**Dental History Form**

**and Instruction Packet**

**Dental History Form**

Thank you for participating in this investigation of risk factors for osteonecrosis of the jaw (ONJ). This questionnaire is related to dental diagnoses and treatments provided to the patient you have selected for the study. Since you are the primary oral health care provider for this patient, your role is critical in determining what diagnoses were made and what treatments were provided by you, **other dentists or specialists from the year** 2000 to the present.

We tried to keep this form succinct but the detailed information we seek is critical to the success of this project. We sincerely appreciate your patience, time, and effort in completing this form.

**If the patient was under the care of another dentist or specialist after January 2000, please contact them to obtain the information necessary to complete this questionnaire.**

This questionnaire is divided into 8 sections (A-H). Please complete all sections. If any section is not applicable to this subject, please check the “N/A” box. If any question within a section is not applicable, please write “N/A” in response to those questions.

**Case-Control Study of Osteonecrosis of the Jaw**

**Dental History Form**

|  |  |
| --- | --- |
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**Time Started**: \_\_\_\_:\_\_\_\_ AM/PM

**GSTTIME GSTAMPM**

**A. Patient Screening and Enrollment**

**Patient signed consent and received copy**

* Patient must sign consent form and receive a copy to participate in this study.
* If the patient does NOT consent to participate in this study, you must STOP filling out this form.
1. **Practitioner ID - Patient ID**
* Practitioner ID is the number assigned to your practice by the PBRN. If unsure, please call the PBRN coordinator at (telephone #).
* Patient ID is assigned by you in sequential order, starting with 001. The sequence should continue regardless of whether the patient is an ONJ case or a control. For example, your first ONJ case and its respective three control patients should be numbered 001 to 004, in random fashion.
1. **Patient initials**
* The PBRN will inform you if entering patient initials is allowed under local IRB rules. If permitted, enter the patient’s first, middle and last name initials, or just the first and last name, if no middle name is known.
1. **Date of last visit to your office**
* Please enter the last date this patient was seen in your office. If the date is unknown, check the (b) box.
1. **Patient Month/Year of Birth.**
* Enter birth month and year only, not day of month.
* Use date format MM/YYYY
1. **Patient Gender**
* Enter the patient’s gender (sex) as (M)ale or (F)emale.
1. **Is this patient an ONJ case or a control patient?**
* Check the box corresponding to the patient’s status.
1. **Type of Practice the case was selected from**
* Enter the type of practice the ONJ case patient is being drawn from - general practitioner or specialist (oral surgeon, periodontist, etc).
* If the patient was a referral, indicate the type of provider who referred the patient (general practitioner or physician referring to specialist).
1. **Type of Practice the controls were selected from**
* Enter the type of practice the three Control patients are being drawn from - general practitioner or specialist (oral surgeon, periodontist, etc).

**A. Patient Screening and Enrollment**

|  |  |  |
| --- | --- | --- |
| **Has written informed consent been obtained? GCONSENT**  | **Yes** | **No** |
|  |  |

**If patient does not sign the consent form, (s)he CANNOT participate in this study.
Please STOP filling out this form.**

*Practitioner ID* is the number we have assigned to you. If you do not know that number or can’t remember, please call the PRECEDENT office at 206-616-6160.

For the *Patient ID*, please assign sequential numbers starting with 001.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **1. Practitioner ID – Patient ID GHDPID** |  |  |  | **-** |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **2. Patient initials ~~GHINITIAL~~** |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **3a. Date of last visit to your office GLVMON** **GLVDAT** **GLVDATE** **GLVYR** |  |  | / |  |  | / |  |  |  |  |
| M | M | / | D | D | / | Y | Y | Y | Y |
| **3b.** Check the box to your right if the date of the last visit is unknown. **GLVUNK** | **[ ]**  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **4. Patient month/year of Birth GHBIRTHMY** |  |  | / |  |  |  |  |
| M | M | / | Y | Y | Y | Y |

|  |  |  |
| --- | --- | --- |
| **5.** **Patient Gender GHGENDER** |  |  |
| F | M |

|  |  |  |
| --- | --- | --- |
| **6. Is this patient an ONJ case or a control patient? GCASECTR** | **Case** | **Control** |
|  |  |

