Date	__ __/__ __/__ __ __ __
Patient Participant ID	__ __ __ __
Practitioner completing form	☐ Dentist ☐ Dental Hygienist
Inclusion Criteria	
Note: Any 'no' response in this section disqualifies the patient from study participation. The questionnaire is ended if a participant answers 'no' in this section. Please note as screen fail.	
1. Potential participant is at least 40 years old; *Practitioner: please confirm participant's age. You will be asked to enter their date of birth before randomization to ensure the participant is 40 or older.*	☐ Yes ☐ No
2. Potential participant has 20 or more permanent teeth excluding 3rd molars.	☐ Yes ☐ No
3. Potential participant is in good general health as evidenced by medical history (ASA Class I or II) per the practitioner.	☐ Yes ☐ No
4. Potential participant needs periodontal care for Generalized Stage II-III, Grade A-C periodontitis (previously classified as moderate to severe periodontitis), and a minimum of two quadrants of SRP (CDT code 4341) in practices participating in the National Dental PBRN PAAS study, with current need for NSPT.	☐ Yes ☐ No
5. Potential participant is willing to comply with all study visits and be available for the duration of the study (12-15 months).	☐ Yes ☐ No
6. Potential participant is willing to provide contact information for self, including a cellular phone number for study text, and one to two emergency contacts to be reached for the follow-up visits and any other study-related matters for the duration of the study.	☐ Yes ☐ No
Exclusion Criteria	
*Note: **Any 'yes' response in this section disqualifies the patient from study participation.** The questionnaire is ended if a participant answers 'yes' in this section. **Please note as screen fail**.*	
7. Potential participant has a known drug allergy to antibiotics or anesthetics.	☐ Yes ☐ No
8. Potential participant has used systemic antibiotics within the last 3 months prior to enrollment.	☐ Yes ☐ No
9. Potential participant has a medical condition which requires antibiotic prophylaxis prior to receiving dental treatments/visits.	☐ Yes ☐ No
10. Potential participant currently uses medications that may cause adverse effects with Amoxicillin/Metronidazole (AMXM) such as disulfiram, warfarin, oral contraceptives.	☐ Yes ☐ No
11. Potential participant has a history of receiving periodontal therapy (including SRP D4341, D4342) within the last 6 months prior to enrollment.	☐ Yes ☐ No

12. Potential participant is currently pregnant or lactating per self-report.	☐ Yes ☐ No
13. Potential participant is considered immunocompromised, in the opinion of the practitioner (including diseases and conditions such as HIV/AIDS, immunosuppressive drug therapy and/or radiation), or has chronic mucosal lesions (e.g. pemphigus vulgaris) affecting the gingiva.	☐ Yes ☐ No
14. Potential participant has Diabetes Mellitus with an HBA1c score of >/= 10% within the past 3-months as per self-report.	☐ Yes ☐ No
15. Potential participant is planning to receive another type of adjunct periodontal therapy during the course of the study (the next 12 months). This includes but is not limited to laser therapy, local antibiotic, or periodontal surgery.	☐ Yes ☐ No

Eligible: ___

This patient is eligible for the PAAS study. Please proceed to the consent form.

Pass the tablet to the participant after you click the Submit button below.

Not Eligible: ___

This patient does not qualify for the PAAS study. Please click submit below.

PAAS Baseline Visit Checklist (Day 0)

Date	__ __/__ __/__ __ __ __
Patient Participant ID	__ __ __ __
Which practitioner is completing the form?	☐ Dentist ☐ Dental Hygienist
1. Has OHIP-5 form been completed by the participant?	☐ Yes ☐ No
2. Has patient participant been randomized?	☐ Yes ☐ No
3. Has medication been distributed and administered, to include medication instructions? *Recommended at least 30-60 minutes prior to the procedure*	☐ Yes ☐ No
4. Has plaque sample been collected? *only if patient participant consented to collection*	☐ Yes ☐ No ☐ N/A
5. Has local anesthetic been administered today?	☐ Yes ☐ No
If "yes" to Question 5,	
5a. Which type of anesthetic was administered	☐ Local anesthetic ☐ Topical anesthetic (e.g., Oraqix) ☐ None ☐ Other specify: _____
6. What quadrants were treatment planned to undergo SRP?	Upper Right (UR) ☐ Yes ☐ No Upper Left (UL) ☐ Yes ☐ No Lower Left (LL) ☐ Yes ☐ No Lower Right (LR) ☐ Yes ☐ No
7. What quadrants received SRP today?	Upper Right (UR) ☐ Yes

