The dental practice parameters describe the clinical considerations in the diagnosis and treatment of 30 oral health conditions and 4 types of evaluations. Each year the parameters are reviewed by a committee of dentists and are updated, as necessary. They are intended to be used voluntarily by dentists to aid in their clinical decision making.

In the health care fields, many different terms are applied to documents that are aimed at providing clinical guidance to practitioners, such as “parameters,” “guidelines,” “standards,” “clinical recommendations,” “clinical options,” and so forth. Although these terms are commonly used interchangeably, the developers of the guidance documents often choose a particular label they think connotes the intended use and force of the recommendations presented in the documents. Thus, the ADA defined parameters as distinct from “guidelines” and “standards” and defined the terms as follows (Trans.1993: 47):

- **Parameters** describe the range of appropriate treatment for a given condition. In comparison to standards or guidelines, parameters broaden the range of professional judgment for the practitioner. They strengthen the ability of the provider to evaluate options and arrive at appropriate treatment.

- **Guidelines** are intended to be more flexible than standards. Guidelines should be followed in most cases, but they recognize that treatment can and should be tailored to fit individual needs, depending on the patient, setting and other factors. Deviations from guidelines would be fairly common and could be justified by differences in individual circumstances.

- **Standards** are intended to be applied rigidly and carry the expectation that they be applied in all cases and any deviation from them would be difficult to justify. A standard of care indicates that measurable criteria are present and these criteria shall be used in order to arrive at a given level of outcome. Standards say what must be done.
Another distinction among standards, guidelines and parameters, postulated in the 1990s, was the degree to which each was based on scientific evidence versus professional consensus. Today as evidence-based practice has come to the fore, guidelines, parameters, standards, recommendations, etc. are equally likely to be developed on the basis of scientific evidence. This is clearly apparent in perusing the National Guidelines Clearinghouse, www.guidelines.gov, which is a database of guidelines, parameters, standards, recommendations, protocols, etc. that are evidence-based, albeit to varying degrees. The dental practice parameters were developed through a professional consensus process.

The American Dental Association continues to maintain the dental practice parameters; but, in addition, it is developing evidence-based information and recommendations. The dentist may thus refer to both sources of information.

The American Dental Association developed these dental practice parameters for voluntary use by practicing dentists. The parameters are intended, foremost, as an aid to clinical decision making and thus, they describe clinical considerations in the diagnosis and treatment of oral health conditions. Evaluation in the context of these parameters includes diagnosis. Additionally, parameters will assist the dental profession by providing the basis on which the profession’s commitment to high-quality care can be demonstrated and can continue to be improved.

The dental practice parameters are condition-based, presenting an array of possible diagnostic and treatment considerations for oral health conditions. Condition-based parameters, rather than procedure-based parameters, were determined to be the most useful because this approach recognizes the need for integrated treatments of oral conditions rather than emphasizing isolated treatment procedures. The parameters are also oriented toward the process of care and describe elements of diagnosis and treatment. While the parameters describe the common elements of diagnosis and treatment, it is acknowledged that unique clinical circumstances, and individual patient preferences, must be factored into clinical decisions. This requires the dentist’s careful professional judgment. Balancing individual patient needs with scientific soundness is a necessary step in providing care.

It is understood that treatment provided by the dentist may deviate from the parameters, in individual cases, depending on the clinical circumstances presented by the patient. This should be documented and explained to the patient.

The elements of care that are described in the parameters were derived from a consensus of professional opinion. This consensus included expert opinion on the topic and the clinical
experience of practicing dentists. In addition, the research literature, and parameters and guidelines of other dental organizations were reviewed.

The American Dental Association recognizes that other interested parties, such as payers, courts, legislators and regulators may also opt to use these parameters. The Association encourages users to become familiar with these parameters as the profession’s statement on the scope of clinical oral health care.

However, these parameters are not designed to address considerations outside of the clinical arena and, therefore, may not be directly applicable to all health policy issues.

Furthermore, these parameters are intended to describe the range of acceptable treatment modalities. They are intended as educational resources, not legal requirements. As such, the parameters are not intended to establish standards of dental care, which are rigid and inflexible, and represent what must be done; nor are they guidelines which are less rigid, but represent what should be done; nor are they intended to undermine or restrict the dentist’s exercise of professional judgment. In this context, considerable thought was given to the use of the verbs "may," "should" and "must." The verb "may" clearly allows the practitioner to decide whether to act.

The verb "should" indicates a degree of preference and differs in meaning from "must" or "shall" (which require the practitioner to act).

Throughout the parameter document, "dentist" refers to the patient’s attending dentist. Additionally, elements of the parameters concerned with patient consent refer to the patient’s parent, guardian or other responsible party, when the patient is a minor or is incompetent.

The Association intends to continually develop, revise and maintain parameters, in order to include all dental conditions and to accommodate advances in dental technology and science.


**DENTAL ABRASION:**

- The key element in the design of this set of parameters for dental abrasion is the professional judgment of the attending dentist, for a specific patient, at a specific time.
- The patient’s chief complaint, concerns and expectations should be considered by the dentist.
Following oral evaluation (see limited, comprehensive, periodic, detailed and extensive evaluation parameters) and consideration of the patient's needs, the dentist should provide the patient with information about dental abrasion prior to obtaining consent for treatment.

The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the prognosis, progression and management of dental abrasion.

In developing a treatment plan, the dentist should consider that dental abrasion may be the result of one or many factors and can be in combination with other dental conditions, such as dental erosion and microfractures of tooth structure associated with occlusal forces.

In developing a treatment plan, the dentist should consider that dental abrasion can be generalized or site-specific, progressive and predisposing to other conditions.

When the dentist considers it necessary, (an)other health care professional(s) should be consulted to acquire additional information.

Factors affecting the patient’s oral function and/or orofacial aesthetics should be considered by the dentist in developing a treatment plan.

The behavioral, psychological, anatomical, developmental and physiological limitations of the patient should be considered by the dentist in developing the treatment plan.

Restorative implications, pulpal/endodontic status, tooth position, and periodontal status and prognosis should be considered in developing a treatment plan.

The dentist may counsel the patient concerning the potential effects of the patient’s health condition, medication use, and behaviors and/or habits on his or her oral health. (See: Statement on Intraoral/Perioral Piercing.)

Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by dental treatment provided without the medication or its modification. The dentist should consult with the prescribing health care professional(s) before modifying medications being taken by the patient for known conditions. (See: ADA Statement on Antibiotic Prophylaxis, Prevention of Bacterial Endocarditis: A Statement for the Dental Profession (PDF), and A-Z Topic: Antibiotic Prophylaxis.)

After consideration of the individual circumstances, the dentist should decide whether the dental abrasion should be monitored or treated.

The dentist should recommend treatment; present treatment options, if any; and discuss the probable benefits, prognosis, limitations and risks associated with treatment, and the probable consequences of no treatment.

Any treatment performed should be with the concurrence of the patient and the dentist. If the patient insists upon treatment not considered by the dentist to be beneficial for the patient, the dentist may decline to provide treatment. If the
patient insists upon treatment considered by the dentist to be harmful to the patient, the dentist should decline to provide treatment.

- Following evaluation, treatment priority should be given to the management of pain, infection, traumatic injuries or other emergency conditions.
- The dentist should refer the patient to (an)other health professional(s) when the dentist determines that it is in the best interest of the patient.
- Relevant and appropriate information about the patient and any coordinated treatment should be communicated and coordinated between the referring dentist and the health professional(s) accepting the referral.
- The dentist should consider the characteristics and requirements of each patient in selecting material(s) and treatment(s).
- The dentist should consider the compatibility of the selected treatment with the surrounding oral tissues and should provide an environment accessible for maintenance.
- Counseling and/or therapy for parafunctional behaviors which can contribute to abrasion may be performed.
- Following occlusal evaluation, the dentist may use guards, splinting and/or adjustments to facilitate treatment.
- The dentist should attempt to manage the patient’s pain, anxiety and behavior during treatment to facilitate safety, efficiency and patient cooperation. (See: ADA Policy Statement: The Use of Sedation and General Anesthesia by Dentists and Guidelines for the Use of Sedation and General Anesthesia by Dentists.) Placement of restorations, or modification or replacement of restorations may be performed to facilitate treatment or reduce symptoms resulting from lost tooth structure.
- Transitional or provisional restorations may be utilized by the dentist to facilitate treatment.
- The dentist may alter tooth morphology and/or position, and/or modify occluding, articulating, adjacent or approximating teeth or the tooth in question to facilitate treatment or reduce symptoms.
- Pulpal tissue should be protected by the dentist when indicated.
- Endodontic therapy may be performed by the dentist.
- Fixed, removable and/or implant-supported restorations (prostheses) may be repaired, modified or replaced, as determined by the dentist.
- The dentist should communicate by prescription the necessary information for fabrication of the prosthesis(es) to the dental laboratory technician. Although the fabrication may be delegated, the dentist is responsible for the accuracy of the prosthesis(es).
- Periodontal procedures, including surgery, may be performed by the dentist to facilitate treatment.
Chemotherapeutic agents may be used.

Teeth may be removed, as determined by the dentist. When appropriate, the patient should be informed of the necessity to replace any removed teeth.

The dentist should inform the patient that he or she should participate in a prescribed program of continuing care to allow the dentist to evaluate the effectiveness of the treatment provided and the status of dental abrasion.

The patient should be informed that the success of the treatment is often dependent upon patient compliance with the prescribed treatment and recommendations for behavioral modifications. Lack of compliance should be recorded.

Documentation of treatment provided, counseling and recommended preventive measures, as well as consultations with and referrals to other health care professionals, should be included in the patient’s dental record.

**DENTAL ATTRITION:**

- The key element in the design of this set of parameters for dental attrition is the professional judgment of the attending dentist, for a specific patient, at a specific time.
- The patient’s chief complaint, concerns and expectations should be considered by the dentist.
- Following oral evaluation of the patient (see limited, comprehensive, periodic, detailed and extensive evaluation parameters) and consideration of the patient’s needs, the dentist should provide the patient with information about dental attrition prior to obtaining consent for treatment.
- The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the prognosis, progression and management of dental attrition.
- In developing a treatment plan, the dentist should consider that dental attrition can be generalized or site-specific, progressive and predisposing to other conditions.
- When the dentist considers it necessary, (an)other health care professional(s) should be consulted to acquire additional information.
- Factors affecting the patient’s speech, function and orofacial aesthetics should be considered by the dentist in developing a treatment plan.
- In developing a treatment plan, the dentist should consider that the etiology of dental attrition can be multifactorial, characterized by craniofacial, musculoskeletal, stomatognathic and/or dental interrelationships that are dynamic throughout life.
- The behavioral, psychological, anatomical, developmental and physiological limitations of the patient should be considered by the dentist in developing the treatment plan.
• Restorative implications, pulpal/endodontic status, tooth position, and periodontal status and prognosis should be considered in developing a treatment plan.

• The dentist may counsel the patient concerning the potential effects of the patient’s health condition, medication use, and behaviors and/or habits on his or her oral health.

• Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by dental treatment provided without the medication or its modification. The dentist should consult with the prescribing health care professional(s) before modifying medications being taken by the patient for known conditions. (See: ADA Statement on Antibiotic Prophylaxis, Prevention of Bacterial Endocarditis: A Statement for the Dental Profession (PDF), and A-Z Topic: Antibiotic Prophylaxis.)

• After consideration of the individual circumstances, the dentist should decide whether the dental attrition should be monitored or treated.

• The dentist should recommend treatment; present treatment options, if any; and discuss the probable benefits, prognosis, limitations and risks associated with treatment, and the probable consequences of no treatment.

• Any treatment performed should be with the concurrence of the patient and the dentist. If the patient insists upon treatment not considered by the dentist to be beneficial for the patient, the dentist may decline to provide treatment. If the patient insists upon treatment considered by the dentist to be harmful to the patient, the dentist should decline to provide treatment.

• Following evaluation, treatment priority should be given to the management of pain, infection, traumatic injuries or other emergency conditions.

• The dentist should refer the patient to (an)other health professional(s) when the dentist determines that it is in the best interest of the patient.

• Relevant and appropriate information about the patient and any coordinated treatment should be communicated and coordinated between the referring dentist and the health professional(s) accepting the referral.

• The dentist should consider the characteristics and requirements of each patient in selecting material(s) and treatment(s).

• The dentist should consider the compatibility of the selected treatment with the surrounding oral tissues and should provide an environment accessible for maintenance.

• Counseling and/or therapy for parafunctional behaviors which can contribute to attrition may be performed.

