Dental Effects of HPP Registry

Thank you for participating!

Your patient _____, DOB _____, has signed a records release form to allow you to share their records with us as part of a study on the dental effects of hypophosphatasia (HPP). A copy is included in this packet.

Please fill out as much as you can on the following forms. In addition, please include copies of any of the following records you might have:

- ☐ radiographs
- ☐ extra- and intra-oral photographs
- ☐ copies of dental records
- ☐ tooth charts
- ☐ periodontal charting
- ☐ pathology reports
- ☐ laboratory reports

Instructions for sending it back to us:

Fax to **614-292-1125**

OR

Mail to **Dr. Ann Griffen**
Division of Pediatric Dentistry
305 W. 12th Avenue
Columbus, OH 43210.

HPP Tooth Loss Questions

Tooth loss in the primary dentition:

Age Lost									
Tooth	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**
Tooth	**T**	**S**	**R**	**Q**	**P**	**O**	**N**	**M**	**L**	**K**
Age Lost									

Tooth loss in the permanent dentition:

Age Lost															
Tooth	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
Tooth	**32**	**31**	**30**	**29**	**28**	**27**	**26**	**25**	**24**	**23**	**22**	**21**	**20**	**19**	**18**	**17**
Age Lost															

Have you submitted a lost tooth to an oral pathologist for analysis? <u>If your patient has any more teeth that you would like to submit, we are collecting teeth for analysis and will be able to provide you and your patient with the results! Please contact us for more information**</u>**

