients; total of 24 points)
- 1 point per oral hygiene instructions (minimum of 6 patients; total of 6 points)
- 1 point for each competency
- 1 point per sealant per tooth
- 1 point for Tobacco Cessation (must complete all 4 phases of counseling)

GRADING
The final grade for the junior course will be reported to the Registrar as either a Pass or Fail. The F grade must be remediated or the course repeated. Remediation will be determined by the Course Director and may occur during the month of August in the PG clinic.

REQUIREMENTS FOR CLINICAL PREVENTION II (SENIOR YEAR)

Competencies:
1 Oral Hygiene Instruction
1 Preventive Therapy Plan
1 Chemotherapeutic

Requirements: A Tobacco Cessation counseling which includes 4 phases on one patient must be completed by February of the senior year. Four community service credits and all forms completed (approval form, contact form, reflection paper and summary form)

PASS/FAIL FOR COMPETENCIES
- Failure to complete/pass a competency will result in a failing grade for the course.
- All fail grades will require remediation before attempting another competency. After completion of the remediation and successful completion of the competency requirement, a grade no higher than a C will be awarded.
- Minimum of 70 points, cumulative for both years are required to pass.

The final grade for the senior course will be a letter grade A to F and based on the criteria listed below. The course grade reported to the Registrar will be either an A, B+, B, C+, C, or D and will represent the sum of the points accumulated from the junior and senior years, since the junior course grade is reported as a Pass/Fail. The F grade in the senior course must be
remediated or the course repeated. Remediation will be determined by the Course Director and will occur after the official graduation of the class and possibly, if needed, up to and during the month of August in the PG clinic. If a senior student is deficient in requirements, which are required by graduation date, due to patient availability, then an “INC” (Incomplete) grade will be issued and additional time will be granted to the student. The grade for the senior course will be computed as follows:

**TOTAL REQUIREMENTS & COMPETENCIES**

**JUNIOR AND SENIOR YEARS**

<table>
<thead>
<tr>
<th>REQUIREMENTS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Oral Hygiene Instruction Competencies</td>
</tr>
<tr>
<td>2 Preventive Therapy Plan Competencies</td>
</tr>
<tr>
<td>2 Chemotherapeutic Competencies</td>
</tr>
<tr>
<td>1 Tobacco Cessation</td>
</tr>
<tr>
<td>12 Oral Hygiene Instruction</td>
</tr>
<tr>
<td>12 Adult Prophylaxis</td>
</tr>
<tr>
<td>8 Community service credits (4 in junior year and 4 in senior year)</td>
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</tbody>
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**Clinic Points**
- 69 and below = F
- 70-74 = C
- 75-79 = C+
- 80-84 = B
- 85-89 = B+
- 90 and above