• Following occlusal evaluation, occlusal guards, splinting and/or adjustments may be used to facilitate treatment.

• The dentist should attempt to manage the patient’s pain, anxiety and behavior during treatment to facilitate safety, efficiency and patient cooperation. (See: ADA Policy
Statement: The Use of Sedation and General Anesthesia by Dentists and Guidelines for the Use of Sedation and General Anesthesia by Dentists.)

- Placement of restorations, or modification or replacement of restorations may be performed to facilitate treatment or reduce symptoms resulting from lost tooth structure.
- Transitional or provisional restorations may be utilized by the dentist to facilitate treatment.
- The dentist may alter tooth morphology and/or position, and/or modify occluding, articulating, adjacent or approximating teeth, or the tooth in question, to facilitate treatment or reduce symptoms.
- Pulpal tissue should be protected by the dentist when indicated.
- Endodontic therapy may be performed by the dentist.
- Fixed, removable and/or implant-supported restorations (prostheses) may be repaired, modified or replaced, as determined by the dentist.
- The dentist should communicate by prescription the necessary information for fabrication of the prosthesis(es) to the dental laboratory technician. Although the fabrication may be delegated, the dentist is responsible for the accuracy of the prosthesis(es).
- Periodontal procedures, including surgery, may be performed by the dentist to facilitate treatment.
- Chemotherapeutic agents may be used.
- Teeth may be removed, as determined by the dentist. When appropriate, the patient should be informed of the necessity to replace any removed teeth.
- The dentist should inform the patient that he or she should participate in a prescribed program of continuing care to allow the dentist to evaluate the effectiveness of the treatment provided and the status of dental attrition.
- The patient should be informed that the success of the treatment is often dependent upon patient compliance with the prescribed treatment and recommendations for behavioral modifications. Lack of compliance should be recorded.
- Documentation of treatment provided, counseling and recommended preventive measures, as well as consultations with and referrals to other health care professionals, should be included in the patient’s dental record.

**DENTAL CARIES:**

- The key element in the design of this set of parameters of dental caries is the professional judgment of the attending dentist, for a specific patient, at a specific time.
- The patient’s chief complaint, concerns and expectations should be considered by the dentist.
- The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the prognosis, progression, and management of dental caries.
- Following oral evaluation of the patient (see limited, comprehensive, periodic, detailed and extensive evaluation parameters) and consideration of the patient’s needs, the dentist should provide the patient with information about dental caries prior to obtaining consent for further treatment.
- Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by dental treatment provided without the medication or its modification. The dentist should consult with the prescribing health care professional(s) before modifying medications being taken by the patient for known conditions. (See: ADA Statement on Antibiotic Prophylaxis, Prevention of Bacterial Endocarditis: A Statement for the Dental Profession (PDF), and A-Z Topic: Antibiotic Prophylaxis.)
- The dentist may counsel the patient concerning the potential effects of the patient’s health condition, medication use, and behaviors on his or her oral health.
- The dentist should recommend treatment; present treatment options, if any; and discuss the probable benefits, limitations and risks associated with treatment, and the probable consequences of no treatment.
- Any treatment performed should be with the concurrence of the patient and the dentist. If the patient insists upon treatment not considered by the dentist to be beneficial for the patient, the dentist may decline to provide treatment. If the patient insists upon treatment considered by the dentist to be harmful to the patient, the dentist should decline to provide treatment.
- Following evaluation, treatment priority should be given to the management of pain, infection, traumatic injuries or other emergency conditions.
- The behavioral, psychological, anatomical, developmental and physiological limitations of the patient should be considered by the dentist in developing the treatment plan.
- The dentist should attempt to manage the patient’s pain, anxiety and behavior during treatment to facilitate safety, efficiency and patient cooperation. (See: ADA Policy Statement: The Use of Sedation and General Anesthesia by Dentists and Guidelines for the Use of Sedation and General Anesthesia by Dentists.)
- When the dentist considers it necessary, (an)other health care professional(s) should be consulted to acquire additional information.
- Additional diagnostic tests relevant to the dental caries of the patient may be performed and used by the dentist in diagnosis and treatment planning.
• The dentist should refer the patient to (an)other health professional(s) when the dentist determines that it is in the best interest of the patient.

• Relevant and appropriate information about the patient and any necessary coordinated treatment should be communicated and coordinated between the referring dentist and the health professional(s) accepting the referral.

• After consideration of the individual circumstances, the dentist should decide whether the tooth with a carious lesion(s) should be monitored, treated or removed.

• Factors affecting the patient’s speech, function, and orofacial aesthetics should be considered by the dentist in developing a treatment plan.

• The dentist should emphasize the prevention and early detection of oral diseases through patient education in preventive oral health practices, which may include oral hygiene instructions.

• The dentist should consider the characteristics and requirements of each patient in selecting material(s) and treatment(s).

• The tooth preparation should be appropriate for the extent of the lesion and/or the choice of the restorative material. (See: FDA Approvals of Laser Systems for Hard Tissue Applications)

• All clinically apparent caries should be removed before the restoration is placed, except in some instances where indirect pulp-capping or pulpotomy techniques are used.

• Pulpal tissue should be protected by the dentist when indicated.

• The restorative material selected should restore form and function, and withstand the forces of occlusion. (See: ADA Statement on Dental Amalgam)

• The dentist may modify occluding, articulating, adjacent or approximating teeth to enhance the final restoration’s form and function as well as its ability to withstand the forces of occlusion.

• Tissues and/or restorations adjacent to the restorative site may be altered by the dentist to facilitate treatment or sustain the tooth being restored.

• Orthodontic repositioning may be performed by the dentist to facilitate treatment.

• Transitional or provisional restorations may be utilized by the dentist to facilitate treatment or reduce pulpal symptoms.

• Dental sealants may be applied as a preventive measure. (See: Bisphenol A and Dental Materials)

• Chemotherapeutic agents may be used for caries prevention and the treatment of incipient caries.

• Modification of the root surface followed by application of chemotherapeutic agents may be used to treat caries.

• Depth and narrowness of pits and fissures may be modified by the dentist for caries prevention.
- Dietary fluoride supplements may be prescribed by the dentist. (See: Facts About Fluorides/Dietary Fluoride Supplements)
- Topical fluoride may be applied or prescribed as a preventive measure. (See: Facts About Fluoride/Topical Fluorides)
- Endodontic therapy and/or root resection may be performed by the dentist in the treatment of caries.
- Teeth may be removed, as determined by the dentist. When appropriate, the patient should be informed of the necessity to replace any removed teeth.
- The dentist should inform the patient that he or she should participate in a prescribed program of continuing care to allow the dentist to evaluate the effectiveness of the treatment provided and the condition of the oral cavity.
- The dentist should determine the frequency and type of preventive treatment based on the patient’s risk factors or presence of oral disease. (See: ADA Statement on Sugar-free Foods and Medication)
- Documentation of treatment provided, counseling and recommended preventive measures, as well as consultations with and referrals to other health care professionals, should be included in the patient’s dental record.

**DENTAL EROSION:**

- The key element in the design of this set of parameters for dental erosion is the professional judgment of the attending dentist, for a specific patient, at a specific time.
- The patient’s chief complaint, concerns and expectations should be considered by the dentist.
- Following oral evaluation (see limited, comprehensive, periodic, detailed and extensive evaluation parameters) and consideration of the patient’s needs, the dentist should provide the patient with information about dental erosion prior to obtaining consent for treatment.
- The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the prognosis, progression and management of dental erosion.
- When the dentist considers it necessary, (an)other health care professional(s) should be consulted to acquire additional information.
- In developing a treatment plan, the dentist should consider that dental erosion may be the result of one or many factors and can be in combination with other dental conditions, such as dental abrasion and microfractures of tooth structure associated with occlusal forces.
In developing a treatment plan, the dentist should consider that dental erosion can be
generalized or site-specific, progressive and predisposing to other conditions.

Factors affecting the patient’s oral function and orofacial aesthetics should be
considered by the dentist in developing a treatment plan.

The behavioral, psychological, anatomical, developmental and physiological status of
the patient should be considered by the dentist in developing the treatment plan.

Restorative implications, pulpal/endodontic status, tooth position, and periodontal
status and prognosis should be considered in developing a treatment plan.

The dentist may counsel the patient concerning the potential effects of the patient’s
health condition, medication use, and behaviors and/or habits on his or her oral
health.

Medications should be prescribed, modified and/or administered for dental patients
whose known conditions would affect or be affected by dental treatment provided
without the medication or its modification. The dentist should consult with the
prescribing health care professional(s) before modifying medications being taken by
the patient for known conditions. (See: ADA Statement on Antibiotic Prophylaxis,
Prevention of Bacterial Endocarditis: A Statement for the Dental Profession (PDF),
and A-Z Topic: Antibiotic Prophylaxis.)

After consideration of the individual circumstances, the dentist should decide
whether the dental erosion should be monitored or treated.

The dentist should recommend treatment; present treatment options, if any; and
discuss the probable benefits, prognosis, limitations and risks associated with
treatment, and the probable consequences of no treatment.

Any treatment performed should be with the concurrence of the patient and the
dentist. If the patient insists upon treatment not considered by the dentist to be
beneficial for the patient, the dentist may decline to provide treatment. If the
patient insists upon treatment considered by the dentist to be harmful to the patient,
the dentist should decline to provide treatment.

Following evaluation, treatment priority should be given to the management of pain,
infection, traumatic injuries or other emergency conditions.

The dentist should refer the patient to (an)other health professional(s) when the
dentist determines that it is in the best interest of the patient.

Counseling and/or referral for therapy for eating disorders or behaviors which can
contribute to erosion (e.g., diet, bulimia or use of smokeless tobacco) may be
provided.

Relevant and appropriate information about the patient and any coordinated
treatment should be communicated and coordinated between the referring dentist
and the health professional(s) accepting the referral.
• The dentist may take this opportunity to emphasize the prevention and early detection of oral diseases through patient education in preventive oral health practices, which may include oral hygiene instructions.

• The dentist should consider the characteristics and requirements of each patient in selecting material(s) and treatment(s).

• The dentist should consider the compatibility of the selected treatment with the surrounding oral tissues and should provide an environment accessible for maintenance.

• Following occlusal evaluation, occlusal guards, splinting and/or adjustments may be used to facilitate treatment.

• The dentist should attempt to manage the patient’s pain, anxiety and behavior during treatment to facilitate safety, efficiency and patient cooperation. (See: ADA Policy Statement: The Use of Sedation and General Anesthesia by Dentists and Guidelines for the Use of Sedation and General Anesthesia by Dentists.)

• Transitional or provisional restorations may be utilized by the dentist to facilitate treatment.

• The dentist may alter tooth morphology and/or position, and/or modify occluding, articulating, adjacent or approximating teeth, or the tooth in question, to facilitate treatment or reduce symptoms.

• Placement of restorations, or modification or replacement of restorations may be performed to facilitate treatment or reduce symptoms resulting from lost tooth structure.

• Pulpal tissue should be protected by the dentist when indicated.

• Endodontic therapy may be performed by the dentist.

• Fixed, removable, and/or implant-supported restorations (prostheses) may be repaired, modified or replaced, as determined by the dentist.

• Periodontal procedures, including surgery, may be performed by the dentist to facilitate treatment.

• The dentist should communicate by prescription the necessary information and authorization for fabrication of the prosthesis(es) to the dental laboratory technician. Although the fabrication may be delegated, the dentist is responsible for the accuracy of the prosthesis(es).

• Teeth may be removed, as determined by the dentist. When appropriate, the patient should be informed of the necessity to replace any removed teeth.

• Chemotherapeutic agents may be used.

• The dentist should inform the patient that he or she should participate in a prescribed program of continuing care to allow the dentist to evaluate the effectiveness of the treatment provided and the status of dental erosion.
The patient should be informed that the success of the treatment is often dependent upon patient compliance with the prescribed treatment and recommendations for behavioral modifications. Lack of compliance should be recorded.

Documentation of treatment provided, counseling and recommended preventive measures, as well as consultations with and referrals to other health care professionals, should be included in the patient’s dental record.

