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

Time Started: ____:____ AM/PM

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.

2. **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.

3. **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.

4. **Patient Month/Year of Birth.**
   - Enter birth month and year only, not day of month.
   - Use date format MM/YYYY

5. **Patient Gender**
   - Enter the patient's gender (sex) as (M)ale or (F)emale.

6. **Is this patient an ONJ case or a control patient?**
   - Check the box corresponding to the patient's status.

7. **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).

8. **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

	Yes	No
Has written informed consent been obtained?		

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 ____ - ____

2. Patient initials ____ ____ ____

3a. Date of last visit to your office ____ ____ / ____ ____ / ____ ____ ____ ____

M M / D D / Y Y Y Y

3b. Check the box to your right if the date of the last visit is unknown. ☐

4. Patient month/year of Birth ____ ____ / ____ ____ ____ ____

M M / Y Y Y Y

5. Patient Gender ____ ____

F M

	Case	Control
6. Is this patient an ONJ case or a control patient?		

7a. Type of Practice the case was selected from _____

7b. If the patient is a referral, what type of provider referred the patient _____

8. Type of Practice the controls were selected from _____

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?

YES — Check 'N/A' box to the right and proceed to Section C. ***N/A*** ☐

NO — Please complete the dental diagnoses details below.

Dental Diagnoses	Possible entries	2000	2001	2002	2003	2004	2005	2006	*2007*
Number of maxillary teeth present	0-16								
Number of mandibular teeth present	0-16								
Periodontal Disease (Circle the appropriate response)	I/II/III/IV NA	I II III IV NA	I II III IV NA	I II III IV NA	I II III IV NA	I II III IV NA	I II III IV NA	I II III IV NA	*I II III IV NA*
Caries (two or more per year) (Circle the appropriate response)	Yes/No NA	YES NO NA	YES NO NA	YES NO NA	YES NO NA	YES NO NA	YES NO NA	YES NO NA	*YES NO NA*
Endodontic Problems (Circle the appropriate response)	Yes/No NA	YES NO NA	YES NO NA	YES NO NA	YES NO NA	YES NO NA	YES NO NA	YES NO NA	*YES NO NA*
	Tooth#								
Gingival Bleeding (Circle the appropriate response)	Yes/No NA	YES NO NA	YES NO NA	YES NO NA	YES NO NA	YES NO NA	YES NO NA	YES NO NA	*YES NO NA*
Suppuration (Circle the appropriate response)	Yes/No NA	YES NO NA	YES NO NA	YES NO NA	YES NO NA	YES NO NA	YES NO NA	YES NO NA	*YES NO NA*
Pain or Sensitivity (Circle the appropriate response)	Yes/No NA	YES NO NA	YES NO NA	YES NO NA	YES NO NA	YES NO NA	YES NO NA	YES NO NA	*YES NO NA*
Neurosensory Disturbances (Circle the appropriate response)	Yes/No NA	YES NO NA	YES NO NA	YES NO NA	YES NO NA	YES NO NA	YES NO NA	YES NO NA	*YES NO NA*
TMD *(Circle the appropriate response)*	*Yes/No NA*	*YES NO NA*	*YES NO NA*	*YES NO NA*	*YES NO NA*	*YES NO NA*	*YES NO NA*	*YES NO NA*	*YES NO NA*