**7a. Type of Practice the case was selected from ­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **GCASETYP**

**7b. If the patient is a referral, what type of provider referred the patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **GREFTYP**

**8. Type of Practice the controls were selected from 00 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **GCTRTYP**

**B. Dental Diagnoses**

If the patient was **NOT** edentulous in the year 2000, complete the table listing dental diagnoses prior to ONSET of ONJ symptoms in ONJ subjects, or since the year 2000 in controls.

If the patient was fully edentulous in the year 2000, check the N/A box and leave the rest of this section blank.

**Number of maxillary teeth present**: Enter the number of maxillary teeth this patient had in the year.

**Number of mandibular teeth present**: Enter the number of mandibular teeth this patient had in the year.

**Periodontal Disease**: Enter the AAP classification of periodontal diseases in the year:

**I**: **Gingivitis** is present when inflammation is apparent and the gingiva is characterized by changes in color, form, position and appearance. Bleeding and/or exudate may be present.

**II**: **Slight periodontitis** is present when inflammation has progressed from the gingiva to deeper periodontal structures and bone, with slight bone loss. Probing depths are 3 to 4 mm, and there is some loss of connective tissue attachment.

**III**: **Moderate periodontitis** is a more advanced stage of Slight Periodontitis, with increased destruction and tooth mobility. There may be furcation involvement in multirooted teeth.

**IV**: **Advanced periodontitis** involves major loss of bone support and increased tooth mobility and furcation involvement.

**Caries Diagnoses**: Circle “yes” if this patient had at least two restorative procedures in the year.

**Endodontic Problems**: Circle “yes” and indicate the tooth number if this patient had any endodontic problem in the year.

**Gingival Bleeding**: Circle “yes” if the patient had moderate-severe (more than pinpoint) bleeding upon gentle probing in the year.

**Suppuration**: Circle “yes” if a draining fistula was present or if there was visible puss associated with any tooth, either spontaneous or elicited by pressure in the year.

**Pain or Sensitivity**: Circle “yes” if the patient had dental-related pain in the year.

**Neurosensory Disturbances**: Circle “yes” if the patient experienced any neurosensory problems during the listed year. Examples include (partial) loss of sensation (anesthesia), pins and needles or heaviness (parasthesia), pain without obvious source (neuralgia, e.g. tic doloreux), pain with mild stimulation (neuritis, e.g. glossodynia), loss of taste (dysgeusia), or any other undiagnosed sensory abnormality.

**Temporomandibular Disorders**: Circle “yes” if the patient was diagnosed with any temporomandibular-related problem in the year. Examples include myofascial pain disorder, capsulitis, disc displacement, arthritis, locked bite, etc.

**B. Dental Diagnoses**

Prior to ONSET of ONJ symptoms in ONJ subjects or since the year 2000 in controls.