EDENTULOUS ARCH (S):

- The key element in the design of this set of parameters for edentulous arch(es) is the professional judgment of the attending dentist, for a specific patient, at a specific time.
- The patient’s chief complaint, concerns and expectations should be considered by the dentist.
- The dental and medical histories should be considered by the dentist in identifying medications and predisposing conditions that may affect the prognosis, progression, and management of patients with edentulism.
- Following oral evaluation of the patient (see limited, comprehensive, periodic, detailed and extensive evaluation parameters) and consideration of the patient’s needs, the dentist should provide the patient with information about edentulism prior to obtaining consent for treatment.
- Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by dental treatment provided without the medication or its modification. The dentist should consult with the prescribing health care professional(s) before modifying medications being taken by the patient for known conditions. (See: ADA Statement on Antibiotic Prophylaxis, Prevention of Bacterial Endocarditis: A Statement for the Dental Profession (PDF), and A-Z Topic: Antibiotic Prophylaxis.)
- When the dentist considers it necessary, (an)other health care professional(s) should be consulted to acquire additional information.
- Following evaluation, treatment priority should be given to the management of pain, infection, traumatic injuries or other emergency conditions.
- The behavioral, psychological, anatomical, developmental and physiological limitations of the patient should be considered by the dentist in developing the treatment plan.
- The dentist should attempt to manage the patient’s pain, anxiety and behavior during treatment to facilitate safety, efficiency and patient cooperation. (See: ADA Policy Statement: The Use of Sedation and General Anesthesia by Dentists and Guidelines for the Use of Sedation and General Anesthesia by Dentists.)
• The dentist may counsel the patient concerning the potential effects of the patient’s health condition, medication use, and behaviors on his or her oral health.
• The dentist should refer the patient to (an)other health professional(s) when the dentist determines that it is in the best interests of the patient.
• Relevant and appropriate information about the patient and any necessary coordinated treatment should be communicated and coordinated between the referring dentist and the health professional(s) accepting the referral.
• The dentist should recommend treatment; present treatment options, if any; and discuss the probable benefits, limitations and risks associated with treatment, and the probable consequences of no treatment.
• The patient should be informed that the success of treatment is often dependent upon his or her adaptability to, and acceptance and tolerance of the prosthesis.
• Any treatment performed should be with the concurrence of the patient and the dentist. If the patient insists upon treatment not considered by the dentist to be beneficial for the patient, the dentist may decline to provide treatment. If the patient insists upon treatment considered by the dentist to be harmful to the patient, the dentist should decline to provide treatment.
• The dentist should emphasize the prevention and early detection of oral diseases through patient education in preventive oral health practices, which may include oral health instructions.
• After consideration of the individual circumstances, the dentist should determine if the missing teeth should be replaced.
• Additional diagnostic procedures relevant to the patient’s edentulous arch(es) may be performed and used by the dentist in developing a treatment plan.
• The presence, prognosis, stability, position and treatment implications of any teeth, implants or prostheses in the opposing arch should be considered by the dentist in developing and implementing a treatment plan.
• The dentist should consider the characteristics and requirements of each patient in selecting material(s) and treatment(s).
• Factors affecting the patient’s speech, function and orofacial aesthetics should be considered by the dentist in developing a treatment plan.
• Tissue-and/or implant-supported prosthetic options should be considered by the dentist in developing a treatment plan.
• Fixed prosthesis(es), removable prosthesis(es) or a combination of these prosthetic options should be considered by the dentist in developing a treatment plan.
• Soft and hard tissue characteristics and morphology, ridge relationships, occlusion and occlusal forces, aesthetics, and parafunctional habits should be considered by the dentist in the design of the prosthesis(es). Craniofacial, musculoskeletal relationships,
including the clinically apparent status of the temporomandibular joints, should be considered by the dentist in developing a treatment plan.

- The dentist should consider the compatibility of the selected treatment with the surrounding oral tissues and should provide an environment accessible for maintenance.
- Pre-prosthetic surgical procedures to alter hard and soft tissue morphology may be performed by the dentist to facilitate treatment.
- Oral and maxillofacial surgical procedures may be performed by the dentist to facilitate treatment.
- Tissue conditioners may be used by the dentist to facilitate treatment.
- Transitional or provisional prostheses may be utilized by the dentist to facilitate treatment.
- The dentist should communicate to the dental laboratory technician necessary information and authorization for fabrication of the prosthesis(es). Although the fabrication may be delegated, the dentist is responsible for the accuracy of the prosthesis(es).
- Removable prostheses may be repaired, modified, relined, rebased or replaced, as determined by the dentist.
- Fixed, implant-supported prostheses may be repaired, modified or replaced, as determined by the dentist.
- The patient should be instructed by the dentist in the use and care of the prosthesis(es). The patient should be informed that the success of treatment is often dependent upon his or her compliance with the instructions. Lack of compliance should be recorded.
- The patient should be informed by the dentist that the prosthesis(es) may need future replacement, rebasing and/or relining.
- The dentist should inform the patient that he or she should participate in a prescribed program of continuing care to allow the dentist to evaluate the prosthesis(es) and the condition of the oral cavity.
- The dentist should determine the frequency and type of preventive treatment based on the patient’s risk factors or presence of oral disease.
- Documentation of treatment provided, counseling and recommended preventive measures, as well as consultations with and referrals to other health care professionals, should be included in the patient’s dental record.

**FRACTURED TOOTH:**

- The key element in the design of this set of parameters for a fractured (cracked) tooth is the professional judgment of the attending dentist, for a specific patient, at a specific time.
The patient’s chief complaint, concerns and expectations should be considered by the dentist.

The dental and medical histories should be considered by the dentist in identifying medications and predisposing conditions that may affect the prognosis, progression, and management of patients with a fractured (cracked) tooth.

Following oral evaluation of the patient (see limited, comprehensive, periodic, detailed and extensive evaluation parameters) and consideration of the patient’s needs, the dentist should provide the patient with information about the fractured (cracked) tooth prior to obtaining consent for treatment.

The patient should be provided appropriate information by the dentist about fractured (cracked) tooth prior to giving consent for further evaluation and/or treatment.

Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by dental treatment provided without the medication or its modification. The dentist should consult with the prescribing health care professional(s) before modifying medications being taken by the patient for known conditions. (See: ADA Statement on Antibiotic Prophylaxis, Prevention of Bacterial Endocarditis: A Statement for the Dental Profession (PDF), and A-Z Topic: Antibiotic Prophylaxis.)

The dentist may counsel the patient concerning the potential effects of the patient’s health condition, medication use and behaviors on his or her oral health. (See: Statement on Intraoral/Perioral Piercing.)

The dentist should recommend treatment; present treatment options, if any; and discuss the probable benefits, limitations and risks associated with treatment, and the probable consequences of no treatment.

Any treatment performed should be with the concurrence of the patient and the dentist. If the patient insists upon treatment not considered by the dentist to be beneficial for the patient, the dentist may decline to provide treatment. If the patient insists upon treatment considered by the dentist to be harmful to the patient, the dentist should decline to provide treatment.

Following evaluation, treatment priority should be given to the management of pain, infection, traumatic injuries or other emergency conditions.

The behavioral, psychological, anatomical, developmental and physiological limitations of the patient should be considered by the dentist in developing the treatment plan.

The dentist should attempt to manage the patient’s pain, anxiety and behavior during treatment to facilitate safety, efficiency and patient cooperation. (See: ADA Policy Statement: The Use of Sedation and General Anesthesia by Dentists and Guidelines for the Use of Sedation and General Anesthesia by Dentists.)
• When the dentist considers it necessary, (an)other health care professional(s) should be consulted to acquire additional information.
• Additional diagnostic tests relevant to the fractured (cracked) tooth of the patient may be performed and used by the dentist in diagnosis and treatment planning.
• The dentist may take this opportunity to emphasize the prevention and early detection of oral diseases through patient education in preventive oral health practices, which may include oral hygiene instructions.
• The dentist should refer the patient to (an)other health professional(s) when the dentist determines that it is in the best interests of the patient.
• Relevant and appropriate information about the patient and any necessary coordinated treatment should be communicated and coordinated between the referring dentist and the health professional(s) accepting the referral.
• After consideration of the circumstances in each case, including the condition of the hard and soft tissues, and the extent and type of fracture (crack), the dentist should determine whether the fractured (cracked) tooth should be monitored, treated or removed.
• The dentist should consider the characteristics and requirements of each patient, in selecting material(s) and treatment(s).
• The dentist may facilitate treatment by restorative and surgical extension of the clinical crown, orthodontic repositioning or a combination of these.
• Pulpal tissue should be protected by the dentist when indicated.
• The dentist may modify occluding, articulating, adjacent or approximating teeth to enhance the final restoration’s form and function as well as its ability to withstand the normal forces of occlusion.
• Tissues and/or restorations adjacent to the restorative site may be altered by the dentist to facilitate treatment.
• Orthodontic repositioning and/or alteration of tooth morphology adjacent to the restorative site may be performed by the dentist to facilitate treatment.
• Transitional or provisional restorations may be utilized by the dentist to facilitate treatment or reduce pulpal symptoms.
• An interim treatment may be utilized by the dentist to attempt reduction of signs and symptoms.
• Fractured (cracked) tooth fragments may be removed.
• Endodontic therapy and root resection may be used by the dentist in treating a fractured (cracked) tooth.
• Stabilization may be used by the dentist in the treatment of fractured (cracked) teeth.
• Occlusal guards may be used by the dentist for patients with fractured (cracked) teeth.
• Fractured (cracked) teeth may be removed, as determined by the dentist.
• The dentist should inform the patient that he or she should participate in a prescribed program of continuing care to allow the dentist to evaluate the effectiveness of the treatment provided and the status of the fractured (cracked) tooth.
• The dentist should determine the frequency and type of preventive treatment based on the patient’s risk factors or presence of oral disease.
• Documentation of treatment provided, counseling and recommended preventive measures, as well as consultations with and referrals to other health care professionals, should be included in the patient’s dental record.

GINGIVITIS:

• The key element in the design of this set of parameters for gingival inflammation without the loss of periodontal attachment (gingivitis) is the professional judgment of the attending dentist, for a specific patient, at a specific time.
• The patient’s chief complaint, concerns and expectations should be considered by the dentist.
• The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the prognosis, progression, and management of gingivitis.
• Following oral evaluation of the patient (see limited, comprehensive, periodic, and detailed and extensive evaluation parameters) and consideration of the patient’s needs, the dentist should provide the patient with information about gingivitis prior to obtaining consent for treatment. (See: Periodontal Screening and Recording® (PSR®): An Early Detection System Q & A.)
• Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by dental treatment provided without the medication or its modification. The dentist should consult with the prescribing health care professional(s) before modifying medications being taken by the patient for known conditions. (See: ADA Statement on Antibiotic Prophylaxis, Prevention of Bacterial Endocarditis: A Statement for the Dental Profession (PDF), and A-Z Topic: Antibiotic Prophylaxis.)
• The dentist may counsel the patient concerning the potential effects of the patient’s health condition, medication use and behaviors on his or her oral health.
• The dentist should recommend treatment; present treatment options, if any; and discuss the probable benefits, limitations and risks associated with treatment, and the probable consequences of no treatment.
• Any treatment performed should be with the concurrence of the patient and the dentist. If the patient insists upon treatment not considered by the dentist to be beneficial for the patient, the dentist may decline to provide treatment. If the
patient insists upon treatment considered by the dentist to be harmful to the patient, the dentist should decline to provide treatment.

- When the dentist considers it necessary, (an)other health professional(s) should be consulted to acquire additional information.
- When recommending treatment, the dentist should recognize that periodontal disease that can be episodic or linear, and generalized or site specific.
- Following evaluation, treatment priority should be given to the management of pain, infection, traumatic injuries or other emergency conditions.
- The behavioral, psychological, anatomical, developmental and physiological limitations of the patient should be considered by the dentist in developing the treatment plan.
- The dentist should attempt to manage the patient’s, pain, anxiety and behavior during treatment to facilitate safety, efficiency and patient cooperation. (See: ADA Policy Statement: The Use of Sedation and General Anesthesia by Dentists and Guidelines for the Use of Sedation and General Anesthesia by Dentists.)
- The dentist should refer the patient to (an)other health professional(s) when the dentist determines that it is in the best interest of the patient.
- Relevant and appropriate information about the patient and any necessary coordinated treatment should be communicated and coordinated between the referring dentist and the health professional(s) accepting the referral.
- The dentist should emphasize the prevention and early detection of oral diseases through patient education in preventive oral health practices, which may include oral hygiene instructions.
- The patient should be informed that the success of the treatment is often dependent upon patient compliance with home care instructions and recommendations for behavioral modifications. Lack of compliance should be recorded.
- The presence of carious lesions should be considered in developing a treatment plan.
- The relationship of the mucogingival junction to the loss of attachment should be noted and considered in developing a treatment plan.
- Additional diagnostic tests relevant to the gingivitis of the patient may be performed and used by the dentist in diagnosis and treatment planning.
- Clinically apparent plaque, calculus and other local etiologic factors should be removed.
- Chemotherapeutic agents may be used by the dentist to facilitate treatment.
- Alteration of tooth morphology and/or position, placement of restorations, modification or replacement of restorations, and treatment of carious lesions may be performed by the dentist to facilitate treatment.
- Gingival tissue may be altered by the dentist to produce a more acceptable gingival contour.
- The dentist should inform the patient that he or she should participate in a prescribed program of continuing care to allow the dentist to evaluate the effectiveness of the treatment provided and the condition of the periodontium.