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

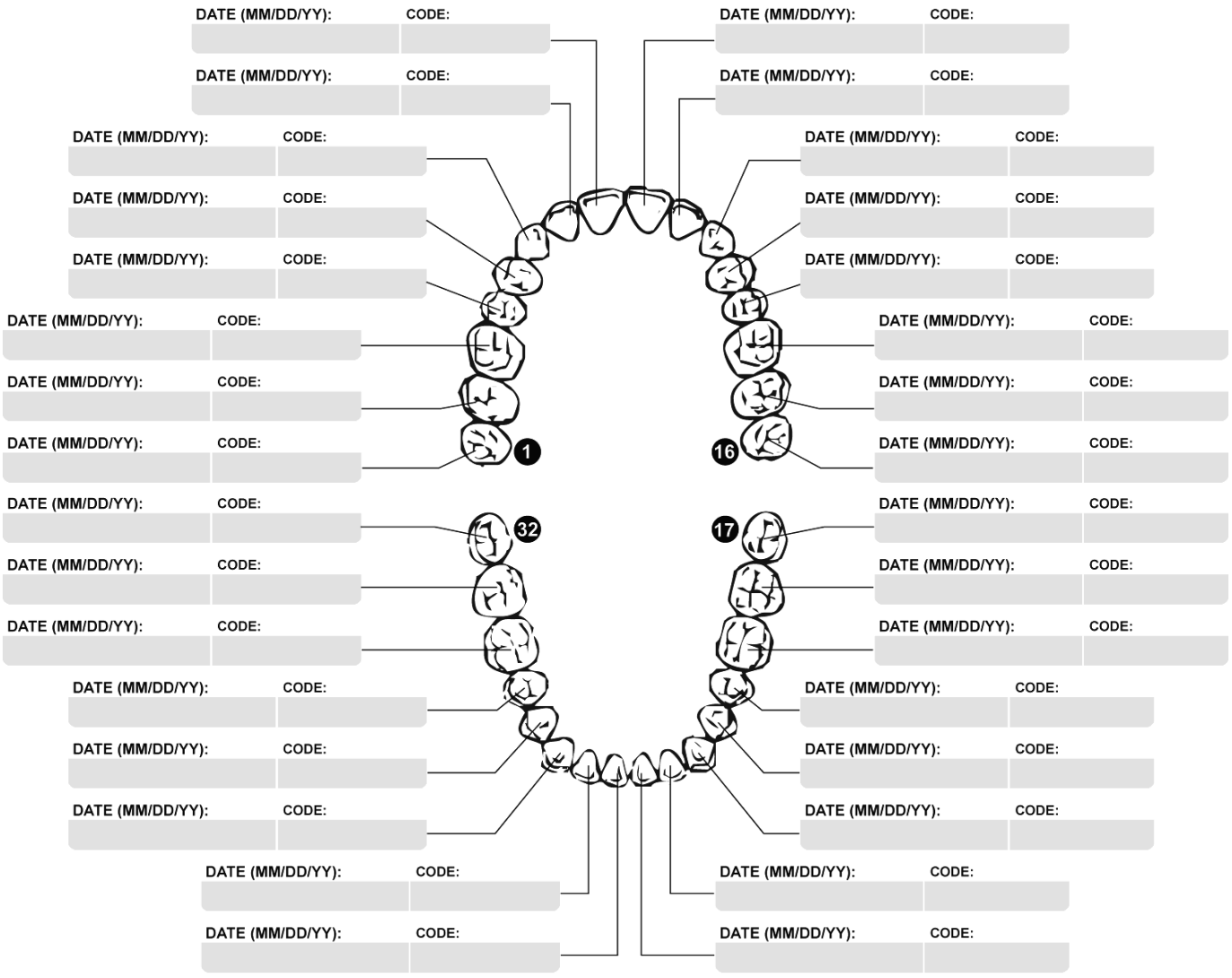
Has the patient had any teeth extracted since the year 2000?

NO — Check 'N/A' box to the right and proceed to Section D. ***N/A*** ☐

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.

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

DATE (MM/DD/YY):	CODE:
09/07/06	7111



If deciduous or supernumerary: Tooth Number: ____ (A-T)

Supernumerary: Yes / No

DATE (MM/DD/YY):	CODE:

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 **UR** = Upper Right
LL = Lower Left **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?

NO — Check 'N/A' box to the right and proceed to Section E. ***N/A*** ☐

YES — Please complete the details of periodontal treatment given either prior to onset of ONJ or as indicated in the years below.