|  |  |
| --- | --- |
| Was the patient edentulous in the year 2000? **GEDENTUL** |  |
| **YES** — Check ‘N/A’ box to the right and proceed to Section C. **NO** — Please complete the dental diagnoses details below. | **N/A** |
| **[ ]**  |
|  |
| **Dental Diagnoses** | **Possible entries** | **2000** | **2001** | **2002** | **2003** | **2004** | **2005** | **2006** | **2007** |
| **Number of maxillary teeth present****GMAXINUM0-7** | 0-16 |  |  |  |  |  |  |  |  |
| **Number of mandibular teeth****PresentGMANDNUM0-7** | 0-16 |  |  |  |  |  |  |  |  |
| **Periodontal Disease**(Circle the appropriate response)**GPERIODZ0-7** | I/II/III/IVNA | I IIIII IVNA | I IIIII IVNA | I IIIII IVNA | I IIIII IVNA | I IIIII IVNA | I IIIII IVNA | I IIIII IVNA | I IIIII IVNA |
| **Caries** (two or more per year)(Circle the appropriate response) **G2CARI0-7** | Yes/NoNA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA |
| **Endodontic Problems**(Circle the appropriate response)**GENDOPRB0-7****GENDTOOTH0-7** | Yes/NoNA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA |
| Tooth# |  |  |  |  |  |  |  |  |
| **Gingival Bleeding**(Circle the appropriate response)**GGINGBL0-7** | Yes/NoNA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA |
| **Suppuration**(Circle the appropriate response)**GSUPPUR0-7** | Yes/NoNA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA |
| **Pain or Sensitivity**(Circle the appropriate response)**GPAIN0-7** | Yes/NoNA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA |
| **Neurosensory Disturbances**(Circle the appropriate response)**GNEUROS0-7** | Yes/NoNA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA |
| **TMD**(Circle the appropriate response)**GTMD0-7** | Yes/NoNA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA |

**C. Oral Surgery**

Please list all oral surgical procedures done on this subject either prior to the initial diagnosis of ONJ or since the year 2000 (if the subject was not diagnosed with ONJ).

If the patient has not had any teeth extracted or any other oral surgical procedure performed in the past five years, check the N/A box and leave the rest of this section blank.

If extractions or other surgical procedures have been performed, please enter the date and ADA code number for the type of extraction (simple, surgical, impaction, root removal, etc) or surgical procedure in the box for each respective tooth.

If the patient had an extraction or other surgical procedure in a primary (deciduous) or supernumerary tooth, enter the tooth letter (A-T), or circle yes for supernumerary at the bottom of the page and enter the date and ADA code in the box.

**Use the following codes when completing this section**

|  |  |
| --- | --- |
| **7110** | Extraction-Single tooth |
| **7120** | Extraction-Each additional tooth |
| **7111** | Extraction, remnants of deciduous tooth |
| **7140** | Extraction, exposed root |
| **7210** | Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth |
| **7220** | Removal of impacted tooth – soft tissue |
| **7230** | Removal of impacted tooth – partially bony |
| **7240** | Removal of impacted tooth – completely bony |
| **7241** | Removal of impacted tooth – completely bony with unusual surgical complications |
| **7250** | Surgical removal of residual tooth roots including cutting of soft tissue and bone, removal of bone structure and closure |
| **7310** | Alveoloplasty in conjunction with extraction |
| **7320** | Alveoloplasty not in conjunction with extraction |
| **7470** | Removal of exostosis |
| **7550** | Sequestrectomy |

**C. Oral Surgery**

|  |  |
| --- | --- |
| Has the patient had any teeth extracted since the year 2000? **GORALSUR** |  |
| **NO** — Check ‘N/A’ box to the right and proceed to Section D. **YES** — Please complete the extraction details using the chart below. Please indicate the date and the code related to **each permanent tooth extracted prior to the onset of ONJ or the year 2000.** Enter this information in the boxes linked to each tooth. | **N/A** |
| **[ ]**  |

**EXAMPLE** For each box below, please fill in as follows:

7111

09/07/06





**GOSDATE01-32 GOSCODE01-32**



 **GSUPERNUM GOSDATE GOSCODE**



**If deciduous or supernumerary:** **Tooth Number: \_\_\_\_ (A-T)**

Supernumerary: Yes / No **GSUPERNU**

**D. Periodontal Treatments**

Please list all periodontal treatments performed on this subject either prior to the initial diagnosis of ONJ or since the year 2000 (if the subject was not diagnosed with ONJ)

If the patient received no periodontal treatment in the last five years, check the N/A box and leave the rest of this section blank.