- The dentist should determine the frequency and type of preventive treatment, based on the patient’s risk factors or presence of oral disease.

- Documentation of treatment provided, counseling and recommended preventive measures, as well as consultations with and referrals to other health care professionals, should be included in the patient’s dental record.

**PERIODONTITIS:**

- The key element in the design of this set of parameters for gingival inflammation with loss of connective tissue attachment (periodontitis) is the professional judgment of the attending dentist, for a specific patient, at a specific time.

- The patient’s chief complaint, concerns and expectations should be considered by the dentist.

- The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the prognosis, progression, and management of periodontitis.

- Following evaluation of the patient (see limited, comprehensive, periodic, detailed and extensive evaluation parameters) and consideration of the patient’s needs, the dentist should provide the patient with information about periodontitis prior to obtaining consent for treatment. (See: Periodontal Screening and Recording® (PSR®): An Early Detection System Q & A.)

- Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by dental treatment provided without the medication or its modification. The dentist should consult with the prescribing health care professional(s) before modifying medications being taken by the patient for known conditions. (See: ADA Statement on Antibiotic Prophylaxis, Prevention of Bacterial Endocarditis: A Statement for the Dental Profession (PDF), and A-Z Topic: Antibiotic Prophylaxis.)

- The dentist may counsel the patient concerning the potential effects of the patient’s health condition, medication use and behaviors on his or her oral health.

- The dentist should recommend treatment; present treatment options, if any; and discuss the probable benefits, limitations and risks associated with treatment, and the probable consequences of no treatment.

- Any treatment performed should be with the concurrence of the patient and the dentist. If the patient insists upon treatment not considered by the dentist to be beneficial for the patient, the dentist may decline to provide treatment. If the
patient insists upon treatment considered by the dentist to be harmful to the patient, the dentist should decline to provide treatment.

- When the dentist considers it necessary, (an)other health professional(s) should be consulted to acquire additional information.
- When recommending treatment, the dentist should recognize that periodontal disease that can be episodic or linear, and generalized or site specific.
- Following evaluation, treatment priority should be given to the management of pain, infection, traumatic injuries or other emergency conditions.
- The behavioral, psychological, anatomical, developmental and physiological limitations of the patient should be considered by the dentist in developing the treatment plan.
- The dentist should attempt to manage the patient’s pain, anxiety and behavior during treatment to facilitate safety, efficiency and patient cooperation. (See: ADA Policy Statement: The Use of Sedation and General Anesthesia by Dentists and Guidelines for the Use of Sedation and General Anesthesia by Dentists.)
- The dentist should refer the patient to (an)other health professional(s) when the dentist determines that it is in the best interest of the patient.
- Relevant and appropriate information about the patient and any necessary coordinated treatment should be communicated and coordinated between the referring dentist and the health professional(s) accepting the referral.
- The dentist should emphasize the prevention and early detection of oral diseases through patient education in preventive oral health practices, which may include oral hygiene instructions.
- The patient should be informed that the success of the treatment is often dependent upon patient compliance with home care instructions and recommendations for behavioral modifications. Lack of compliance should be recorded.
- Additional diagnostic tests relevant to the periodontitis of the patient may be performed and used by the dentist in diagnosis and treatment planning.
- The presence of carious lesions should be considered in developing a treatment plan.
- The relationship of the mucogingival junction to the loss of attachment should be noted and considered in developing a treatment plan.
- Clinically apparent plaque, calculus and other local etiologic factors should be removed.
- Root planing should be performed.
- Chemotherapeutic agents may be used by the dentist to facilitate treatment.
- Alteration of tooth morphology and/or position, placement of restorations, modification or replacement of restorations, and treatment of carious lesions may be performed by the dentist to facilitate treatment.
The replacement of missing teeth and/or those indicated for extraction may be performed by the dentist to facilitate treatment.

Occlusal analysis and adjustments may be performed by the dentist to facilitate treatment.

Occlusal guards and/or splinting may be used by the dentist to stabilize mobile teeth.

Resective, regenerative, recontouring and/or augmentation procedures may be performed by the dentist.

Root resection may be performed by the dentist.

Endodontic therapy may be performed by the dentist.

Teeth may be removed as determined by the dentist.

The dentist should inform the patient that he or she should participate in a prescribed program of continuing care to allow the dentist to evaluate the effectiveness of the treatment provided and the condition of the periodontium.

The dentist should determine the frequency and type of preventive treatment, based on the patient’s risk factors or presence of oral disease.

Documentation of treatment provided, counseling and recommended preventive measures, as well as consultations with and referrals to other health care professionals, should be included in the patient’s dental record.

**IMPACTED TOOTH:**

The key element in the design of this set of parameters for an impacted/unerupted tooth is the professional judgment of the attending dentist, for a specific patient, at a specific time.

The patient’s chief complaint, concerns and expectations should be considered by the dentist.

Following oral evaluation (see limited, comprehensive, periodic, detailed and extensive evaluation parameters) and consideration of the patient’s needs, the dentist should provide the patient with information about the impacted/unerupted tooth prior to obtaining consent for treatment.

The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the prognosis, progression and management of the impacted/unerupted tooth.

Factors affecting the patient’s speech, function and orofacial aesthetics should be considered by the dentist in developing a treatment plan.

In developing a treatment plan, the dentist should consider that the etiology of the impacted/unerupted tooth may be multifactorial.

The behavioral, psychological, anatomical, developmental and physiological limitations of the patient should be considered by the dentist in developing the treatment plan.
- Restorative implications, pulpal/endodontic status, tooth position, and periodontal status and prognosis should be considered in developing a treatment plan.
- The dentist may counsel the patient concerning the potential effects of the patient’s health condition, medication use and behaviors on his or her oral health.
- Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by dental treatment provided without the medication or its modification. The dentist should consult with the prescribing health care professional(s) before modifying medications being taken by the patient for known conditions. (See: ADA Statement on Antibiotic Prophylaxis, Prevention of Bacterial Endocarditis: A Statement for the Dental Profession (PDF), and A-Z Topic: Antibiotic Prophylaxis.)
- The dentist may recommend that the patient return for further evaluation. The frequency and type of evaluation(s) should be determined by the dentist, based on the patient’s risk factors.
- When the dentist considers it necessary, (an)other health care professional(s) should be consulted to acquire additional information.
- After consideration of the individual circumstances, the dentist should decide whether the impacted/unerupted tooth should be monitored or treated.
- Following evaluation, treatment priority should be given to the management of pain, infection, traumatic injuries or other emergency conditions.
- The dentist should recommend treatment; present treatment options, if any; and discuss the probable benefits, limitations and risks associated with treatment, and the probable consequences of no treatment.
- Any treatment performed should be with the concurrence of the patient and the dentist. If the patient insists upon treatment not considered by the dentist to be beneficial for the patient, the dentist may decline to provide treatment. If the patient insists upon treatment considered by the dentist to be harmful to the patient, the dentist should decline to provide treatment.
- The dentist should refer the patient to (an)other health professional(s) when the dentist determines that it is in the best interest of the patient.
- Relevant and appropriate information about the patient and any necessary coordinated treatment should be communicated and coordinated between the referring dentist and the health professional(s) accepting the referral.
- The dentist may take this opportunity to emphasize the prevention and early detection of oral diseases through patient education in preventive oral health practices, which may include oral hygiene instructions.
- The dentist should consider the characteristics and requirements of each patient in selecting material(s) and treatment(s).
- The dentist should attempt to manage the patient’s pain, anxiety and behavior during treatment to facilitate safety, efficiency and patient cooperation. (See: ADA Policy
Statement: The Use of Sedation and General Anesthesia by Dentists and Guidelines for the Use of Sedation and General Anesthesia by Dentists.

- The dentist may alter tooth morphology and/or position by modifying occluding, articulating, adjacent or approximating surfaces or by placing or replacing restorations to facilitate treatment.
- Chemotherapeutic agents may be used by the dentist to facilitate treatment.
- Periodontal surgical procedures may be performed by the dentist to facilitate treatment.
- Endodontic therapy and/or root resection may be performed by the dentist to facilitate treatment.
- Orthodontic repositioning may be performed by the dentist to facilitate treatment.
- Teeth may be removed, as determined by the dentist. When appropriate, the patient should be informed of the necessity to replace any removed teeth.
- The dentist should inform the patient that he or she should participate in a prescribed program of continuing care to allow the dentist to evaluate the effectiveness of the treatment provided and/or the status of an impacted/unerupted tooth.
- The patient should be informed that the success of the treatment is often dependent upon patient compliance with the prescribed treatment and recommendations for behavioral modifications. Lack of compliance should be recorded.
- Documentation of treatment provided, counseling and recommended preventive measures, as well as consultations with and referrals to other health care professionals, should be included in the patient’s dental record.

MALOCCLUSION:

- The key element in the design of this set of parameters for malocclusion is the professional judgment of the attending dentist, for a specific patient, at a specific time.
- Following oral evaluation (see limited, comprehensive, periodic, detailed and extensive evaluation parameters) and consideration of the patient’s needs, the dentist should provide the patient with information about malocclusion prior to obtaining consent for treatment.
- The patient’s chief complaint, concerns and expectations should be considered by the dentist.
- The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the prognosis, progression and management of malocclusion.
- In developing a treatment plan, the dentist should consider that the etiology of malocclusion may be hereditary and/or multifactorial, and may be characterized by
craniofacial, musculoskeletal, stomatognathic and/or dental interrelationships that are dynamic throughout life.

- The dentist should consider that malocclusion requiring treatment may develop at any time during an individual’s lifetime, regardless of the patient’s previous treatment history.
- When possible, a family health history should be obtained in addition to a general health history to assist in understanding the growth pattern of the patient.
- The dentist may recommend that the patient return for further evaluation. The frequency and type of evaluation(s) should be determined by the dentist, based on the patient’s risk factors.
- When the dentist considers it necessary, (an) other health care professional(s) should be consulted to acquire additional information.
- Factors affecting the patient’s speech, function and orofacial aesthetics should be considered by the dentist in developing a treatment plan.
- The behavioral, psychological, anatomical, developmental and physiological limitations of the patient should be considered by the dentist in developing the treatment plan.
- Restorative implications, pulpal/endodontic status, tooth position, and periodontal status and prognosis should be considered in developing a treatment plan.
- The dentist may counsel the patient concerning the potential effects of the patient’s health condition, medication use and behaviors on his or her oral health.
- Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by dental treatment provided without the medication or its modification. The dentist should consult with the prescribing health care professional(s) before modifying medications being taken by the patient for known conditions. (See: ADA Statement on Antibiotic Prophylaxis, Prevention of Bacterial Endocarditis: A Statement for the Dental Profession (PDF), and A-Z Topic: Antibiotic Prophylaxis.)
- After consideration of the individual circumstances, the dentist should decide whether the malocclusion should be monitored or treated.
- Following evaluation, treatment priority should be given to the management of pain, infection, traumatic injuries or other emergency conditions.
- The dentist should recommend treatment; present treatment options, if any; and discuss the probable benefits, limitations and risks associated with treatment, and the probable consequences of no treatment.
- The dentist should recommend and discuss post-treatment retention options, when indicated.
- Any treatment performed should be with the concurrence of the patient and the dentist. If the patient insists upon treatment not considered by the dentist to be beneficial for the patient, the dentist may decline to provide treatment. If the
patient insists upon treatment considered by the dentist to be harmful to the patient, the dentist should decline to provide treatment.