Treatment		Code	2000	2001	2002	2003	2004	2005	2006	*2007*
Periodontal maintenance (check under each year, if performed)		**4910**	YES NO NA	YES NO NA	YES NO NA	YES NO NA	YES NO NA	YES NO NA	YES NO NA	*YES NO NA*
Scaling and Root Planing (circle the quadrant/s)		**4341**	UL UR LL LR	UL UR LL LR	UL UR LL LR	UL UR LL LR	UL UR LL LR	UL UR LL LR	UL UR LL LR	*UL UR LL LR*
Other non-surgical periodontal procedures		**Local Antibiotics (4381)** (tooth #)								
		Other Procedures (List codes and oral medications)								
Surgical periodontal procedures (For each quadrant enter dates and codes)	**Upper Left**	**Date**								
		Code								
Surgical periodontal procedures (For each quadrant enter dates and codes)	**Upper Right**	**Date**								
		Code								
Surgical periodontal procedures (For each quadrant enter dates and codes)	**Lower Left**	**Date**								
		Code								
Surgical periodontal procedures (For each quadrant enter dates and codes)	**Lower Right**	**Date**								
		Code								

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

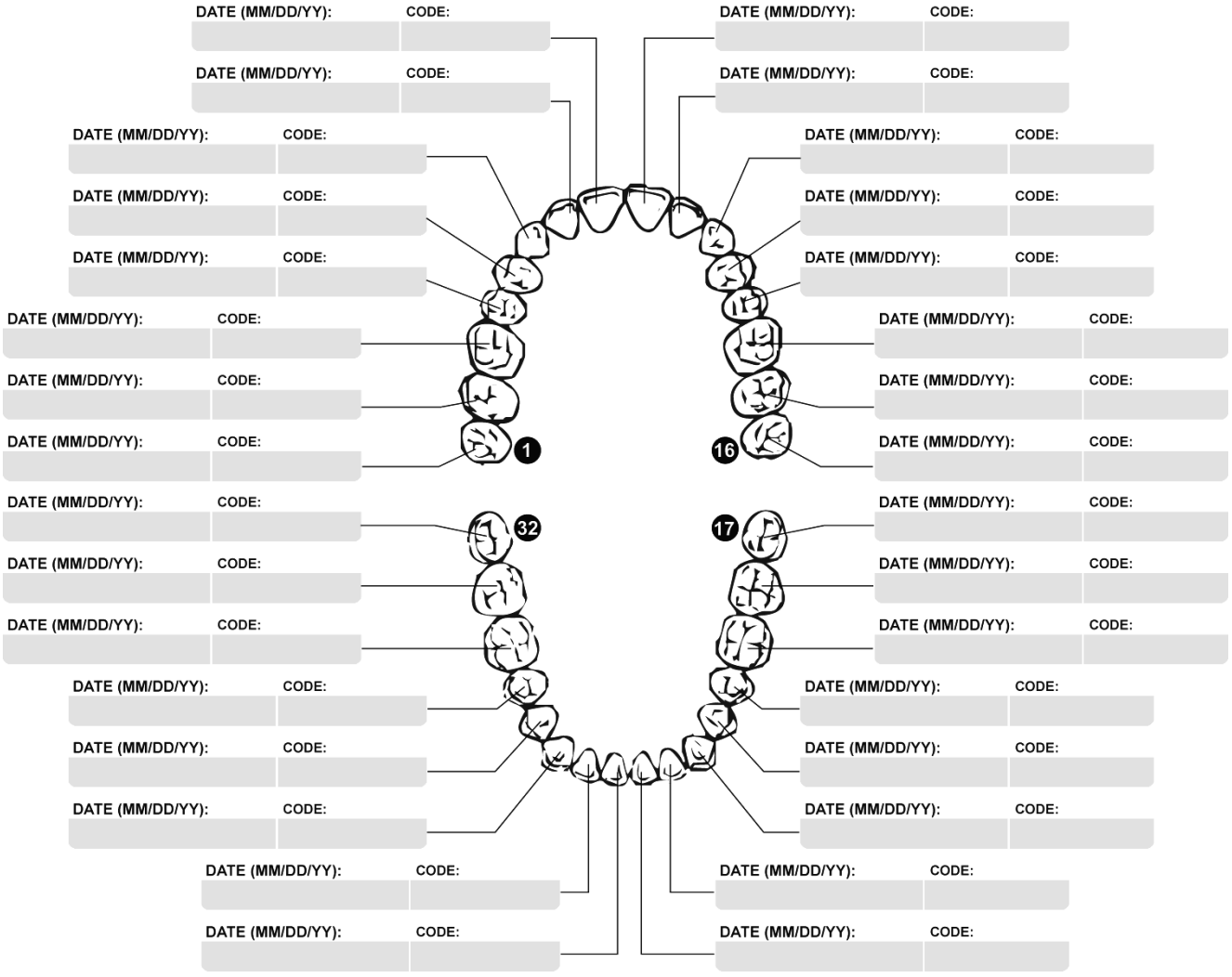
Pulp Capping	**3110**	Pulp Cap - Direct (Excluding Final Restoration)
	3120	Pulp Cap - Indirect (Excluding Final Restoration)
Endodontic Therapy (Including Treatment Plan, Clinical Procedures and Follow-Up Care)	**3310**	Anterior (Excluding Final Restoration)
	3320	Bicuspid (Excluding Final Restoration)
	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?