**Periodontal maintenance (4910)**: Check “yes” if the procedure was performed in the year.

**Scaling and root planning (4341)**: Circle each quadrant that was treated in the year. If a quadrant was treated twice in one year, enter “X2”; three times, enter “X3”, etc.

|  |  |  |
| --- | --- | --- |
| **Quadrant:**  | **UL** = Upper Left **LL** = Lower Left | **UR** = Upper Right **LR** = Lower Right |

**Non-surgical Periodontal Procedures
 Local Antibiotics (4381)**: Enter the tooth number or, if a quadrant was treated, the specific quadrant. Procedures to be listed here include sulcular placement of chlorhexidine chips, tetracycline fibers, antibiotic cream or powder and sulcular irrigation with chlorhexidine or iodine solution.

**Other Procedures**: Enter the ADA code of any periodontal non-surgical procedure that was performed on this patient, except 4910, 4341 and 4381.

**Codes: Other Non-surgical Periodontal Procedures**

|  |  |
| --- | --- |
| **4320** | Provisional splinting intracoronal |
| **4321** | Provisional splinting extracoronal |
| **4342** | Periodontal scaling and root planing one to three teeth |
| **4355** | Full mouth debridement |
| **4920** | Unscheduled dressing change |
| **4999** | Unspecified periodontal procedure |

**Surgical Periodontal Procedures**: Enter the date(s) and ADA code(s) of the surgical periodontal treatment(s) performed for each quadrant treated in a specific year. Enter a code for each date listed, even if it is the same procedure performed previously.
**Codes: Surgical Periodontal Procedures**

|  |  |
| --- | --- |
| **4210** | Gingivectomy or gingivoplasty (4 or more contiguous teeth/quad) |
| **4211** | Gingivectomy or gingivoplasty (1-3 contiguous teeth/quad) |
| **4240** | Gingival flap procedure including root planing (4 or more contiguous teeth/quad) |
| **4241** | Gingival flap procedure including root planing (1-3 contiguous teeth/quad) |
| **4245** | Apically positioned flap |
| **4249** | Crown lengthening |
| **4260** | Osseous surgery (4 or more contiguous teeth/quad) |
| **4261** | Osseous surgery (1-3 contiguous teeth/quad) |
| **4263** | Bone replacement graft (1st site in quadrant) |
| **4264** | Bone replacement graft (each additional site in quadrant) |
| **4265** | Biologic materials to aid in soft and osseious tissue regeneration |
| **4266** | Guided tissue regeneration (resorbable barrier) |
| **4267** | Guided tissue regeneration (non-resorbable barrier) |
| **4268** | Surgical revision procedure |
| **4270** | Pedicle soft tissue graft procedure |
| **4271** | Free soft tissue graft procedure |
| **4273** | Subepithelial connective tissue graft procedure |
| **4274** | Distal or proximal wedge procedure |
| **4275** | Soft tissue allograft |
| **4276** | Combined connective tissue and double pedicle graft |

**D. Periodontal Treatments**

|  |  |
| --- | --- |
| Has the patient had any periodontal treatment since the year 2000? **GPERIOTRT** |  |
| **NO** — Check ‘N/A’ box to the right and proceed to Section E. **YES** — Please complete the details of periodontal treatment given either prior to onset of ONJ or as indicated in the years below.  | **N/A** |
| **[ ]**  |
|  |
| **Treatment** | **Code** | **2000** | **2001** | **2002** | **2003** | **2004** | **2005** | **2006** | **2007** |
| **Periodontal maintenance**(check under each year, if performed)**GMAINT0-7** | **4910****~~GPT4910~~** | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA | YESNONA |
| **Scaling and  Root Planing**(circle the quadrant/s)**~~GSCALE0-7~~****GSCALEUL0-7****GSCALEUR0-7****GSCALELL0-7****GSCALELR0-7** | **4341****~~GPT4341~~** | UL URLL LR | UL URLL LR | UL URLL LR | UL URLL LR | UL URLL LR | UL URLL LR | UL URLL LR | UL URLL LR |
| Other non-surgical periodontal procedures**G4381\_0-7****GPTOT0-7** | **Local Antibiotics(4381)**(tooth #)**~~GPT4381~~** |  |  |  |  |  |  |  |  |
| **Other Procedures** (List codes and oral medications)**~~GPTOT~~** |  |  |  |  |  |  |  |  |
| Surgical periodontal procedures (For each quadrant enter dates and codes) | **Upper Left** | **Date****GULDATE0-7** |  |  |  |  |  |  |  |  |
| **Code****GULCODE0-7** |  |  |  |  |  |  |  |  |
| Surgical periodontal procedures (For each quadrant enter dates and codes) | **Upper Right** | **Date****GURDATE0-7** |  |  |  |  |  |  |  |  |
| **Code****GURCODE0-7** |  |  |  |  |  |  |  |  |
| Surgical periodontal procedures (For each quadrant enter dates and codes) | **Lower Left** | **Date****GLLDATE0-7** |  |  |  |  |  |  |  |  |
| **Code****GLLCODE0-7** |  |  |  |  |  |  |  |  |
| Surgical periodontal procedures (For each quadrant enter dates and codes) | **Lower Right** | **Date****GLRDATE0-7** |  |  |  |  |  |  |  |  |
| **Code****GLRCODE0-7** |  |  |  |  |  |  |  |  |