- The patient should be referred to (an) other health professional(s) when the dentist determines that it is in the best interest of the patient.
- Relevant and appropriate information about the patient and any necessary coordinated treatment should be communicated and coordinated between the referring dentist and the health professional(s) accepting the referral.
- The dentist should consider the characteristics and requirements of each patient in selecting material(s) and treatment(s).
- The dentist should emphasize the prevention and early detection of oral diseases through patient education in preventive oral health practices, which may include oral hygiene instructions.
- The dentist should determine the frequency and type of preventive treatment based on the patient’s risk factors or presence of oral disease.
- The dentist may reposition teeth orthodontically.
- The dentist should be responsible for instructing the patient in oral hygiene methods appropriate for the patient’s malocclusion treatment.
- The dentist should be responsible for informing the patient about the effects of dietary habits in maintaining oral hygiene and the integrity of any orthodontic appliances.
- In orthodontic treatment, the treatment appliance(s) should be as non-irritating to the surrounding tissues as is practical.
- The patient should be informed that the success of treatment is often dependent upon patient compliance with prescribed treatment and recommendations for behavioral modifications. Lack of compliance should be recorded.
- The dentist should evaluate the treatment progress and modify the treatment plan if indicated.
- The dentist should consider, and inform the patient, that orthodontic treatment may include multiple phases of treatment, with periods of observation, stabilization and/or retention between phases of active treatment.
- The dentist should attempt to manage the patient’s pain, anxiety and behavior during treatment to facilitate safety, efficiency and patient cooperation. (See: ADA Policy Statement: The Use of Sedation and General Anesthesia by Dentists and Guidelines for the Use of Sedation and General Anesthesia by Dentists.)
- When periodontal diseases are present, the dentist should initiate treatment before orthodontic appliances are placed. During orthodontic treatment, the periodontal condition should be monitored and treated. Some aspects of periodontal therapy may be delayed until after the malocclusion is resolved.
- Occlusal guards may be used by the dentist to facilitate and maintain treatment.
The dentist should periodically evaluate occlusal guards and/or appliances for their effectiveness and appropriateness.

- When necessary, the dentist should modify, replace or discontinue the use of occlusal guards or appliances.
- The dentist may modify occluding, articulating, adjacent or approximating teeth to facilitate treatment.
- The dentist may alter tooth morphology and/or position by placing restorations to facilitate treatment.
- The dentist may modify or replace existing restorations.
- Transitional or provisional restorations (prostheses) may be utilized by the dentist to facilitate treatment.
- Oral and maxillofacial surgical procedures may be performed.
- Presurgical orthodontic treatment may be utilized in preparation for oral and maxillofacial surgery, and a modified orthodontic appliance may be utilized for post-surgical fixation.

When appliances or prostheses are to be used, the patient should be informed about the potential for injury (e.g. soft tissue injury or aspiration).

When appropriate, the dentist should recommend that oral protective appliances be used during occupational, recreational and sporting activities.

The dentist should communicate by prescription the necessary information for the fabrication of the appliance(s) or prosthesis(es) to the dental laboratory technician. Although the fabrication may be delegated, the dentist is responsible for the appliance(s) or prosthesis(es).

The dentist should evaluate the treated occlusion and, based upon the needs of the individual patient, should implement a maintenance and retention plan at the completion of active treatment.

The dentist should inform the patient that he or she should participate in a prescribed program of continuing care to allow the dentist to evaluate the effectiveness of the treatment provided and the status of malocclusion.

Documentation of treatment provided, counseling and recommended preventive measures, as well as consultations with and referrals to other health care professionals, should be included in the patient’s dental record.

**OROFACIAL INFECTIONS:**

- The key element in the design of this set of parameters for orofacial infection(s) is the professional judgment of the attending dentist, for a specific patient, at a specific time.
- The patient’s chief complaint, concerns and expectations should be considered by the dentist.
The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the management of orofacial infections.

Following oral evaluation (see limited, comprehensive, periodic, detailed and extensive evaluation parameters) and consideration of the patient’s needs, the dentist should provide the patient with information about orofacial infection(s) prior to obtaining consent for treatment.

Following evaluation, treatment priority should be given to the management of pain, infection, traumatic injuries or other emergency conditions.

Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by dental treatment provided without the medication or its modification. The dentist should consult with the prescribing health care professional(s) before modifying medications being taken by the patient for known conditions. (See: ADA Statement on Antibiotic Prophylaxis, Prevention of Bacterial Endocarditis: A Statement for the Dental Profession (PDF), and A-Z Topic: Antibiotic Prophylaxis.)

The dentist should utilize a process of differential diagnosis when evaluating orofacial infection(s) and developing a treatment plan.

Additional diagnostic tests relevant to orofacial infection(s) of the patient may be performed and used by the dentist in diagnosis and treatment planning.

The dentist may recommend that the patient return for further evaluation. The sequencing, frequency and type of evaluation(s) should be determined by the dentist, based on the patient’s risk factors.

In developing a treatment plan, the dentist should consider that the etiology of orofacial infection(s) may be bacterial, viral and/or fungal in nature.

When the dentist considers it necessary, (an) other health care professional(s) should be consulted to acquire additional information.

The behavioral, psychological, anatomical, developmental and physiological limitations of the patient should be considered by the dentist in developing the treatment plan.

Restorative implications, carious lesions, pulpal/endodontic status, tooth position, and periodontal status and prognosis should be considered in developing a treatment plan.

The dentist may counsel the patient concerning the potential effects of the patient’s health condition, medication use and behaviors and/or habits on his or her oral health. (See: Statement on Intraoral/Perioral Piercing.)

After consideration of the individual circumstances, the dentist should decide whether the orofacial infection(s) should be monitored or treated.
• The dentist should recommend treatment, present treatment options, if any, and discuss the probable benefits, prognosis, limitations and risks associated with treatment and the probable consequences of no treatment.

• Any treatment performed should be with the concurrence of the patient and the dentist. If the patient insists upon treatment not considered by the dentist to be beneficial for the patient, the dentist may decline to provide treatment. If the patient insists upon treatment considered by the dentist to be harmful to the patient, the dentist should decline to provide treatment.

• The dentist should refer the patient to (an)other health professional(s) when the dentist determines that it is in the best interest of the patient.

• Relevant and appropriate information about the patient and any necessary coordinated treatment should be communicated and coordinated between the referring dentist and the health professional(s) accepting the referral.

• The dentist should emphasize the prevention and early detection of oral diseases through patient education in preventive oral health practices, which may include oral hygiene instructions.

• The dentist should determine the frequency and type of preventive treatment based on the patient’s risk factors or presence of oral disease(s).

• The dentist should attempt to manage the patient’s pain, anxiety and behavior during treatment to facilitate safety, efficiency and patient cooperation. (See: ADA Policy Statement: The Use of Sedation and General Anesthesia by Dentists and Guidelines for the Use of Sedation and General Anesthesia by Dentists.)

• Alteration of tooth morphology and/or position, placement of restorations, modification or replacement of restorations, and treatment of carious lesions may be performed by the dentist to facilitate treatment or reduce symptoms.

• The dentist may modify occluding, articulating, adjacent, or approximating teeth or the tooth/teeth in question to facilitate treatment or reduce symptoms.

• The dentist may prescribe and/or administer pharmacological agents.

• Counseling and/or therapy for parafunctional behaviors and/or habits which can contribute to orofacial infection(s) may be performed to facilitate treatment.

• Endodontic therapy, including surgical and nonsurgical approaches, may be performed by the dentist.

• Surgical management, which may include the removal of teeth/implants, and other intra-oral and/or extra-oral surgical approaches may be utilized. The patient should be informed of appropriate treatment to maintain space and/or replace any removed teeth.

• Fixed, removable and/or implant-supported restorations (prostheses) and/or appliances may be repaired, modified or replaced as determined by the dentist.

• Periodontal procedures may be performed by the dentist to facilitate treatment.
• The dentist should consider the compatibility of the selected treatment with the surrounding oral tissues and should provide an environment accessible for maintenance.
• Transitional or provisional restorations may be utilized by the dentist to facilitate treatment or reduce symptoms.
• The dentist should inform the patient that he or she should participate in a prescribed program of continuing care to allow the dentist to evaluate the effectiveness of the treatment provided and the condition of orofacial infection(s).
• Documentation of treatment provided, counseling and recommended preventive measures, as well as consultations with and referrals to other health care professionals, should be included in the patient’s dental record.

OROFACIAL OSSEOUS LESIONS:

• The key element in the design of this set of parameters for orofacial osseous lesions is the professional judgment of the attending dentist, for a specific patient, at a specific time.
• The patient’s chief complaint, concerns and expectations should be considered by the dentist.
• Following oral evaluation (see limited, comprehensive, periodic, detailed and extensive evaluation parameters) and consideration of the patient’s needs, the dentist should provide the patient with information about orofacial osseous lesions prior to obtaining consent for treatment.
• The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the prognosis, progression and management of (a) orofacial osseous lesion(s).
• The dentist should utilize a process of differential diagnosis when evaluating orofacial osseous lesion(s) and developing a treatment plan.
• In developing a treatment plan, the dentist should consider that the etiology of osseous lesions can be multifactorial, and that these lesions could be benign, premalignant or malignant.
• The dentist should consider that orofacial osseous lesion(s) may be self-limiting, and episodic and/or progressive and may recommend that the patient return for further evaluation.
• The dentist should consider that clinical manifestations of orofacial osseous lesion(s) may not coincide with cytological changes.
• The dentist should inform the patient that an osseous lesion has the potential for cytological change and should be monitored and/or evaluated through diagnostic procedures.
The dentist should determine the need for, and/or type of diagnostic procedure(s), including, but not limited to, biopsy or cytological evaluation.

When an osseous lesion has been diagnosed as malignant, the dentist should consider that malignant lesions have the potential for rapid growth and metastasis, and may be primary or metastatic.

When the dentist considers it necessary, (an)other health care professional(s) should be consulted to acquire additional information.

The dentist should refer the patient to (an)other health professional(s) when the dentist determines that it is in the best interest of the patient.

After consideration of the individual circumstances, including microscopic evaluation, if any, the dentist should decide whether the orofacial osseous lesion should be monitored or treated.

Factors affecting the patient’s speech, function, and orofacial aesthetics should be considered by the dentist in developing a treatment plan.

The behavioral, psychological, anatomical, developmental and physiological limitations of the patient should be considered by the dentist in developing a treatment plan.

Restorative implications, pulpal/endodontic status, tooth position, and periodontal status and prognosis should be considered in developing a treatment plan.

The dentist may counsel the patient concerning the potential effects of the patient’s health condition, medication use and behaviors on his or her oral health.

Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by treatment provided without the medication or its modification. The dentist should consult with the prescribing health care professional(s) before modifying medications being taken by the patient for known conditions. (See: ADA Statement on Antibiotic Prophylaxis, Prevention of Bacterial Endocarditis: A Statement for the Dental Profession, and Antibiotic Prophylaxis for Dental Patients With Total Joint Replacements.)

Following evaluation, treatment priority should be given to the management of pain, infection, traumatic injuries or other emergency conditions.

The dentist should recommend treatment; present treatment options, if any; and discuss the probable benefits, limitations and risks associated with treatment and the probable consequences of no treatment.

The patient should be informed that the success of treatment is often dependent upon patient compliance with prescribed treatment and recommendations for behavioral modifications. Lack of compliance should be recorded.

Any treatment performed should be with the concurrence of the patient and the dentist. If the patient insists upon treatment not considered by the dentist to be beneficial for the patient, the dentist may decline to provide treatment. If the
patient insists upon treatment considered by the dentist to be harmful to the patient, the dentist should decline to provide treatment.

- The dentist should emphasize the prevention and early detection of oral diseases through patient education in preventive oral health practices.
- The dentist should determine the frequency and type of preventive treatment based on the patient’s risk factors or presence of oral disease(s).
- The dentist should be responsible for educating the patient about maintaining good oral hygiene when the orofacial osseous lesion(s) and/or treatment limits the patient’s ability to achieve an appropriate level of oral hygiene.
- The dentist should consider, and inform the patient, that treatment for orofacial osseous lesions may include multiple phases of treatment.
- The dentist should consider that orofacial osseous lesions requiring treatment may develop at any time during an individual’s lifetime, regardless of the patient’s previous treatment history.
- The dentist should attempt to manage the patient’s pain, anxiety and behavior during treatment to facilitate safety, efficiency and patient cooperation. (See: ADA Policy Statement: The Use of Conscious Sedation, Deep Sedation, and General Anesthesia in Dentistry and Guidelines for the Use of Conscious Sedation, Deep Sedation, and General Anesthesia for Dentists.)
- When chemotherapy and/or radiotherapy are used in treating orofacial osseous lesion(s), the sequencing, frequency and type of palliative and/or preventive dental treatment should be determined by the dentist.
- Relevant and appropriate information about the patient and any necessary coordinated treatment should be communicated between the referring dentist and the health professional(s) accepting the referral.
- Surgical management of this condition may include removal of teeth, and other intra-oral and extra-oral surgical approaches. The patient should be informed of appropriate treatments to maintain space and/or replace teeth.
- The dentist may resect or ablate the orofacial osseous lesions with or without associated structures.
- Surgical reconstruction may be performed primarily or secondarily by the dentist.
- Maxillofacial restoration(s) (prostheses), including implant-supported restoration(s) (prostheses), may be used for therapy and reconstructive purposes.
- Fixed, removable and implant-supported restoration(s) (prostheses) may be placed, repaired, modified or replaced, as determined by the dentist.
- Endodontic therapy and/or root resection may be performed by the dentist.
- Local etiologic factors may be removed.
- Periodontal procedures may be performed by the dentist to facilitate treatment.
The dentist may alter tooth morphology and/or position by modifying occluding, articulating, adjacent or approximating teeth to facilitate treatment or reduce symptoms.

