



# SENSITIVE TEETH STUDY

## Symptomatic Exam (2<sup>nd</sup> Line Treatment Visit)

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="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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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 restoration(s) present on sensitive tooth/teeth only.



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"/>	<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"/>

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

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

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

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): <ul style="list-style-type: none"> <li><input type="checkbox"/> To stop product, habit and/or behavior. If yes, what product/habit/behavior? _____</li> <li><input type="checkbox"/> To decrease product, habit and/or behavior. If yes, what product/habit/behavior? _____</li> <li><input type="checkbox"/> To start or increase behavior. If yes, what behavior? _____</li> </ul>				
<input type="checkbox"/> Other (please specify): _____				

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

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

 \_\_\_\_\_  
 Practitioner Signature

 Date: |\_\_|\_|\_|/|\_\_|\_|\_|/|\_2\_|\_0\_|\_1\_|\_|  
           m  m  d  d  y  y  y  y

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

Questions? Contact your Regional Coordinator.