**E. Endodontic Treatments or RCT**

Please list all endodontic treatment given to this subject either prior to the initial diagnosis of ONJ or since the year 2000 (if the subject was not diagnosed with ONJ)

If the patient received no endodontic treatment in the last five years, check the N/A box and leave the rest of this section blank.

If endodontic treatments have been performed, please enter the date and ADA code number for the type of procedure in the box for each respective tooth.

List the teeth that required re-treatment and the date that re-treatment was performed.

**Use the following codes when completing this section on endodontic treatments**

|  |  |  |
| --- | --- | --- |
| **Pulp Capping** | **3110** | Pulp Cap - Direct (Excluding Final Restoration) |
| **3120** | Pulp Cap - Indirect (Excluding Final Restoration) |
| **Endodontic Therapy (Including Treatment Plan, Clinical Procedures and Follow-Up Care)** | **3310** | Anterior (Excluding Final Restoration) |
| **3320** | Bicuspid (Excluding Final Restoration) |
| **3330** | Molar (Excluding Final Restoration) |
| **3331** | Treatment of Root Canal Obstruction; Non-Surgical Access |
| **3332** | Incomplete Endodontic Therapy; Inoperable, Unrestorable or Fractured Tooth |
| **3333** | Internal Root Repair of Perforation Defects |
| **Endodontic Retreatment** | **3346** | Retreatment of Previous Root Canal Therapy - Anterior |
| **3347** | Retreatment of Previous Root Canal Therapy - Bicuspid |
| **3348** | Retreatment of Previos Root Canal Therapy - Molar |
| **Apicoectomy / Periradicular Services** | **3410** | Apicoectomy/Periradicular Surgery - Anterior |
| **3421** | Apicoectomy/Periradicular Surgery – Bicuspid (First Root) |
| **3425** | Apicoectomy/Periradicular Surgery - Molar (First Root) |
| **3426** | Apicoectomy/Periradicular Surgery (Each Additional Root) |
| **3430** | Retrograde Filling - Per Root |
| **3450** | Root Amputation - Per Root |
| **3460** | Endodontic Endosseous Implant |
| **3470** | Intentional Reimplantation (Including Necessary Splinting) |
| **Other Endodontic****Procedures** | **3910** | Surgical Procedure for Isolation of Tooth with Rubber Dam |
| **3920** | Hemisection (Including Any Root Removal), not including Root Canal Therapy |
| **3950** | Canal Preparation and Fitting of Preformed Dowel or Post |
| **3999** | Unspecified Endodontic Procedure, by Report |

**E. Endodontic Treatments or RCT**

|  |  |
| --- | --- |
| Has the patient had any endodontic treatment since the year 2000? **GENDOTRT** |  |
| **NO** — Check ‘N/A’ box to the right and proceed to Section F. **YES** — Please complete the **endodontic treatment** details using the chart below. Please indicate the date and the code related to **each treated tooth prior to the onset of ONJ or the year 2000**. Enter this information in the boxes linked to each tooth. | **N/A** |
| **[ ]**  |