	☐ No Upper Left (UL) ☐ Yes ☐ No Lower Left (LL) ☐ Yes ☐ No Lower Right (LR) ☐ Yes ☐ No
8. Has the treatment area been verified for completion of residual calculus with an ODU 11/12 explorer (included in patient participant package)?	☐ Yes ☐ No
9. Has patient participant reported an Adverse Event?	☐ Yes ☐ No
10. Has practitioner reviewed and provided patient participant with the post-op oral hygiene instructions at this visit?	☐ Yes ☐ No
11. Does a second appointment for scaling and root planing need to be made to complete this procedure?	☐ Yes ☐ No
11a. If yes, enter date	----------
11b. If no, please answer question 12.	
12. Has practitioner uploaded the periodontal chart image? ***Please ensure PD, BoP, and GR are captured***	☐ Yes ☐ No

PAAS Optional Second Baseline Visit Checklist – if necessary(Day 2-10)

Date	__ __/__ __/__ __ __ __
Patient Participant ID	__ __ __ __
Which Practitioner is completing the form?	☐ Dentist ☐ Dental Hygienist
Days since first Baseline visit	__ __
1. Has local anesthetic been administered today?	☐ Yes ☐ No
If "yes" to Question 1,	
1a. Which type of anesthetic was administered	☐ Local anesthetic ☐ Topical anesthetic (e.g., Oraqix) ☐ None ☐ Other specify: _____
2. What quadrants received SRP today?	Upper Right (UR) ☐ Yes ☐ No Upper Left (UL) ☐ Yes ☐ No Lower Left (LL) ☐ Yes ☐ No Lower Right (LR) ☐ Yes ☐ No
3. Has the treatment area been verified for completion of residual calculus with an ODU 11/12 explorer (included in patient participant package)?	☐ Yes ☐ No
4. Has patient participant been provided oral hygiene instructions at this visit?	☐ Yes ☐ No
5. Has patient participant reported an adverse event?	☐ Yes ☐ No
6. Has practitioner uploaded the periodontal chart image? ***Please ensure PD, BoP and GR have been captured***	☐ Yes ☐ No

PAAS Medication Compliance Form

Date: __ __/__ __/ __ __ __ __

Patient Participant ID: __ __ __ __

1. Please count the number of capsules you have left in the vials of medications that were given to you at your research study visit and record below.

Vial A: ___ ___ capsules

Vial B: ___ ___ capsules

PAAS Re-Eval Visit Checklist (6 weeks +3 weeks)

Date	__ __/__ __/__ __ __ __
Patient Participant ID	__ __ __ __
Which practitioner is completing the form?	☐ Dentist ☐ Dental Hygienist
1. Has OHIP-5 form been completed by the patient participant?	☐ Yes ☐ No
2. Has plaque sample been collected? *only if patient participant consented to collection*	☐ Yes ☐ No ☐ N/A
3. Did patient participant previously report any Adverse Events?	☐ Yes ☐ No
If "yes" to Question 3,	
3a. Were all open AEs reviewed with patient participant?	☐ Yes ☐ No
4. Did patient participant report any new adverse events?	☐ Yes ☐ No
If "yes" to Question 4,	
4a. Were the new AEs recorded on the AE log?	☐ Yes ☐ No
5. Has patient participant received any subsequent antibiotics for a newly diagnosed condition?	☐ Yes ☐ No
6. Has the periodontal maintenance interval been established?	☐ Yes ☐ No
If "yes" to Question 5,	
5a. How frequently should the patient participant return for periodontal maintenance?	☐ Every 3 months ☐ Every 4 months
7. Has patient participant been provided oral hygiene instructions at this visit?	☐ Yes ☐ No
8. Has practitioner uploaded the periodontal chart image? ***Please ensure PD, BoP and GR have been captured***	☐ Yes ☐ No

PAAS Re-Eval Visit Checklist (6 weeks +3 weeks)

Date	__ __/__ __/__ __ __ __
Patient Participant ID	__ __ __ __
Which practitioner is completing the form?	☐ Dentist ☐ Dental Hygienist
1. Has OHIP-5 form been completed by the patient participant?	☐ Yes ☐ No
2. Has plaque sample been collected? *only if patient participant consented to collection*	☐ Yes ☐ No ☐ N/A
3. Did patient participant previously report any Adverse Events?	☐ Yes ☐ No
If "yes" to Question 3,	
3a. Were all open AEs reviewed with patient participant?	☐ Yes ☐ No
4. Did patient participant report any new adverse events?	☐ Yes ☐ No
If "yes" to Question 4,	
4a. Were the new AEs recorded on the AE log?	☐ Yes ☐ No
5. Has patient participant received any subsequent antibiotics for a newly diagnosed condition?	☐ Yes ☐ No
6. Has the periodontal maintenance interval been established?	☐ Yes ☐ No
If "yes" to Question 5,	
5a. How frequently should the patient participant return for periodontal maintenance?	☐ Every 3 months ☐ Every 4 months
7. Has patient participant been provided oral hygiene instructions at this visit?	☐ Yes ☐ No
8. Has practitioner uploaded the periodontal chart image? ***Please ensure PD, BoP and GR have been captured***	☐ Yes ☐ No

PAAS Adverse Events Form

Instructions for adverse event follow up: *Below are the unresolved adverse events previously reported by the participant. Review these adverse events with the participant and update the instance if anything has changed. The data is populated with the answers you entered the last time you submitted a report on this adverse event. Be sure to update the report type, Visit # and current status at a minimum.*

If the event continues to be unresolved, you will follow up with the participant at the next visit.

