

SENSITIVE TEETH STUDY

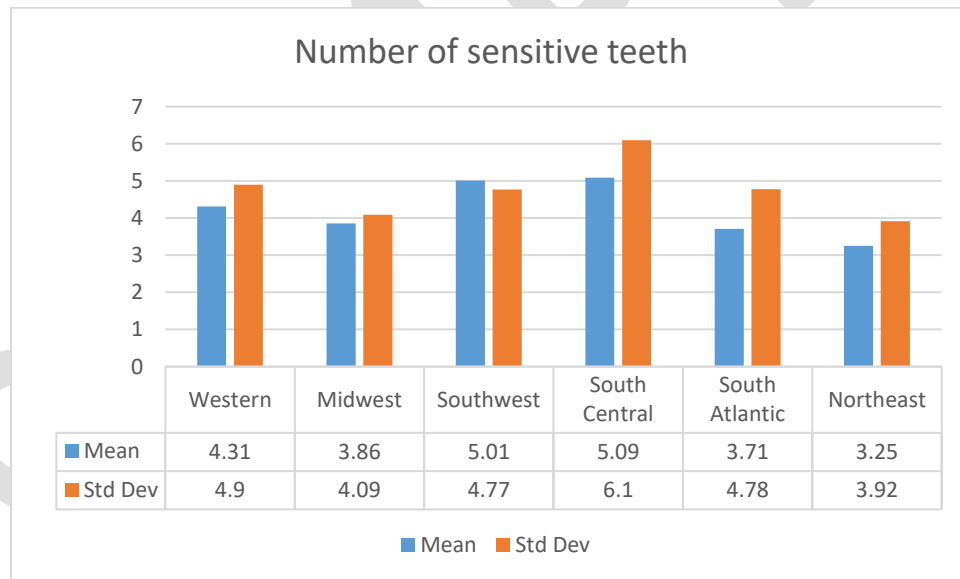
Baseline Exam

Visit Date: |__|_|_|/|__|_|_|/|_2_|_0_|_|_1_|_|_|
 m m d d y y y y

Dentist-assessed signs of dentin hypersensitivity

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

2	3	4	5	6	7	8	9	10	11	12	13	14	15	B/F
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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The average number of sensitive teeth per region was as follows:

Region	Mean
South Central	5.1
South West	5.0
Western	4.3
South Atlantic	3.7
Midwest	3.9
Northeast	3.2

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

	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Visible Dentin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gingival Recession	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No Restoration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amalgam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PFM Restoration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All Porcelain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cast Metal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Restoration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