**GETDATE01-32 GETCODE01-32**



|  |
| --- |
| If any of the above treatments failed, please indicate the tooth number and date of re-treatment. |
| Tooth Number: | **GETTONUM1** | Date of re-treatment: | **GETTODAT1** | (MM/DD/YY) |
| Tooth Number: | **GETTONUM2** | Date of re-treatment: | **GETTODAT2** | (MM/DD/YY) |
| Tooth Number: | **GETTONUM3** | Date of re-treatment: | **GETTODAT3** | (MM/DD/YY) |
| Tooth Number: | **GETTONUM4** | Date of re-treatment: | **GETTODAT4** | (MM/DD/YY) |
| Tooth Number: | **GETTONUM5** | Date of re-treatment: | **GETTODAT5** | (MM/DD/YY) |

**F. Implants**

Please list all implants done on this subject either prior to the initial diagnosis of ONJ or since the year 2000 (if the subject was not diagnosed with ONJ)

If the patient received no implants in the last five years, check the N/A box and leave the rest of this section blank.

If implants have been performed, please enter the date and ADA code number for the type of procedure in the box for each respective tooth.

|  |
| --- |
| **Implant Services** |
|  | **6010** | Surgical Placement of Implant Body: Endosteal Implant |
| **6040** | Surgical Placement: Eposteal Implant |
| **6050** | Surgical Placement: Transosteal Implant |
| **Implant Supported Prosthetics** | **6053** | Implant/Abutment Supported Removable Denture for Completely Edentulous Arch |
| **6054** | Implant/Abutment Supported Removable Denture for Partially Edentulous Arch |
| **6055** | Dental Implant Supported Connecting Bar |
| **6056** | Prefabricated Abutment - Includes Placement |
| **6057** | Custom Abutment - Includes Placement |
| **6058** | Abutment Supported Porcelain/Ceramic Crown |
| **6059** | Abutment Supported Porcelain Fused to Metal Crown (High Noble Metal) |
| **6060** | Abutment Supported Porcelain Fused to Metal Crown (Predominantly Base Metal) |
| **6061** | Abutment Supported Porcelain Fused to Metal Crown (Noble Metal) |
| **6062** | Abutment Supported Cast Metal Crown (High Noble Metal) |
| **6063** | Abutment Supported Cast Metal Crown (Predominantly Base Metal) |
| **6064** | Abutment Supported Cast Metal Crown (Noble Metal) |
| **6094** | Abutment Supported Crown - (Titanium) |
| **6065** | Implant Supported Porcelain/Ceramic Crown |
| **6066** | Implant Supported Porcelain Fused to Metal Crown (Titanium, Titanium Alloy, High Noble Metal) |
| **6067** | Implant Supported Metal Crown (Titanium, Titanium Alloy, High Noble Metal) |
| **6068** | Abutment Supported Retainer for Porcelain/Ceramic FPD |
| **6069** | Abutment Supported Retainer for Porcelain Fused to Metal FPD (High Noble Metal) |
| **6070** | Abutment Supported Retainer for Porcelain Fused to Metal FPD (Predominantly Base Metal) |
| **6071** | Abutment Supported Retainer for Porcelain Fused to Metal FPD (Noble Metal) |
| **6072** | Abutment Supported Retainer for Cast Metal FPD (High Noble Metal) |
| **6073** | Abutment Supported Retainer for Cast Metal FPD (Predominantly Base Metal) |
| **6074** | Abutment Supported Retainer for Cast Metal FPD (Noble Metal) |
| **6194** | Abutment Supported Retainer Crown for FPD - (Titanium) |
| **6075** | Implant Supported Retainer for Ceramic FPD |
| **6076** | Implant Supported Retainer for Porcelain Fused to Metal FPD (Titanium, Titanium Alloy, or High Noble Metal) |
| **6077** | Implant Supported Retainer for Cast Metal FPD (Titanium, Titanium Alloy, or High Noble Metal) |
| **6078** | Implant/Abutment Supported Fixed Denture for Completely Edentulous Arch |
| **6079** | Implant/Abutment Supported Fixed Denture for Partially Edentulous Arch |
| **Other Implant Services** | **6080** | Implant Maintenance Procedures, Including Removal of Prosthesis, Cleansing of Prosthesis and Abutments and Reinsertion of Prosthesis |
| **6090** | Repair Implant Supported Prosthesis, by Report |
| **6095** | Repair Implant Abutment, by Report |
| **6100** | Implant Removal, by Report |
| **6190** | Radiographic/Surgical Implant Index, by Report |
| **6199** | Unspecified Implant Procedure, by Report |