After reviewing all unresolved adverse events, answer the question about any new adverse events the participant needs to report. If new adverse events are reported, you will complete a new adverse event instance for each new symptom.

Question at Baseline visit: Has the participant reported any adverse events at this visit? Yes/No

Question at all other visits: Has the participant experienced any NEW adverse events since their last visit? Yes/No

Participant ID: Report date: This is the date you are filling out the report •	Visit #: *Select the visit number below. This should be the visit where this event is being reported OR the closest visit that has already occurred if reporting between visits.* • Baseline (V1) • Optional Baseline (V1b) • Re-evaluation (V2) • Final (V3) • Between visits
1. Description of event *Describe the symptom/event in detail. Only include one symptom per report.*	
2. Date of event *This is the date the event happened. The date may be today or may be a date in the past.*	
3. According to study personnel, was this event expected or unexpected? *Expected events are as follows (you will be asked to select the appropriate expected symptom in the next question if expected is marked):* • *Post procedural tooth sensitivity* • *Post procedural pain* • *Nausea* • *Allergic reaction: rash or itching* • *Allergic reaction: difficulties breathing* • *Periodontal abscess* • *Diarrhea*	• Expected • Unexpected
a. If expected, please select the expected symptom:	• Post procedural tooth sensitivity • Post procedural pain • Nausea

	• Allergic reaction: rash or itching • Allergic reaction: difficulties breathing • Periodontal abscess • Diarrhea
4. Did the event result in any of the following actions or could it be classified as: *Checking any option except "None" makes this a serious adverse event. If the event is classified as serious, your Node Coordinator will reach out to collect additional information about the event.*	• A life-threatening event • A hospitalization (initial or prolonged) that required at least one night in the hospital • A disability or permanent damage that resulted in a substantial disruption to their ability to conduct normal life functions • A pregnancy resulting in a congenital abnormality or birth defect • Other serious important medical event that may require medical or surgical intervention to prevent one of the other outcomes listed above • None of the above
5. How would you rate the severity of this event? *In the opinion of the practitioner*	• Mild • Moderate • Severe
6. Was this event study drug related? *In the opinion of the practitioner*	• Definitely • Probably • Possibly • Remotely • Definitely not • Unknown
7. What is the current status of the event? ***Additional reporting will be required at future study visits for conditions that are improving, present and unchanged and deteriorating.*** ***If a death is being reported, additional reporting is required as a serious adverse event. Your Node Coordinator will reach out to gather additional details***	• Completely recovered • Recovered with some residual problems • Condition improving • Condition present and unchanged • Condition deteriorating • Death (skip to 7b)
a. On what date was this event resolved?	MM/DD/YYYY
b. Date of death?	MM/DD/YYYY
Per the protocol, the study PI should review the report and confirm the following information:	
8. ***PI complete this field only:*** In the PI's view, was this event expected or unexpected? *Expected events are as follows (you will be asked to select the appropriate expected symptom in the next question)*	• Expected • Unexpected

• *Post procedural tooth sensitivity* • *Post procedural pain* • *Nausea* • *Allergic reaction: rash or itching* • *Allergic reaction: difficulties breathing* • *Periodontal abscess* • *Diarrhea*	
a.If expected, please select the expected symptom:	• Post procedural tooth sensitivity • Post procedural pain • Nausea • Allergic reaction: rash or itching • Allergic reaction: difficulties breathing • Periodontal abscess • Diarrhea
9. **PI complete this field only:** In the PI's view, was this event study drug related?	• Definitely • Probably • Possibly • Unlikely • Not related
10. PI complete this field only: Does the PI agree with the classification of serious or not serious in question 4 above?	• A life-threatening event • A hospitalization (initial or prolonged) that required at least one night in the hospital • A disability or permanent damage that resulted in a substantial disruption to their ability to conduct normal life functions • A pregnancy resulting in a congenital abnormality or birth defect • Other serious important medical event that may require medical or surgical intervention to prevent one of the other outcomes listed above • None of the above
If no to question 10: You indicated you do not agree with the practitioner's assessment of seriousness. Contact the NCC as soon as possible to resolve this issue.	
11. **PI Complete this field only:** In the PI's view, does this event suggest that research places participants or others at a greater risk of harm (including physical, psychological, economic, or social harm) than was previously known or recognized).	• Yes • No
PI attests they have reviewed this adverse event, submitted their evaluation and verified that all	• Yes • No

information is complete	MM/DD/YYYY