Placement of restoration(s) (prostheses), and modification or replacement of restoration(s) (prostheses) may be performed to facilitate treatment or reduce symptoms.

Transitional or provisional restorations (prostheses) may be utilized by the dentist to facilitate treatment.

When the dentist removes an osseous lesion, a microscopic evaluation must be considered.

The dentist may prescribe and/or administer pharmacological agents.

The dentist should consider the characteristics and requirements of each patient in selecting material(s) and treatment(s).

The dentist should communicate, by prescription, necessary information and authorization for the fabrication of the appliance(s) or prosthesis(es) to the dental laboratory technician. Although the fabrication may be delegated, the dentist is responsible for the accuracy and delivery of the appliance(s) or prosthesis(es).

The dentist may recommend that the patient return for further evaluation. The frequency and type of evaluation(s) should be determined by the dentist based on the patient’s risk factors.

Documentation of findings, treatment provided, counseling and recommended preventive measures, as well as consultations with and referrals to other health care professionals, should be included in the patient’s dental record.

OROFACIAL SOFT TISSUE LESIONS:

- The key element in the design of this set of parameters for orofacial soft tissue lesion(s) is the professional judgment of the attending dentist, for a specific patient, at a specific time.
- The patient’s chief complaint, concerns and expectations should be considered by the dentist.
- Following oral evaluation (see limited, comprehensive, periodic, detailed and extensive evaluation parameters) and consideration of the patient’s needs, the dentist should provide the patient with information about orofacial soft tissue lesion(s) prior to obtaining consent for treatment.
- The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the prognosis, progression and management of orofacial soft tissue lesion(s).
- The dentist should determine the need for, and/or type of, biopsy or cytological evaluation.
- Factors affecting the patient’s speech, function and orofacial aesthetics should be considered by the dentist in developing a treatment plan.
- In developing a treatment plan, the dentist should consider that the etiology of orofacial soft tissue lesion(s) may be multifactorial.
- In developing a treatment plan, the dentist should consider that the underlying pathosis(es) of orofacial soft tissue lesion(s) may be inflammatory, degenerative, hyperplastic, dysplastic and/or neoplastic in nature.
- The behavioral, psychological, anatomical, developmental and physiological limitations of the patient should be considered by the dentist in developing the treatment plan.
- Restorative and reconstructive implications, pulpal/endodontic status, tooth position, and periodontal status and prognosis should be considered in developing a treatment plan.
- The dentist may recommend that the patient return for further evaluation. The frequency and type of evaluation(s) should be determined by the dentist, based on the patient’s risk factors.
- When the dentist considers it necessary, (an)other health care professional(s) should be consulted to acquire additional information.
- The dentist may counsel the patient concerning the potential effects of the patient’s health condition, medication use and behaviors on his or her oral health.
- Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by dental treatment provided without the medication or its modification. The dentist should consult with the prescribing health care professional(s) before modifying medications being taken by the patient for known conditions. (See: ADA Statement on Antibiotic Prophylaxis, Prevention of Bacterial Endocarditis: A Statement for the Dental Profession (PDF), and A-Z Topic: Antibiotic Prophylaxis.)
- Any treatment performed should be with the concurrence of the patient and the dentist. If the patient insists upon treatment not considered by the dentist to be beneficial for the patient, the dentist may decline to provide treatment. If the patient insists upon treatment considered by the dentist to be harmful to the patient, the dentist should decline to provide treatment.
- The dentist should recommend treatment; present treatment options, if any; and discuss the probable benefits, limitations and risks associated with treatment, and the probable consequences of no treatment.
- After consideration of the individual circumstances, including microscopic evaluation, if any, the dentist should decide whether the orofacial soft tissue lesion(s) should be monitored or treated.
- Following evaluation, treatment priority may be given to the management of pain, infection, traumatic injuries or other emergency conditions.
The dentist should refer the patient to (an)other health professional(s) when the dentist determines that it is in the best interest of the patient.

Relevant and appropriate information about the patient and any necessary coordinated treatment should be communicated and coordinated between the referring dentist and the health professional(s) accepting the referral.

The dentist may take this opportunity to emphasize the prevention and early detection of orofacial disease through patient education.

The dentist should attempt to manage the patient’s pain, anxiety and behavior during treatment to facilitate safety, efficiency and patient cooperation. (See: ADA Policy Statement: The Use of Sedation and General Anesthesia by Dentists and Guidelines for the Use of Sedation and General Anesthesia by Dentists.)

When chemotherapy and/or radiotherapy are used in treating orofacial soft tissue lesion(s), the frequency and type of palliative and/or preventive dental treatment should be determined by the dentist.

The dentist should consider the characteristics and requirements of each patient in selecting material(s) and treatment(s).

The patient should be instructed regarding the nature of the orofacial soft tissue lesion(s). The patient should be informed that the success of the treatment is often dependent upon patient compliance with the prescribed treatment and recommendations for behavioral modifications. Lack of compliance should be recorded.

Chemotherapeutic agents may be used by the dentist to facilitate treatment.

The dentist may excise or ablate the orofacial soft tissue lesion(s) with or without associated structures.

Surgical reconstruction may be performed primarily or secondarily by the dentist.

Maxillofacial restoration(s) (prostheses), including implant-supported restoration(s) (prostheses), may be used for therapy and reconstructive purposes.

Pulpal/endodontic therapy and/or root resection may be performed by the dentist.

Local etiologic factors should be removed.

Periodontal surgical procedures may be performed by the dentist to facilitate treatment.

The dentist may alter tooth morphology and/or position by modifying occluding, articulating, adjacent or approximating teeth to facilitate treatment or reduce symptoms.

Placement of restoration(s) (prostheses), and modification or replacement of restoration(s) (prostheses) may be performed to facilitate treatment or reduce symptoms.

Teeth may be removed, as determined by the dentist. When appropriate, the patient should be informed of the necessity to replace any removed teeth.
• Fixed, removable and implant-supported restoration(s) (prostheses) may be placed, repaired, modified or replaced, as determined by the dentist.
• The dentist should inform the patient that he or she should participate in a prescribed program of continuing care to allow the dentist to evaluate the effectiveness of the treatment provided and the status of orofacial soft tissue lesion(s).
• Documentation of treatment provided, counseling and recommended preventive measures, as well as consultations with and referrals to other health care professionals, should be included in the patient’s dental record.

OROFACIAL TRAUMA:

• The key element in the design of this set of parameters for orofacial trauma is the professional judgment of the attending dentist, for a specific patient, at a specific time.
• In a patient presenting with orofacial trauma, medical stabilization takes precedence over dental treatment.
• The patient’s chief complaint, concerns and expectations should be considered by the dentist.
• When possible, the dentist should instruct the patient on the protocol for managing the orofacial trauma prior to evaluation.
• The dentist should attempt to manage the patient’s pain, anxiety and behavior during examination and treatment to facilitate safety, efficiency and patient cooperation. (See: ADA Policy Statement: The Use of Sedation and General Anesthesia by Dentists and Guidelines for the Use of Sedation and General Anesthesia by Dentists.)
• Following oral evaluation (see limited, comprehensive, periodic, detailed and extensive evaluation parameters) and consideration of the patient’s needs, the dentist should provide the patient with information about orofacial trauma prior to obtaining consent for treatment.
• The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the prognosis, progression and management of orofacial trauma.
• The dentist should utilize a process of differential diagnosis when evaluating orofacial trauma.
• The dentist should consider that the cause of orofacial trauma may be multifactorial and may affect multiple sites with differing degrees of severity.
• The dentist should consider the possibility that the patient may be the victim of physical abuse and/or neglect.
• When the dentist considers it necessary, (an)other health care professional(s) should be consulted to acquire additional information.
• The dentist should refer the patient to (an)other health professional(s) when the dentist determines that it is in the best interest of the patient.

• Factors affecting the patient's speech, function, and orofacial aesthetics should be considered by the dentist in developing a treatment plan.

• The behavioral, psychological, anatomical, developmental and physiological limitations of the patient should be considered by the dentist in developing a treatment plan.

• Restorative and dental restorative implications, pulpal/endodontic status, tooth position, and periodontal status and prognosis should be considered in developing a treatment plan.

• The dentist may counsel the patient concerning the potential effects of the patient’s health condition, medication use and behaviors on his or her oral health.

• Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by dental treatment provided without the medication or its modification. The dentist should consult with the prescribing health care professional(s) before modifying medications being taken by the patient for known conditions. (See: ADA Statement on Antibiotic Prophylaxis, Prevention of Bacterial Endocarditis: A Statement for the Dental Profession (PDF), and A-Z Topic: Antibiotic Prophylaxis.)

• After consideration of the individual circumstances the dentist should decide whether the orofacial trauma should be monitored or treated.

• Following evaluation, treatment priority should be given to the management of emergency conditions, pain and anxiety.

• The dentist, when possible, should recommend treatment; present treatment options, if any; and discuss the probable benefits, limitations and risks associated with treatment and the probable consequences of no treatment.

• When possible, any treatment performed should be with the concurrence of the patient and the dentist. If the patient insists upon treatment not considered by the dentist to be beneficial for the patient, the dentist may decline to provide treatment. If the patient insists upon treatment considered by the dentist to be harmful to the patient, the dentist should decline to provide treatment.

• Relevant and appropriate information about the patient and any necessary coordinated treatment should be communicated between the referring dentist and the health professional(s) accepting the referral.

• The dentist should consider the individual needs of each patient in selecting material(s) and treatment(s).

• The dentist should be responsible for educating the patient about maintaining good oral hygiene, appropriate for the patient’s condition.

• The dentist should consider, and inform the patient, that treatment for orofacial traumas may include multiple phases of treatment.
• The dentist may prescribe and/or administer pharmacological agents.
• Foreign matter may be removed from the trauma area.
• Lacerations may be repaired.
• Alteration of tooth morphology and/or modification or placement of restorations may be performed by the dentist to facilitate treatment or reduce symptoms.
• Resective and/or reconstructive surgical procedures may be performed by the dentist.
• Endodontic therapy may be performed by the dentist.
• Transitional or provisional restorations may be used by the dentist to facilitate treatment.
• The dentist may utilize manipulation and/or stabilization techniques to facilitate treatment.
• Surgical management of this condition may include the removal, repositioning, and/or reimplantation of teeth, and other intra-oral and extra-oral surgical procedures. The patient should be informed of appropriate treatments to maintain space and/or replace teeth as determined by the dentist.
• The dentist should communicate, by prescription, necessary information and authorization for fabrication of appliance(s) or prosthesis(es) to the dental laboratory technician. Although the fabrication may be delegated, the dentist is responsible for the accuracy and delivery of the appliance(s) or prosthesis(es).
• The dentist should emphasize the prevention of oral trauma through patient education in preventive oral health practices, which may include orofacial protective appliances.
• The dentist should inform the patient that he or she should participate in a prescribed program of continuing care to allow the dentist to evaluate the effectiveness of the treatment provided.
• Documentation of treatment provided, counseling and recommended preventive measures, as well as consultations with and referrals to other health care professionals, should be included in the patient’s dental record.

PARTIALLY EDENTULOUS ARCH (S):

• The key element in the design of this set of parameters for partially edentulous arch(es) is the professional judgment of the attending dentist, for a specific patient, at a specific time.
• The patient’s chief complaint, concerns and expectations should be considered by the dentist.
• The dental and medical histories should be considered by the dentist in identifying medications and predisposing conditions that may affect the prognosis, progression, and management of patients with partial edentulism.
• Following oral evaluation of the patient (see limited, comprehensive, periodic, detailed and extensive evaluation parameters) and consideration of the patient’s needs, the dentist should provide the patient with information about partially edentulous arch(es) prior to obtaining consent for treatment.

• Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by dental treatment provided without the medication or its modification. The dentist should consult with the prescribing health care professional(s) before modifying medications being taken by the patient for known conditions. (See: ADA Statement on Antibiotic Prophylaxis, Prevention of Bacterial Endocarditis: A Statement for the Dental Profession (PDF), and A-Z Topic: Antibiotic Prophylaxis.)

• When the dentist considers it necessary, (an)other health care professional(s) should be consulted to acquire additional information.

• Following evaluation, treatment priority should be given to the management of pain, infection, traumatic injuries or other emergency conditions.

• The behavioral, psychological, anatomical, developmental and physiological limitations of the patient should be considered by the dentist in developing the treatment plan.

• The dentist should attempt to manage the patient’s pain, anxiety and behavior during treatment to facilitate safety, efficiency and patient cooperation. (See: ADA Policy Statement: The Use of Sedation and General Anesthesia by Dentists and Guidelines for the Use of Sedation and General Anesthesia by Dentists.)

• The dentist may counsel the patient concerning the potential effects of the patient’s health condition, medication use and behaviors on his or her oral health.

• The dentist should refer the patient to (an)other health professional(s) when the dentist determines that it is in the best interests of the patient.

• Relevant and appropriate information about the patient and any coordinated treatment should be communicated and coordinated between the referring dentist and the health professional(s) accepting the referral.

• The dentist should recommend treatment; present treatment options, if any; and discuss the probable benefits associated with treatment, and the probable consequences of no treatment.

• The patient should be informed that the success of treatment is often dependent upon his or her adaptability to, and acceptance and tolerance of the prosthesis.

• Any treatment performed should be with the concurrence of the patient and the dentist. If the patient insists upon treatment not considered by the dentist to be beneficial for the patient, the dentist may decline to provide treatment. If the patient insists upon treatment considered by the dentist to be harmful to the patient, the dentist should decline to provide treatment.
• The dentist should emphasize the prevention and early detection of oral diseases through patient education in preventive oral health practices, which may include oral hygiene instructions.
• After consideration of the individual circumstances, the dentist should determine if the missing tooth (teeth) should be replaced.
• Additional diagnostic procedures relevant to the patient’s partially edentulous arch(es) may be performed and used by the dentist in developing a treatment plan.
• The presence, prognosis, stability, positions and treatment implications of any teeth, implants or prostheses in the opposing arch should be considered by the dentist in developing and implementing a treatment plan.
• The dentist should consider the characteristics and requirements of each patient in selecting material(s) and treatment(s).
• Factors affecting the patient’s speech, function, and orofacial aesthetics should be considered by the dentist in developing a treatment plan.
• Tooth, implant and/or tissue supported prosthetic options should be considered by the dentist in developing a treatment plan.
• Fixed prosthesis(es), removable prosthesis(es) or a combination of these prosthetic options should be considered by the dentist in developing a treatment plan.
• Soft and hard tissue characteristics and morphology, ridge relationships, occlusion and occlusal forces, aesthetics, and parafunctional habits should be considered by the dentist in the design of the prosthesis(es).
• Restorative implications, endodontic status, tooth position and periodontal prognosis should be considered by the dentist in developing a treatment plan.
• Craniofacial, musculoskeletal relationships, including the clinically apparent status of the temporomandibular joints, should be considered by the dentist in developing a treatment plan.
• The dentist should consider the compatibility of the selected treatment with the surrounding oral tissues and should provide an environment accessible for maintenance.
• Alteration of tooth morphology and/or occlusal plane, orthodontic repositioning, and placement, replacement or modification of restorations may be performed by the dentist to facilitate treatment.
• Teeth with carious lesions should be monitored or treated by the dentist.
• Endodontic therapy may be performed by the dentist to facilitate treatment.
• Teeth may be removed by the dentist to facilitate treatment.
• Occlusal adjustments, guards and/or splinting may be used by the dentist to facilitate treatment.
• Periodontal surgical procedures may be performed by the dentist to facilitate treatment.
- Pre-prosthetic surgical procedures to alter hard and soft tissue morphology may be performed by the dentist to facilitate treatment.
- Oral and maxillofacial surgical procedures may be performed by the dentist to facilitate treatment.
- Tissue conditioners may be used by the dentist to facilitate treatment.
- Transitional or provisional prostheses may be utilized by the dentist to facilitate treatment.
- The dentist should communicate to the dental laboratory technician necessary information and authorization for fabrication of the prosthesis(es). Although the fabrication may be delegated, the dentist is responsible for the accuracy of the prosthesis(es).
- Removable prostheses may be repaired, modified, relined, rebased or replaced, as determined by the dentist.
- Fixed prostheses may be repaired, modified or replaced, as determined by the dentist.
- The patient should be instructed by the dentist in the use and care of the prosthesis. The patient should be informed that the success of treatment is often dependent upon his or her compliance with the instructions. Lack of compliance should be recorded.
- The patient should be informed by the dentist that the prosthesis(es) may need future replacement, rebasing and/or relining.
- The dentist should inform the patient that he or she should participate in a prescribed program of continuing care to allow the dentist to evaluate the prosthesis(es) and the condition of the oral cavity.
- The dentist should determine the frequency and type of preventive treatment based on the patient’s risk factors or presence of oral disease.
- Documentation of treatment provided, counseling and recommended preventive measures, as well as consultations with and referrals to other health care professionals, should be included in the patient’s dental record.

**PERICORONITIS:**

- The key element in the design of this set of parameters for pericoronitis is the professional judgment of the attending dentist, for a specific patient, at a specific time.
- The patient’s chief complaint, concerns and expectations should be considered by the dentist.
- Following oral evaluation (see limited, comprehensive, periodic, detailed and extensive evaluation parameters) and consideration of the patient’s needs, the
dentist should provide the patient with information about pericoronitis prior to obtaining consent for treatment.

- The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the prognosis, progression and management of pericoronitis.
- Following evaluation, treatment priority should be given to the management of pain, infection, traumatic injuries or other emergency conditions.
- In developing a treatment plan, the dentist should consider that the etiology of pericoronitis may be multifactorial.
- The behavioral, psychological, anatomical, developmental and physiological limitations of the patient should be considered by the dentist in developing the treatment plan.
- Restorative implications, tooth position, pulpal/endodontic status and periodontal prognosis should be considered in developing a treatment plan.
- When recommending treatment, the dentist should recognize that pericoronitis can be episodic and site-specific.
- The dentist may counsel the patient concerning the potential effects of the patient’s health condition, medication use and behaviors on his or her oral health.
- When the dentist considers it necessary, (an)other health care professional(s) should be consulted to acquire additional information.
- Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by dental treatment provided without the medication or its modification. The dentist should consult with the prescribing health care professional(s) before modifying medications being taken by the patient for known conditions. (See: ADA Statement on Antibiotic Prophylaxis, Prevention of Bacterial Endocarditis: A Statement for the Dental Profession (PDF), and A-Z Topic: Antibiotic Prophylaxis.)
- After consideration of the individual circumstances, the dentist should decide whether the pericoronitis should be monitored or treated.
- The dentist should recommend treatment; present treatment options, if any; and discuss the probable benefits, limitations and risks associated with treatment, and the probable consequences of no treatment.
- Any treatment performed should be with the concurrence of the patient and the dentist. If the patient insists upon treatment not considered by the dentist to be beneficial for the patient, the dentist may decline to provide treatment. If the patient insists upon treatment considered by the dentist to be harmful to the patient, the dentist should decline to provide treatment.
- The dentist should refer the patient to (an)other health professional(s) when the dentist determines that it is in the best interest of the patient.
• Relevant and appropriate information about the patient and any necessary coordinated treatment should be communicated and coordinated between the referring dentist and the health professional(s) accepting the referral.

• The dentist should emphasize the prevention and early detection of oral diseases through patient education in preventive oral health practices, which may include oral hygiene instructions.

• The dentist should consider the characteristics and requirements of each patient in selecting material(s) and treatment(s).

• The dentist should attempt to manage the patient’s pain, anxiety and behavior during treatment to facilitate safety, efficiency and patient cooperation. (See: ADA Policy Statement: The Use of Sedation and General Anesthesia by Dentists and Guidelines for the Use of Sedation and General Anesthesia by Dentists.)

• The dentist may modify occluding, articulating, adjacent or approximating tooth/teeth to facilitate treatment or reduce symptoms.

• Chemotherapeutic agents may be used by the dentist to facilitate treatment.

• Teeth may be removed, as determined by the dentist. When appropriate, the patient should be informed of the necessity to replace any removed teeth.

• Local etiologic factors may be removed.

• Debridement and/or lavage may be accomplished by the dentist.

• Soft tissue may be altered by the dentist.

• The patient should be informed that the success of the treatment is often dependent upon patient compliance with the prescribed treatment and recommendations for behavioral modifications. Lack of compliance should be recorded.

• Documentation of treatment provided, counseling and recommended preventive measures, as well as consultations with and referrals to other health care professionals, should be included in the patient’s dental record.

PULPITIS:

• The key element in the design of this set of parameters for pulpitis is the professional judgment of the attending dentist, for a specific patient, at a specific time.

• The patient’s chief complaint, concerns and expectations should be considered by the dentist.

• Following oral evaluation (see limited, comprehensive, periodic, detailed and extensive evaluation parameters) and consideration of the patient’s needs, the dentist should provide the patient with information about pulpitis prior to obtaining consent for treatment.

• The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the prognosis, progression and management of pulpitis.
The dentist should consider that pulpitis can be reversible or irreversible.

When the dentist considers it necessary, (an)other health care professional(s) should be consulted to acquire additional information.

Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by dental treatment provided without the medication or its modification. The dentist should consult with the prescribing health care professional(s) before modifying medications being taken by the patient for known conditions. (See: ADA Statement on Antibiotic Prophylaxis, Prevention of Bacterial Endocarditis: A Statement for the Dental Profession (PDF), and A-Z Topic: Antibiotic Prophylaxis.)

The behavioral, psychological, anatomical, developmental and physiological limitations of the patient should be considered by the dentist in developing the treatment plan.

Following evaluation, treatment priority should be given to the management of pain, infection, traumatic injuries or other emergency conditions.

Factors affecting the patient’s speech, function and orofacial aesthetics should be considered by the dentist in developing a treatment plan.

Restorative implications, occlusion, tooth position, and periodontal status and prognosis should be considered in developing a treatment plan.

The dentist may counsel the patient concerning the potential effects of the patient’s health condition and behaviors on his or her oral health.

After consideration of the individual circumstances, the dentist should decide whether the pulpitis should be monitored or treated.

Any treatment performed should be with the concurrence of the patient and the dentist. If the patient insists upon treatment not considered by the dentist to be beneficial for the patient, the dentist may decline to provide treatment. If the patient insists upon treatment considered by the dentist to be harmful to the patient, the dentist should decline to provide treatment.

The dentist should recommend treatment; present treatment options, if any; and discuss the probable benefits, limitations and risks associated with treatment, and the probable consequences of no treatment.

The dentist should refer the patient to (an)other health professional(s) when the dentist determines that it is in the best interest of the patient.

Relevant and appropriate information about the patient and any necessary coordinated treatment should be communicated and coordinated between the referring dentist and the health professional(s) accepting the referral.

The dentist should emphasize the prevention and early detection of oral diseases through patient education in preventive oral health practices, which may include oral hygiene instructions.
The dentist should determine the frequency and type of preventive treatment based on the patient’s risk factors or presence of oral disease.

The dentist should consider the characteristics and requirements of each patient in selecting material(s) and treatment(s).

The dentist should attempt to manage the patient’s pain, anxiety and behavior during treatment to facilitate safety, efficiency and patient cooperation. (See: ADA Policy Statement: The Use of Sedation and General Anesthesia by Dentists and Guidelines for the Use of Sedation and General Anesthesia by Dentists.)

Alteration of tooth morphology and/or position; placement of restorations; modification or replacement of restorations; and treatment of carious lesions may be performed to facilitate treatment.

Treatment designed to reduce pulpal symptoms and/or protect the pulpal tissue of the tooth with pulpitis may be utilized by the dentist.

The dentist may modify occluding and articulating tooth/teeth to facilitate treatment.

Transitional or provisional restorations may be utilized by the dentist to facilitate treatment.

Counseling and/or therapy for parafunctional behaviors and/or habits (e.g., bruxism) may be performed.

Chemotherapeutic agents may be used by the dentist to facilitate treatment.

Endodontic therapy, including surgical and/or nonsurgical approaches, may be performed by the dentist.

The patient should be informed that the success of the treatment is often dependent upon patient compliance with the treatment instructions and recommendations for behavioral modifications. Lack of compliance should be recorded.