**F. Implants**

|  |  |
| --- | --- |
| Has the patient received any implants since the year 2000? **GIMPLANT** |  |
| **NO** — Check ‘N/A’ box to the right and proceed to Section G. **YES** — Please complete the implant details using the chart below. Please indicate the date and the code related to **each implant placed prior to the onset of ONJ or the year 2000.** Enter this information in the boxes linked to each tooth. | **N/A** |
| **[ ]**  |

**GIPDATE01-32 GIPCODE01-32**



|  |
| --- |
| If any of the above implants failed, please indicate the tooth number and date of failure. |
| Tooth Number: | **GIPTONUM1** | Date of failure: | **GIPTODAT1** | (MM/DD/YY) |
| Tooth Number: | **GIPTONUM2** | Date of failure: | **GIPTODAT2** | (MM/DD/YY) |
| Tooth Number: | **GIPTONUM3** | Date of failure: | **GIPTODAT3** | (MM/DD/YY) |
| Tooth Number: | **GIPTONUM4** | Date of failure: | **GIPTODAT4** | (MM/DD/YY) |
| Tooth Number: | **GIPTONUM5** | Date of failure: | **GIPTODAT5** | (MM/DD/YY) |

**G. Biopsies**

Please list all biopsies done on this subject either prior to the initial diagnosis of ONJ or since the year 2000 (if the subject was not diagnosed with ONJ)

If no biopsies were performed in the last five years, check the N/A box and leave the rest of this section blank.

If biopsies have been performed, please enter the final diagnosis, the sextant, date and ADA code number for the type of procedure in the year.

**Diagnosis:** Enter the final diagnosis.

**Date:** Date biopsy was performed.

**Sextant:**

|  |  |
| --- | --- |
| **UR** = Upper Right | **LR** = Lower Right |
| **UA** = Upper Anterior | **LA** = Lower Anterior |
| **UL** = Upper Left | **LL** = Lower Left |

**Code:** Use the following codes when completing this section on biopsies

|  |  |
| --- | --- |
| **7285** | Biopsy of oral tissue – hard |
| **7286** | Biopsy of oral tissue – soft |
| **7287** | Exfoliative cytological sample collection |