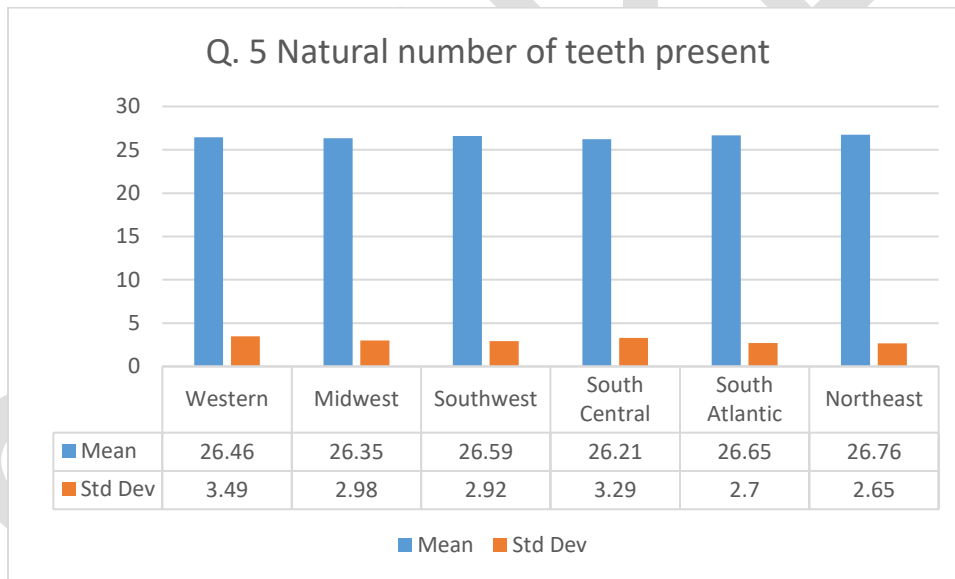
														
31	30	29	28	27	26	25	24	23	22	21	20	19	18	

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

	31	30	29	28	27	26	25	24	23	22	21	20	19	18
Visible Dentin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gingival Recession	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No Restoration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Amalgam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PFM Restoration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All Porcelain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cast Metal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Restoration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

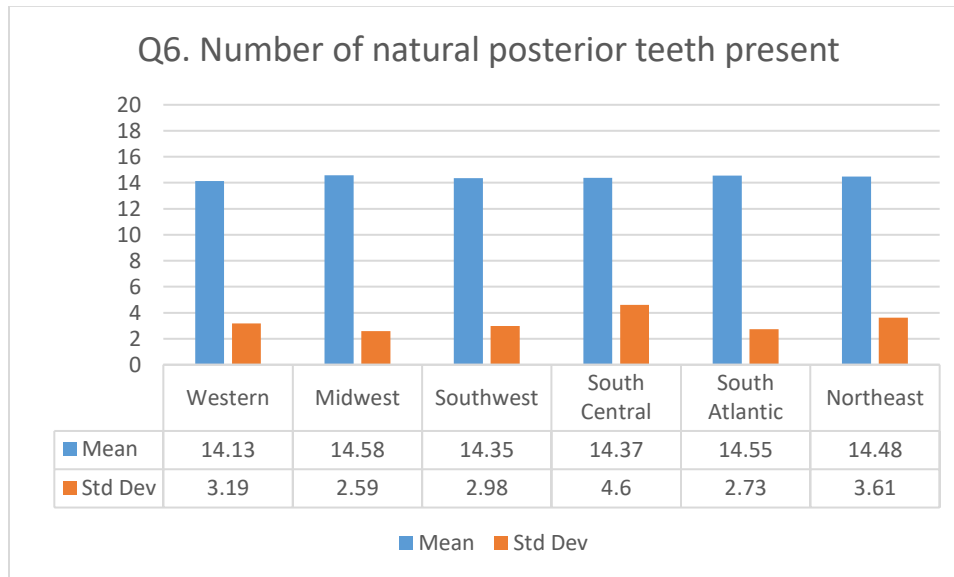
5. Total number of natural teeth present: |__| |__| (3rd molars excluded)



The average number of natural teeth present per region was as follows:

Region	Mean
Northeast	26.8
South Atlantic	26.7
Southwest	26.6
Western	26.5
Midwest	26.4
South Central	26.2

6. Total number of natural posterior teeth present: |__| |__|



The average number of posterior teeth present by region was as follows:

Region	Mean
Midwest	14.6
South Atlantic	14.6
Northeast	14.5
South Central	14.4
Southwest	14.4
Western	14.1

7. Patient out of pocket expense for the preventive visit and/or problem focused exam will be: **(Check one)**

- Both visit types will be covered 100% by the insurance
 Patient will pay a co-payment for both visit types
 Patient will pay 100% out of the pocket for both visit types

8. Treatment recommended and/or prescribed: **(Check and complete all that apply)**

Treatment recommended and/or prescribed		Duration	Frequency
<input type="checkbox"/>	Fluoride (if checked, specify duration and frequency):		
<input type="checkbox"/>	Fluoride Gel (if checked, specify duration and frequency):		
<input type="checkbox"/>	Fluoride Varnish (if checked, specify duration and frequency):		
<input type="checkbox"/>	Fluoride Paste (if checked, specify duration and frequency):		
<input type="checkbox"/>	Fluoride Rinse (if checked, specify duration and frequency):		