Teeth may be removed by the dentist. When appropriate, the patient should be informed of the necessity to replace any teeth that are removed.

The dentist should inform the patient that he or she should participate in a prescribed program of continuing care to allow the dentist to evaluate the effectiveness of the treatment provided and/or the status of the pulpitis.

Documentation of treatment provided, counseling and recommended preventive measures, as well as consultations with and referrals to other health care professionals, should be included in the patient’s dental record.

**SALIVARY GLAND DYSFUNCTION:**

The key element in the design of this set of parameters for salivary gland dysfunction is the professional judgment of the attending dentist, for a specific patient, at a specific time.
- The patient’s chief complaint, concerns and expectations should be considered by the dentist.
- Following oral evaluation (see limited, comprehensive, periodic, detailed and extensive evaluation parameters) and consideration of the patient’s needs, the dentist should provide the patient with information about salivary gland dysfunction prior to obtaining consent for treatment.
- The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the prognosis, progression and management of salivary gland dysfunction.
- The dentist should utilize a process of differential diagnosis when evaluating salivary gland dysfunction.
- The dentist should consider that the etiology of salivary gland dysfunction may be mechanical, developmental, the result of infection, medication, radiation therapy, systemic disease, and/or benign or malignant neoplasms.
- The dentist should consider that the etiology of salivary gland dysfunction may be multifactorial.
- The dentist should determine the need for, and/or type of diagnostic procedures, including, but not limited to, biopsy or cytological evaluation.
- The dentist should consider that salivary gland dysfunction may be self-limiting, and episodic and/or progressive and may recommend that the patient return for further evaluation.
- When the dentist considers it necessary, (an)other health care professional(s) should be consulted to acquire additional information.
- The dentist should refer the patient to (an)other health professional(s) when the dentist determines that it is in the best interest of the patient.
- Factors affecting the patient’s speech, function, and orofacial aesthetics should be considered by the dentist in developing a treatment plan.
- The behavioral, psychological, anatomical, developmental and physiological limitations of the patient should be considered by the dentist in developing a treatment plan.
- Functional and restorative implications of reduced salivary flow should be considered when developing a treatment plan.
- The dentist may counsel the patient concerning the potential effects of the patient’s health condition, medication use and behaviors on his or her oral health.
- Since salivary gland dysfunction may persist or recur intermittently, the dentist should counsel the patient that salivary gland dysfunction is often managed, rather than resolved.
- Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by dental treatment provided
without the medication or its modification. The dentist should consult with the prescribing health care professional(s) before modifying medications being taken by the patient for known conditions. (See: ADA Statement on Antibiotic Prophylaxis, Prevention of Bacterial Endocarditis: A Statement for the Dental Profession (PDF), and A-Z Topic: Antibiotic Prophylaxis.)

- Following evaluation, treatment priority should be given to the management of pain, infection, traumatic injuries or other emergency conditions.
- The dentist may monitor or recommend treatment; present treatment options; and discuss the probable benefits, limitations and risks associated with treatment and the probable consequences of no treatment.
- Any treatment performed should be with the concurrence of the patient and the dentist. If the patient insists upon treatment not considered by the dentist to be beneficial for the patient, the dentist may decline to provide treatment. If the patient insists upon treatment considered by the dentist to be harmful to the patient, the dentist should decline to provide treatment.
- Relevant and appropriate information about the patient and any necessary coordinated treatment should be communicated between the referring dentist and the health professional(s) accepting the referral.
- The dentist should consider the effects of salivary gland dysfunction in selecting material(s) and treatment(s).
- The dentist should emphasize the prevention and early detection of oral diseases through patient education in preventive oral health practices.
- The dentist should determine the frequency and type of preventive treatment based on the patient’s risk factors or presence of oral disease(s).
- The dentist should be responsible for educating the patient about maintaining good oral hygiene when the salivary gland dysfunction and/or treatment limits the patient’s ability to achieve an appropriate level of oral hygiene.
- The dentist should attempt to manage the patient’s pain, anxiety and behavior during treatment to facilitate safety, efficiency and patient cooperation. (See: ADA Policy Statement: The Use of Sedation and General Anesthesia by Dentists and Guidelines for the Use of Sedation and General Anesthesia by Dentists.)
- The dentist may prescribe and/or administer pharmacological agents.
- When chemotherapy and/or radiotherapy affect salivary gland function, the sequencing, frequency and type of palliative and/or preventive dental treatment should be determined by the dentist.
- Resective or reconstructive surgical procedures may be performed by the dentist.
- When the dentist performs resective surgical procedures, a microscopic evaluation of the excised tissue must be considered.
- The dentist should communicate, by prescription, necessary information and authorization for the fabrication of the appliance(s) or prosthesis(es) to the dental
laboratory technician. Although the fabrication may be delegated, the dentist is responsible for the accuracy and delivery of the appliance(s) or prosthesis(es).

- The dentist should inform the patient that he or she should participate in a prescribed program of continuing care to allow the dentist to evaluate the effectiveness of the treatment provided.
- Documentation of treatment provided, counseling and recommended preventive measures, as well as consultations with and referrals to other health care professionals, should be included in the patient’s dental record.

TÉMPOROMANDIBULAR DISORDERS:

- The key element in the design of this set of parameters for temporomandibular (TM) disorders is the professional judgment of the attending dentist, for a specific patient, at a specific time.
- The patient’s chief complaint, concerns and expectations should be considered by the dentist.
- Following oral evaluation (see limited, comprehensive, periodic, detailed and extensive evaluation parameters) and consideration of the patient’s needs, the dentist should provide the patient with information about TM disorders prior to obtaining consent for treatment.
- The dental and medical histories should be considered by the dentist to identify medications and predisposing conditions that may affect the prognosis, progression and management of TM disorders.
- The dentist should consider that TM disorders are characterized by craniofacial, musculoskeletal, stomatognathic and/or dental interrelationships, and/or psychological influences that are dynamic throughout life and that the etiology of TM disorders may be multifactorial.
- The dentist should consider a differential disease classification that may include neuromuscular pain, myofascial pain, neurogenic pain, neurovascular pain, sympathetic and/or referred pain involving the trigeminal and/or oropharyngeal systems, or other medical conditions, which may contribute to or mimic TM disorders.
- Following oral evaluation (see limited, comprehensive, periodic, and detailed and extensive evaluation parameters) and consideration of the patient’s needs, the dentist is responsible for providing the patient with information about the nature of TM disorders prior to obtaining consent for treatment.
- The dentist should consider that TM disorders may be self-limiting, episodic and/or progressive and may recommend that the patient return for further evaluation. The frequency and type of evaluation(s) should be determined by the dentist, based on the patient’s risk factors, and the nature and severity of the patient’s disorder.
When the dentist considers it necessary, (an)other health care professional(s) should be consulted to acquire additional information.

The dentist should refer the patient to (an)other health professional(s) when the dentist determines that it is in the best interest of the patient.

Craniofacial relationships, musculoskeletal relationships, and the status of the temporomandibular joints, should be considered by the dentist in developing a treatment plan.

Factors affecting the patient’s speech, function, and orofacial aesthetics should be considered by the dentist in developing a treatment plan.

The behavioral, psychological, anatomical, developmental and physiological limitations of the patient should be considered by the dentist in developing a treatment plan.

Restorative implications, pulpal/endodontic status, tooth position, and periodontal status and prognosis should be considered in developing a treatment plan.

The dentist may counsel the patient concerning the potential effects of the patient’s health condition, medication use and behaviors on his or her oral health.

The dentist should counsel the patient that TM disorders are often managed, rather than resolved, and that symptoms of TM disorders may persist, change, or recur intermittently.

The patient should be informed that the success of treatment is often dependent upon patient compliance with prescribed treatment and recommendations for behavioral modifications. Lack of compliance should be recorded.

Medications should be prescribed, modified and/or administered for dental patients whose known conditions would affect or be affected by dental treatment provided without the medication or its modification. The dentist should consult with the prescribing health care professional(s) before modifying medications being taken by the patient for known conditions. (See: ADA Statement on Antibiotic Prophylaxis, Prevention of Bacterial Endocarditis: A Statement for the Dental Profession (PDF), and A-Z Topic: Antibiotic Prophylaxis.)

After consideration of the individual circumstances, the dentist should decide whether the TM disorders should be monitored or treated.

Following evaluation, treatment priority should be given to the management of pain, infection, traumatic injuries or other emergency conditions.

The dentist should recommend treatment; present treatment options, if any; and discuss the probable benefits, limitations and risks associated with treatment and the probable consequences of no treatment.

The dentist should treat patients for TM disorder only when there is associated craniomaxillofacial pain and/or functional impairment.
- Initially the dentist should select the least invasive and most reversible therapy that may ameliorate the patient’s pain and/or functional impairment.
- Any treatment performed should be with the concurrence of the patient and the dentist. If the patient insists upon treatment not considered by the dentist to be beneficial for the patient, the dentist may decline to provide treatment. If the patient insists upon treatment considered by the dentist to be harmful to the patient, the dentist should decline to provide treatment.
- The dentist should evaluate the effectiveness of initial therapy prior to considering more invasive and/or irreversible therapy.
- Before initiating invasive and/or irreversible therapy, the dentist should attempt to determine the likelihood of its therapeutic success.
- Relevant and appropriate information about the patient and any necessary coordinated treatment should be communicated between the referring dentist and the health professional(s) accepting the referral.
- The dentist should consider the individual needs and desires of each patient in selecting material(s) and treatment(s).
- The dentist should emphasize the prevention and early detection of oral diseases through patient education in preventive oral health practices.
- The dentist should determine the frequency and type of preventive treatment based on the patient’s risk factors or presence of oral disease(s).
- The dentist should be responsible for educating the patient about the increased difficulty of maintaining good oral hygiene when TM disorders limit the range of jaw motion, and for instruction in methods to achieve an appropriate level of oral hygiene.
- The dentist should be responsible for educating the patient concerning self-management and the elimination of behaviors that may contribute to TM disorders.
- The dentist should consider, and inform the patient, that treatment for TM disorders may include multiple phases of treatment and multiple health care disciplines.
- The dentist should consider that TM disorders requiring treatment may develop at any time during an individual’s lifetime, regardless of the patient’s previous treatment history.
- The dentist may prescribe or administer physical medicine (therapy) modalities.
- The dentist should attempt to manage the patient’s pain, anxiety and behavior during treatment to facilitate safety, efficiency and patient cooperation. (See: ADA Policy Statement: The Use of Sedation and General Anesthesia by Dentists and Guidelines for the Use of Sedation and General Anesthesia by Dentists.)
- When articular derangement and/or condylar dislocation has been determined to be the etiology of the patient’s pain and/or functional impairment, manual manipulation of the mandible may be performed by the dentist.
The dentist may prescribe and/or administer pharmacological agents.

The dentist should periodically evaluate the patient’s medication regimen to determine the effectiveness and appropriateness of continued pharmacological therapy.

Oral orthotics (guards/splints) may be used by the dentist to enhance diagnosis, facilitate treatment or reduce symptoms.

The dentist should periodically evaluate oral orthotics (guards/splints) for their effectiveness, appropriateness and possible risks associated with continued use.

Before restorative and/or occlusal therapy is performed, the dentist should attempt to reduce, through the use of reversible modalities, the neuromuscular, myofascial and temporomandibular joint symptoms.

The dentist may replace teeth, alter tooth morphology and/or position by modifying occluding, articulating, adjacent or approximating surfaces, and by placing or replacing restorations (prostheses) to facilitate treatment.

Transitional or provisional restorations (prostheses) may be utilized by the dentist to facilitate treatment.

Intracapsular and/or intramuscular injection, and/or arthrocentesis may be performed for diagnostic and/or therapeutic purposes.

Orthodontic therapy may be utilized to facilitate treatment.

Orthognathic surgery may be performed to facilitate treatment.

When internal derangement or pathosis has been determined to be the cause of the patient’s pain and/or functional impairment, arthroscopic or open resective or reconstructive surgical procedures may be performed by the dentist.

The dentist should communicate, by prescription, necessary information and authorization for the fabrication of the appliance(s) or prosthesis(es) to the dental laboratory technician. Although the fabrication may be delegated, the dentist is responsible for the accuracy and delivery of the appliance(s) or prosthesis(es).

The dentist should inform the patient that he or she should participate in a prescribed program of continuing care to allow the dentist to evaluate the effectiveness of the treatment provided and the status of the TM disorder.

Documentation of treatment provided, counseling and recommended preventive measures, as well as consultations with and referrals to other health care professionals, should be included in the patient’s dental record.