Indicate if biopsy reports were attached to this form

**G. Biopsies**

|  |  |
| --- | --- |
| Has the patient had any biopsies since the year 2000? **GBIOPSY** |  |
| **NO** — Check ‘N/A’ box to the right and proceed to Section H. **YES** — Please complete the biopsy details since the onset of ONJ or the year 2000 below. | **N/A** |
| **[ ]**  |
|  |
| **Diagnoses** |  | **2000** | **2001** | **2002** | **2003** | **2004** | **2005** | **2006** | **2007** |
| First Biopsy**Diagnosis:****GBI1DIAG (for DPBRN)****GBI1DIAG1, GBI1DIAG3- GBI1DIAG7 (for Precedent)** | **Sextant****GBI1SEXT0-7** |  |  |  |  |  |  |  |  |
| **Date****GBI1DATE0-7** |  |  |  |  |  |  |  |  |
| **Code****GBI1CODE0-7** |  |  |  |  |  |  |  |  |
| Second Biopsy**Diagnosis:****GBI2DIAG (for DPBRN)****GBI2DIAG1, GBI2DIAG3- GBI2DIAG7 (for Precedent)** | **Sextant****GBI2SEXT0-7** |  |  |  |  |  |  |  |  |
| **Date****GBI2DATE0-7** |  |  |  |  |  |  |  |  |
| **Code****GBI2CODE0-7** |  |  |  |  |  |  |  |  |
| Third Biopsy**Diagnosis:****GBI3DIAG (for DPBRN)****GBI3DIAG1, GBI3DIAG3- GBI3DIAG7 (for Precedent)** | **Sextant****GBI3SEXT0-7** |  |  |  |  |  |  |  |  |
| **Date****GBI3DATE0-7** |  |  |  |  |  |  |  |  |
| **Code****GBI3CODE0-7** |  |  |  |  |  |  |  |  |
| Fourth Biopsy**Diagnosis:****GBI4DIAG (for DPBRN)****GBI4DIAG1, GBI4DIAG3- GBI4DIAG7 (for Precedent)** | **Sextant****GBI4SEXT0-7** |  |  |  |  |  |  |  |  |
| **Date****GBI4DATE0-7** |  |  |  |  |  |  |  |  |
| **Code****GBI4CODE0-7** |  |  |  |  |  |  |  |  |

**Please attach all biopsy reports.**

Biopsy reports attached? **GBIOPREP**

YES **[ ]** NO **[ ]**

**H. Certification**

|  |  |
| --- | --- |
| **Certification by Person Completing Form**  |  |

**Time Completed:** Indicate the time you completed the form

**Did you complete the form in one sitting?** Please, indicate if you completed the form in one sitting.

**1. Date Form Completed:** Enter the date the form was completed

**2a. This form was completed by:** Print or type the name of the person completing the form. If more than one person participated in the process, list all. Check the appropriate box for each person completing the form

**2b. Designation of the person:**

|  |  |
| --- | --- |
| **Certification by Dentist** |  |

1. **Certification by Dentist**
* The dentist who diagnosed and treated the patient should review, then print and sign on the provided spaces. If more than one dentist treated this patient, the one who had primary responsibility for the treatment planning and diagnosis should be the signatory.
* The form is considered complete after the dentist has reviewed and confirmed the accuracy of the document.

 **4. Designation of the person:**  If unusual circumstances prevent the treating dentist from signing, please enter the function of the signing person in the dental office.

**H. Certification**

|  |
| --- |
| **Certification by Person Completing Form** |

**Time Completed** \_\_\_\_:\_\_\_\_ AM/PM

 **GCOMTIME GCOMAMPM**

|  |  |  |
| --- | --- | --- |
| Did you complete the form in one sitting?**GCOM1SIT** | **Yes** | **No** |
|  |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1. Date Form Completed GCOMDATE** |  |  | **/** |  |  | **/** |  |  |  |  |
| M | M | / | D | D | / | Y | Y | Y | Y |
| **2a.** **Completed By:** Print name(s) below. If more than one person, list all: | **2b. Designation of the person** (dentist, other, etc) Check all appropriate box(es) |
| **GCOMNAM1****GCOMNAM2****GCOMNAM3****GCOMNAM3****GCOMNAM4****GCOMNAM5** | □ Dentist **GCOMDENT**□ Office Manager **GCOMOM**□ Dental Hygienist **GCOMHYG**□ PBRN Staff **GCOMPBRN**□ Other: Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**GCOMOT GCOMSPE** |
|  |  |

|  |
| --- |
| **Certification by Dentist/PBRN RA** |

**3.** **I have reviewed this data and certify that they are accurate to the best of my knowledge.**

|  |  |  |
| --- | --- | --- |
| **GCERTNAM** |  |  |
| Name |  | Signature |

1. **Designation of the person.**

□ Dentist **GCERTDENT**

□ Other (to be used only when it is impossible for the dentist to certify) **GCERTOT**

Please Specify \_\_\_\_\_\_\_\_\_\_\_ **GCERTSPE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_