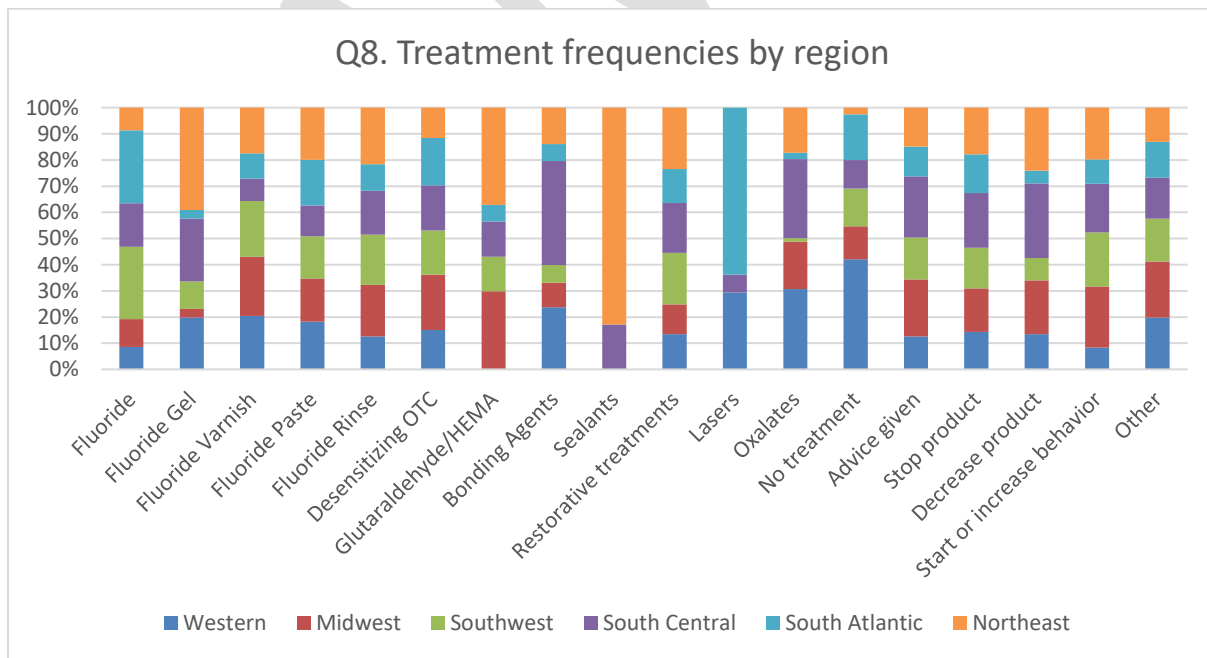
<input type="checkbox"/>	Desensitizing OTC Potassium nitrate toothpastes (if checked, specify duration and frequency):		
<input type="checkbox"/>	Glutaraldehyde/HEMA products		
<input type="checkbox"/>	Bonding agents		
<input type="checkbox"/>	Sealants		
<input type="checkbox"/>	Restorative treatments		
<input type="checkbox"/>	Lasers		
<input type="checkbox"/>	Oxalates		
<input type="checkbox"/>	No treatment		
<input type="checkbox"/>	Advice (If checked, specify below. Check all that apply):		
	<input type="checkbox"/> To stop product, habit and/or behavior. If yes, what product/habit/behavior?		

	<input type="checkbox"/> To decrease product, habit and/or behavior. If yes, what product/habit/behavior?		

	<input type="checkbox"/> To start or increase behavior. If yes, what behavior?		

<input type="checkbox"/>	Other (please specify): _____		

Below, please see the treatment frequencies by region.