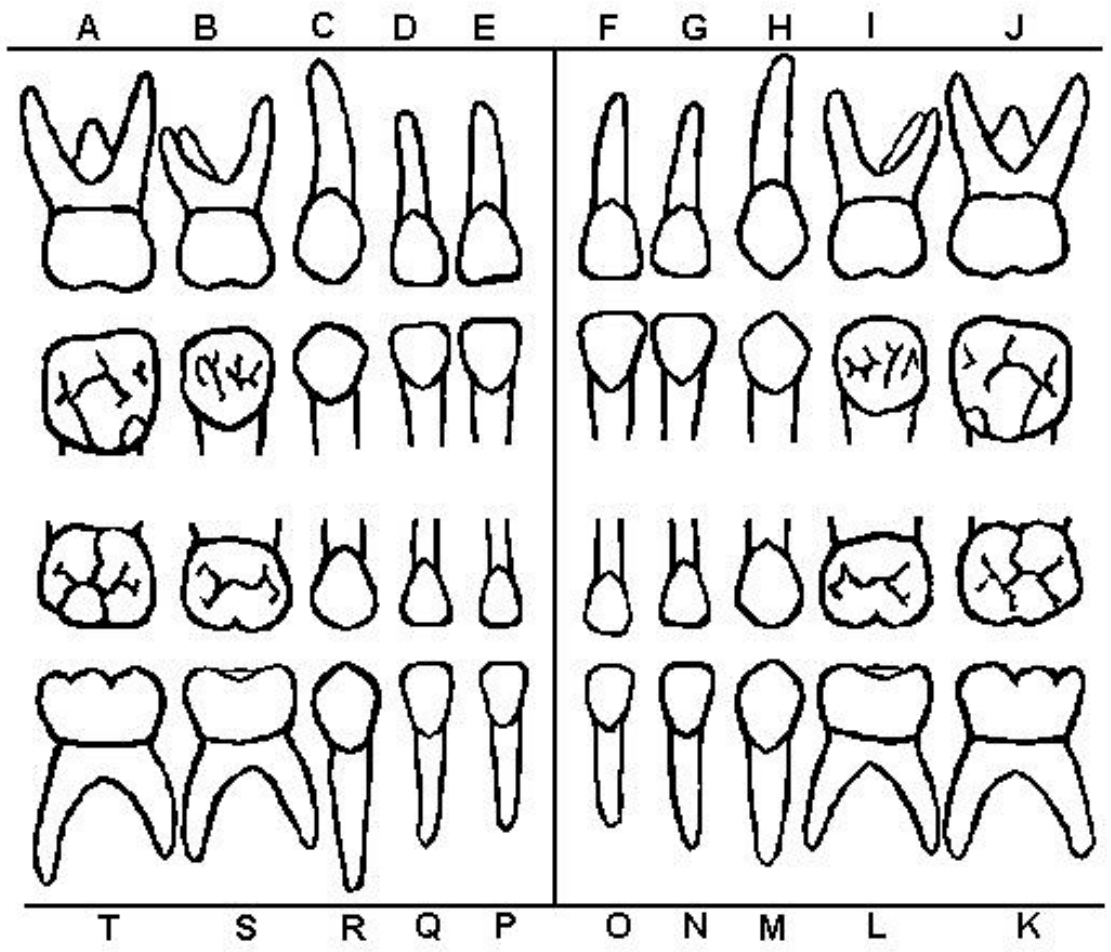
☐ No

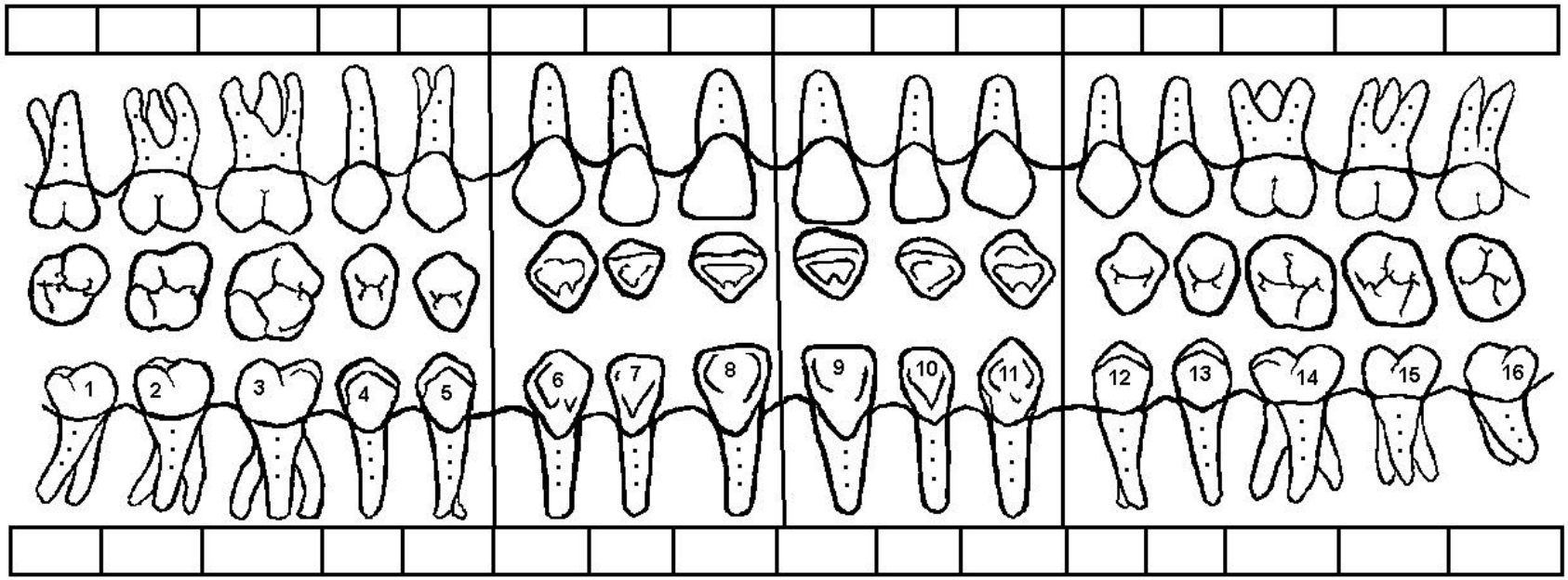
☐ Yes*

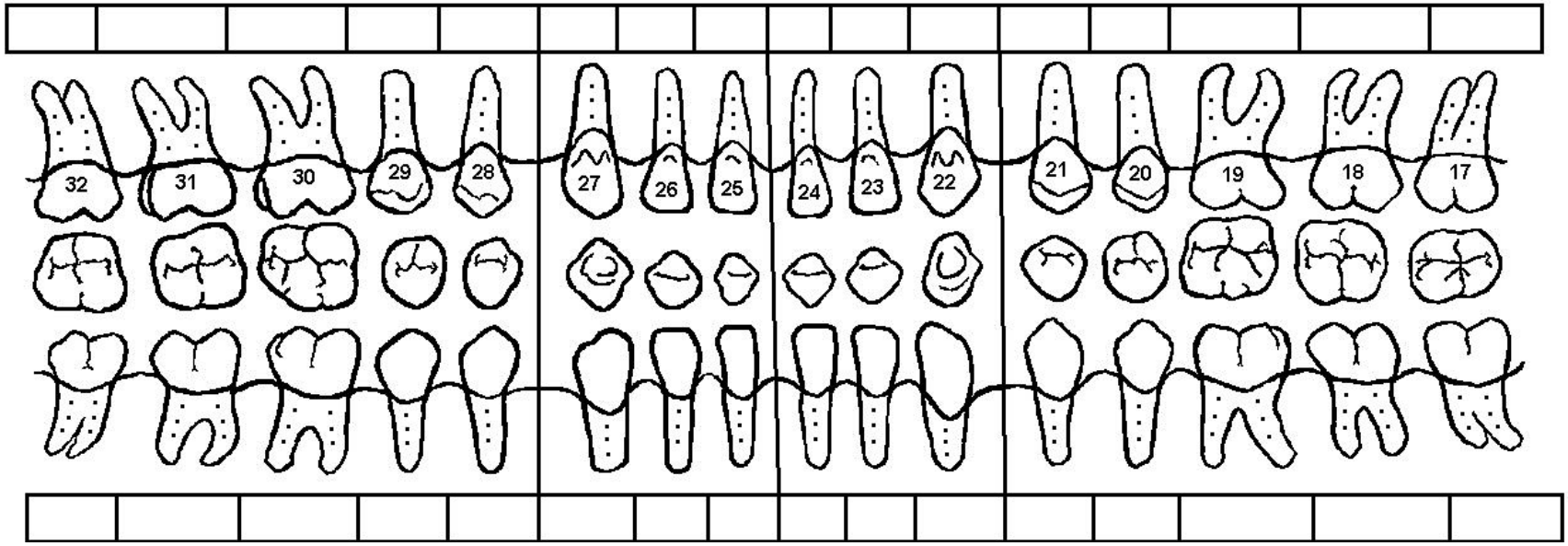
<u>*If yes please specify tooth number and provide and description below (Please also include any available pathology reports):</u>

Tooth Chart (*You may either use the provided form or provide your own)

Carious	
Composite	
Amalgam	
SSC/Gold/Cast Crown	
Strip Crown	
Open Faced/PFM	
Ceramic/Porcelain	
Missing	M
Implant	I




1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16


32
31
30
29
28
27
26
25
24
23
22
21
20
19
18
17

Tooth Abnormalities (*Please provide any level of detail you can.*)

Abnormalities of tooth number:

Missing teeth (Hypodontia)	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Supernumerary teeth (Hyperdontia)	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Other/Comments:	

Abnormalities of tooth shape:

Invagination/ Dens in dente	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Gemination	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Talon Cusp	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:

Taurodontism	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Fusion	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Other/Comments:	

Abnormalities of tooth size:

☐ No

☐ Yes*

*If yes please specify below:

Microdontia	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Macrodontia	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Other/Comments:	

Abnormalities of tooth mineralization:	
Enamel Abnormalities	
Hypoplasia	☐ No ☐ Localized (Please specify where: _____) ☐ Generalized
Hypocalcification	☐ No ☐ Localized (Please specify where: _____) ☐ Generalized
Deep Fissures	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Thin enamel	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Enamel Wear	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Other/Comments:	
Dentin Abnormalities	
☐ No ☐ Yes* *If yes please specify below:	

Other/Comments:	
Cementum Abnormalities	
Hypercementosis	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Hypoplasia or defects	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Other/Comments:	
Radiographic findings of Pulp Abnormalities:	
Enlarged Pulp volume	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Small or obliterated pulp	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:

Pulp calcification	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Other/Comments:	
Abnormalities of tooth eruption/position:	
Early eruption	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Delayed Eruption	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Failure of eruption	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Impacted teeth	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:

Ankylosis/Infraoccluded Teeth	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Ectopic Eruption	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Other/Comments:	
Abnormalities of tooth color:	
Intrinsic staining	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Extrinsic staining	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Tooth Shade	☐Average ☐Yellowish ☐Grayish ☐Other (Please specify: _____)
Other/Comments:	

Occlusion:	
Crowding	☐ None ☐ Mild ☐ Moderate ☐ Severe
Spaced Dentition	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Midline Diastema	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Overjet	☐ Average ☐ Large/ Increased ☐ Negative/ Underbite
Overbite	☐ Average ☐ Deep ☐ Anterior Open bite ☐ Posterior Open bite
Crossbite	☐ None ☐ Anterior *If yes please specify tooth number(s) and provide and description below: ☐ Posterior *If yes please specify tooth number(s) and provide and description below:

Rotated Teeth	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:	
Molar Relationship	**Right**	**Left**
	☐Class I Molar (If primary: Mesial Step)	☐Class I Molar (If primary: Mesial Step)
	☐Flush Terminal Plane/ End-to-End	☐Flush Terminal Plane/ End-to-End
	☐Class II Molar (If Primary: Distal Step)	☐Class II Molar (If Primary: Distal Step)
	☐Class III Molar	☐Class III Molar
Canine Relationship	**Right**	**Left**
	☐Class I Canine	☐Class I Canine
	☐Class II Canine	☐Class II Canine
	☐Class III Canine	☐Class III Canine
Other/Comments:		
Abnormalities of tooth resorption:		
Exfoliation without root resorption	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:	
Premature resorption	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:	

Small/Obliterated pulp chamber	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Internal Resorption	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
External Resorption	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Other/Comments	
Abnormalities of the periodontium (Please provide periodontal charting if available):	
Plaque Level (Please mark all that apply)	☐None ☐Light ☐Moderate ☐Heavy ☐Localized (Please specify where: _____) ☐Generalized
Gingivitis	☐None ☐Localized (Please specify where: _____) ☐Generalized
Periodontitis (Please mark all that apply)	☐None ☐Localized (Please specify where: _____) ☐Generalized ☐Aggressive ☐Chronic ☐Other (Please specify: _____)

Gingival Hyperplasia	☐None ☐Localized (Please specify where: _____) ☐Generalized
Tooth Mobility (**Please provide periodontal charting if available**)	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Calculus (Please mark all that apply)	☐None ☐Localized (Please specify where: _____) ☐Generalized ☐Light ☐Moderate ☐Heavy
Recession	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Bone loss	☐ No ☐ Yes* *If yes please specify tooth number(s) and provide and description below:
Other/Comments:	

Other Pathology Not Mentioned Above

Miscellaneous Dental History Questions

Hx of dental trauma involving the face/teeth:

☐ No

☐ Yes*

*If yes please specify tooth number and provide and description below:

Other Significant Dental History Not Mentioned Above