New York College of Technology
DEN 1200
Vanessa Marino

1. **DEMOGRAPHICS**
New patient, L.T, white, 27 years old, Male, Light/Type I

2. **ASSESSMENT**
    a. No medications, no allergy, no hospital visits, no surgery within the last 5 years, not under the care of a physician, health within normal limits, B/P 131/73 pulse:74, ASA: 1
    b. Non-smoker/ non-drinker, no pre-medication needed, no systemic conditions present, no prescription or over the counter medication taken.
    c. On their initial visit the patient stated his last dental visit was in August of 2018, the patient had no complaints in his oral health but required a dental cleaning. Patient reported oral self-care with the use of a soft manual toothbrush once a day. Flosses five times per week maximum and no mouth rinse used with no oral piercings past or present.

3. **ORAL PATHOLOGY** (Extra and intra oral findings)
    a. E/O: raised round 5-6mm nodule on right side at exterior angle of the mandible, patient is asymptomatic, patient stated his physician confirmed it is a cyst.
    b. I/O: bilateral linea alba, slight bilateral mandible tori, white coated tongue

4. **DENTITION**
    a. Angles classification: Class I bilateral, Overbite: 10%, Overjet:2mm
    b. Attrition on tooth #23-26, Abfraction on tooth #5,
    c. Caries activity on distal/occlusal of #15, and occlusal of #18
    d. Teeth #: 1, 16, 17, and 32 all clinically missing, patient states they were removed years ago, amalgam fillings on #15 O, #18 O, remnants of sealant present on tooth #19, composites present on #3,4,13,14

5. **PERIODONTAL**
    a. Case type: type I gingivitis, generalized probing depths 1-3mm, localized 4mm readings in posterior teeth only five sites, 15DL, 18DB, 20DB, 28DB, 31 DL, localized recession on teeth #28, #19, no bleeding upon probing.
    b. Generalized gingival health: pink tissue, papilla fits snug and fills embrasure space, stippled, firm, with localized rolled, tucked gingiva due to toothbrush abrasion, minimal inflammation

6. **ORAL HYGIENE**
    a. On the initial visit I did not have time to complete a plaque score. I was able to achieve LR quadrant calculus detection as my furthest assessment. Upon the revisit appointment, the plaque index was completed with a score of fair (1.2). Most of the biofilm present was interproximal.
    b. Patient showed no subgingival calculus present, with light supragingival plaque on his lower lingual anterior teeth.

c. Demonstrated proper flossing technique for his at home care because of excess biofilm present in the interproximal areas.

7. RADIOGRAPHS

a. Originally the patient told me that his last dental images were taken in April of 2017 and only bite wings were completed. That time frame and the suspicious caries activity found in the assessment were grounds for additional diagnostic images to be taken. However, upon our following visit, the patient then informed me he had recently received an UR composite filling. I observed it clinically on the occlusal of tooth #3, which I proceeded to add in the patient's chart. The patient informed me that 4 bite wing images were taken at the time of that dental appointment. With that information, I concluded he does not need radiographs at this time.

b. No radiographs were available during data collection

c. I did not see the caries activity that would have been on the occlusal of #3 in our initial assessment; it was not evident on the clinical exam. However, that is where his dentist found a cavity which was treated.

8. TREATMENT MANAGEMENT-Utilizing the Patient concept map

a. My treatment plan was to scale all four quadrants in one visit to remove biofilm and plaque using hand instruments, followed by engine polishing using fine paste. I prefaced the scaling by applying a 20% benzocaine topical anesthetic.

During the first visit, assessments were completed up to calculus detections. During the second visit, I finished the calculus detection and calculated his plaque index score followed by instruction of a homecare routine. We then devised a treatment plan and his consent was given. We were able to complete the above stated treatment plan as specified and I instructed the patient to come back for a 6-month recare visit.

b. There were no medical issues, dental fear or any other psychological factors that impacted the treatment.

c. The patient homecare goals were to develop a flossing routine due to the excess biofilm present interproximally that was revealed to us using the disclosing solution. I explained and demonstrated the 'soft c' and the firm pressure needed on each side of the tooth that the floss should have while gently going slightly under the papilla on both sides. As revealed in the initial interview, the patient said he did floss; however, upon instruction, he explained he was not aware of the proper way to floss. We made a goal to make sure he takes the time to floss at least before bed every night, and not to snap floss through the contact area as I explained it can cause damage to the gingiva.

d. The patient stated he wanted to be more meticulous with his flossing routine and was inquisitive with every aspect of the process.

e. The patient was interested in his oral health and continues to contact me asking questions about everything from toothpaste brands to different powered toothbrushes and brushing techniques.

f. Previously he had localized areas of rolled gingiva due to toothbrushing abrasion, however, upon the second visit those areas showed improvement. He also presented with a food burn palatal between tooth number 8 and 9.

g. The patient was given a referral to a DDS on our first visit for the suspected caries activity on tooth #15, and #18. However, when the patient returned, tooth #3 was treated by his dentist for caries, which originally, I did not have any clinical suspicions about.

h. In hindsight I wouldn’t have changed my plan. I’m happy that he is really interested and wants to floss correctly now. He has informed me he even tries to teach his friends. Also, the engine polishing was successful in removing all residual plaque and the patient expressed gratitude for how “smooth and clean” they felt. It feels great when someone else is happy with what you have done for them.

9. REFLECTION

a. I was able to accomplish everything I planned educationally and mechanically on the day I planned it.

b. He was my first ever patient in clinic and initially I felt I was too slow being that I only got up to calculus detection the first day. However, I am proud of how my time management skills have progressed and although he was a very light patient, I was happy that I finished to completion in the following visit. At the same time, I realized, it’s not how fast I get things done, but how well I treat the patient, how accurate the assessments are, and how comprehensive the treatment is.

c. My clinical weakness is how tight I grasp my instruments. I don’t realize I am using a death grip sometimes and it can really hinder how I work. I also need to remember that only the tip 1/3 is necessary in removal of plaque. Professor Chitlall was very helpful with demonstrating instrumentation on the universal curette to correct this issue. I sometimes feel like I need a refresher course to remind me of things I’m doing wrong, so I don’t get too comfortable in my mistakes if no one is watching.