9. Recommended follow-up time for this patient's sensitive tooth/teeth: **(Check one)**

- More than 4 weeks
- 2-4 weeks
- 2 weeks
- No follow-up is needed
- Other, (Please specify :) _____

Date: |__| |__| |__| |__| / |__| |__| |__| |__| / | **2** | **0** | **1** |__| |
m m d d y y y y

Practitioner Signature

PLEASE REVIEW THIS FORM FOR COMPLETION AND ACCURACY. THANK YOU.

Questions? Contact your Regional Coordinator.

SAMPLE

SENSITIVE TEETH STUDY

Patient Pain Assessment – (Enrollment/Baseline Visit)

Date Completed: |__|__|/|__|__|/|_2_|_0_|_|_1_|__|
 m m d d y y y y

We would like you to describe the pain from your sensitive tooth or teeth by answering the following questions. Please review the scale labels and then use a pen to mark the appropriate point on the scale that best describes your pain. Please use a vertical straight line.

DO NOT USE AN 'X' MARK.

Example below:

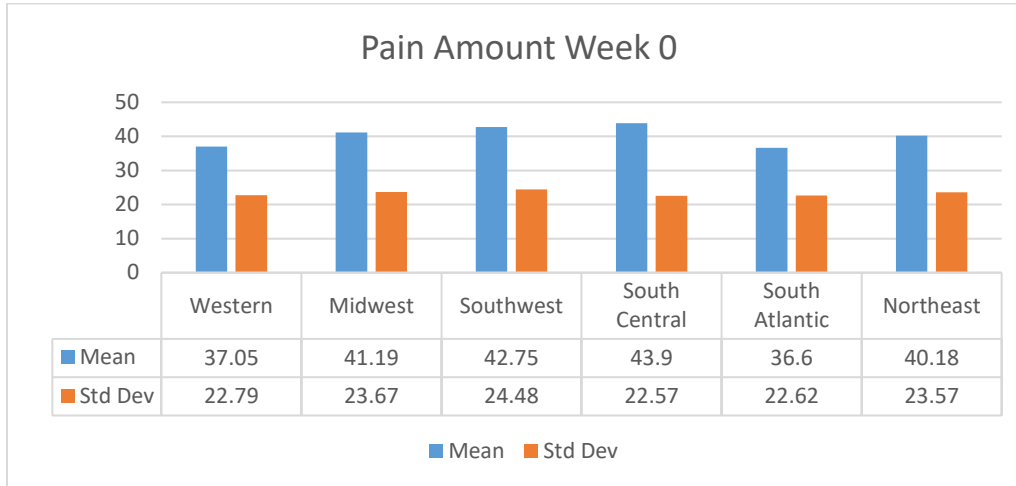


1. Please describe the pain from your sensitive tooth or teeth that you have experienced in the past day (24 hours).



For official use only:

|__|__|__|

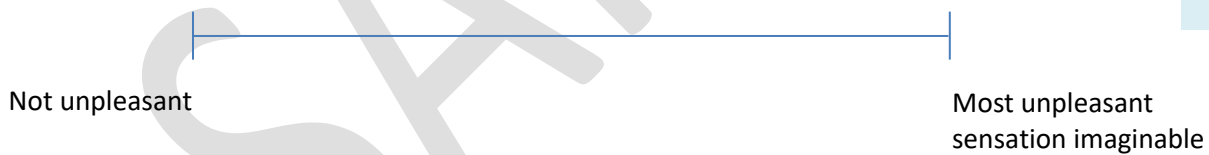


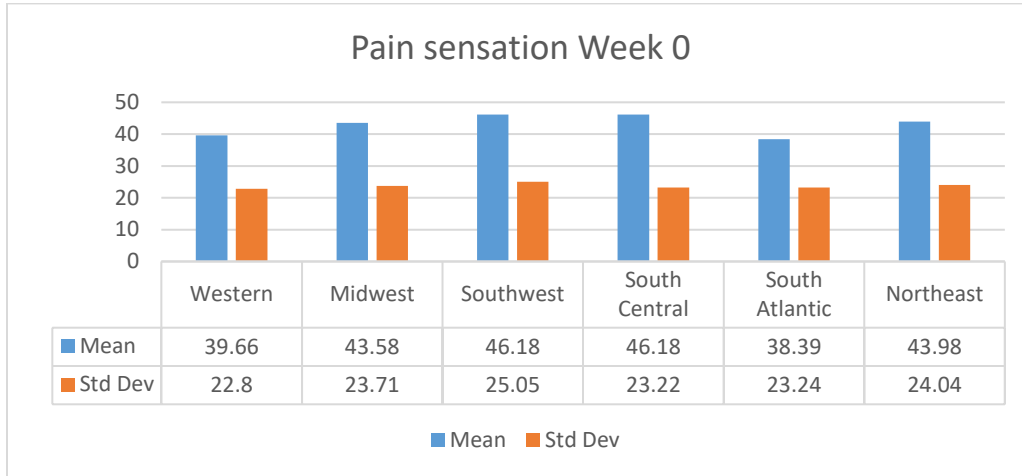
On average, the amount of pain from sensitive tooth or teeth (on a scale from 0-100) that patients have experienced in the past day (24 hours) was by region:

Region	Average pain amount in the past 24 hours
South Central	43.9
Southwest	42.8
Midwest	41.2
Northeast	40.2
Western	37.1
South Atlantic	36.6

2. Please describe the sensation you have felt from your sensitive tooth or teeth in the past day (24 hours).

For official use only:
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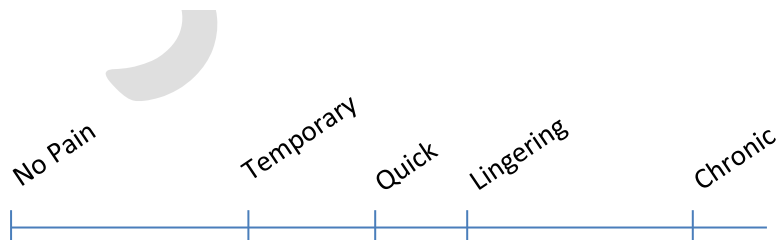


On average, the sensation that patients have felt from the sensitive tooth or teeth (on a scale from 0-100) in the past day (24 hours) was by region:

Region	Average pain sensation in the past 24 hours
South Central	46.2
Southwest	46.2
Northeast	44.0
Midwest	43.6
Western	39.7
South Atlantic	38.4

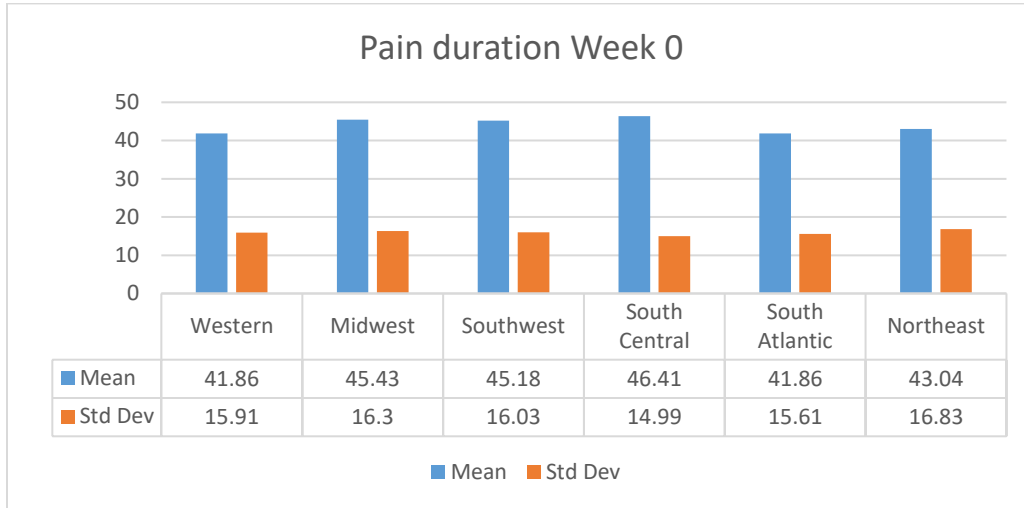
- Now we would like you to describe the pain that you experienced in the past day (24 hours) related to your sensitive tooth or teeth. Please use a pen to mark a vertical **straight line** on the scales below to show how long your pain lasted (duration), how intense your pain was (intensity), how tolerable your pain was (tolerability) and what type of pain you had (description).