NO — Check 'N/A' box to the right and proceed to Section F. ***N/A*** ☐

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.



If any of the above treatments failed, please indicate the tooth number and date of re-treatment.

Tooth Number: _____ Date of re-treatment: _____ (MM/DD/YY)

Tooth Number: _____ Date of re-treatment: _____ (MM/DD/YY)

Tooth Number: _____ Date of re-treatment: _____ (MM/DD/YY)

Tooth Number: _____ Date of re-treatment: _____ (MM/DD/YY)

Tooth Number: _____ Date of re-treatment: _____ (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.

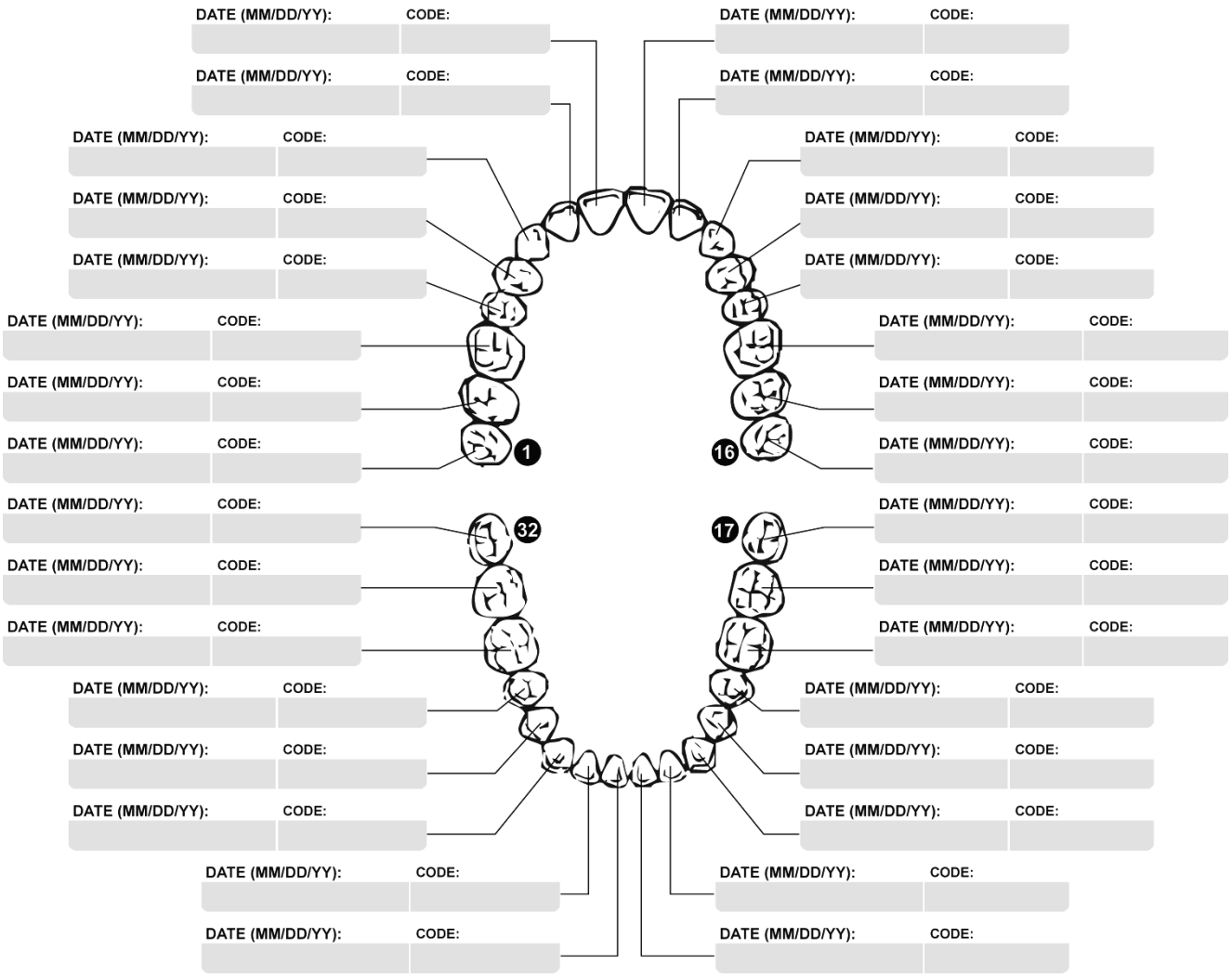
Implant Services		
	6010	Surgical Placement of Implant Body: Endosteal Implant
	6040	Surgical Placement: Eposteal Implant
	6050	Surgical Placement: Transosteal Implant
Implant Supported Prosthetics	**6053**	Implant/Abutment Supported Removable Denture for Completely Edentulous Arch
	6054	Implant/Abutment 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?

NO — Check 'N/A' box to the right and proceed to Section G. *N/A* ☐

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.



If any of the above implants failed, please indicate the tooth number and date of failure.

Tooth Number: _____ Date of failure: _____ (MM/DD/YY)

Tooth Number: _____ Date of failure: _____ (MM/DD/YY)

Tooth Number: _____ Date of failure: _____ (MM/DD/YY)

Tooth Number: _____ Date of failure: _____ (MM/DD/YY)

Tooth Number: _____ Date of failure: _____ (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?

NO — Check 'N/A' box to the right and proceed to Section H. ***N/A*** ☐

YES — Please complete the biopsy details since the onset of ONJ or the year 2000 below.

Diagnoses		2000	2001	2002	2003	2004	2005	2006	*2007*
First Biopsy **Diagnosis:**	**Sextant**								
	Date								
	Code								
Second Biopsy **Diagnosis:**	**Sextant**								
	Date								
	Code								
Third Biopsy **Diagnosis:**	**Sextant**								
	Date								
	Code								
Fourth Biopsy **Diagnosis:**	**Sextant**								
	Date								
	Code								

Please attach all biopsy reports.

Biopsy reports attached?

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

3. 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

Did you complete the form in one sitting?	Yes	No

1. Date Form Completed

		/			/				
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)

☐ Dentist

☐ Office Manager

☐ Dental Hygienist

☐ PBRN Staff

☐ Other: Specify _____

Certification by Dentist/PBRN RA

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

_____ _____
Name Signature

4. Designation of the person.

☐ Dentist

☐ Other (to be used only when it is impossible for the dentist to certify)

Please Specify _____