Duration



For official use only:

____|____|____|

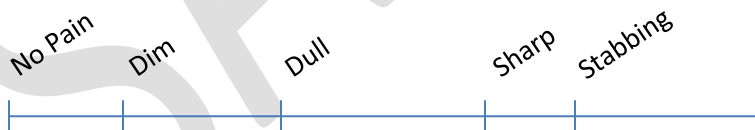


On average, the duration of pain that patients have indicated from the sensitive tooth or teeth in the past day (24 hours) was by region:

Region	Average pain duration in the past 24 hours
South Central	46.4
Midwest	45.4
Southwest	45.2
Northeast	43.0
South Atlantic	41.9
Western	41.9

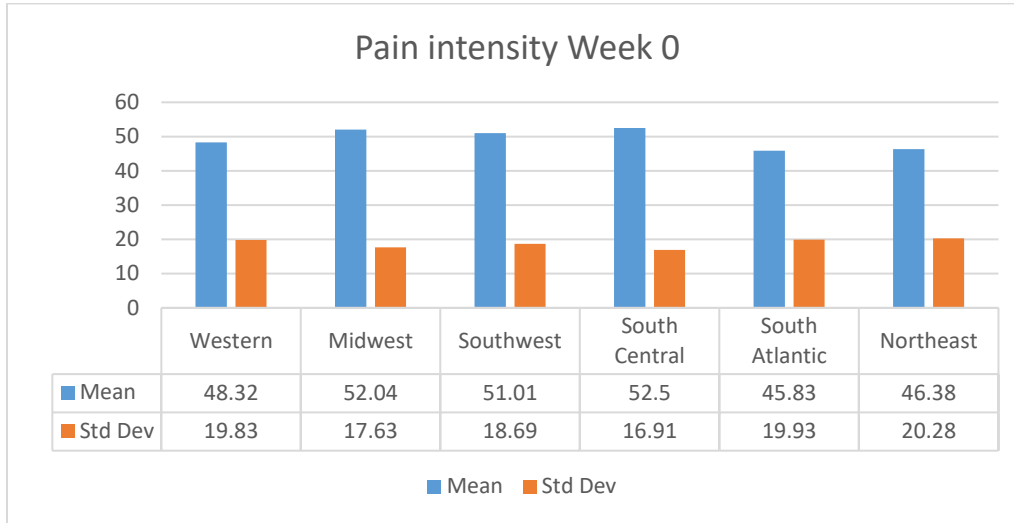
On average, patients rated the duration of pain as temporary and quick.

Intensity



For official use only:

____|____|____|



On average, the pain intensity in the last 24 hours that patients have indicated was by region:

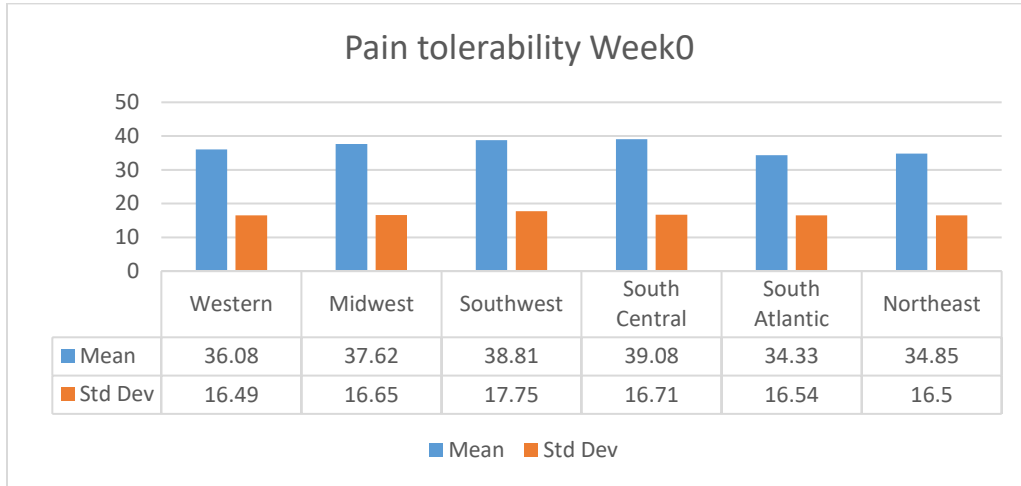
Region	Average pain intensity in the past 24 hours
South Central	52.5
Midwest	52.4
Southwest	51.0
Western	48.3
Northeast	46.4
South Atlantic	45.8

On average, patients rated the pain intensity as dull and sharp.

Tolerability



For official use only:



On average, the pain tolerability in the last 24 hours that patients have indicated was by region:

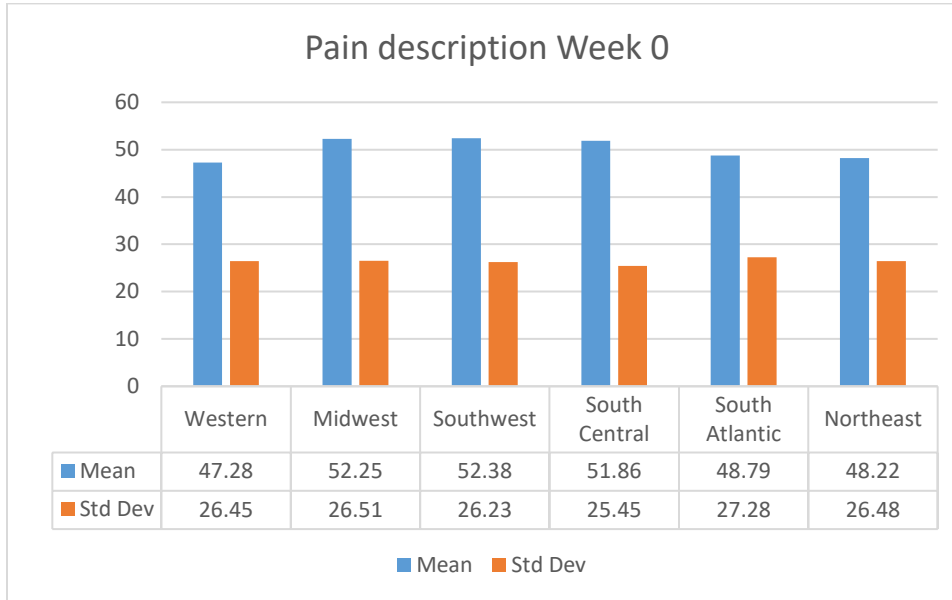
Region	Average pain tolerability in the past 24 hours
South Central	39.0
Southwest	38.8
Midwest	37.6
Western	36.1
Northeast	34.9
South Atlantic	34.3

On average, patients rated the pain tolerability as uncomfortable.

Description



For official use only:



On average, the pain description in the last 24 hours that patients have indicated was by region:

Region	Average pain description in the past 24 hours
Southwest	52.4
Midwest	52.3
South Central	51.9
South Atlantic	48.8
Northeast	48.2
Western	47.3

On average, patients rated the pain description as ache.

Thank you for completing the form!