To some, the word “diagnosis” is taboo for hygienists to even consider using, let alone doing! Diagnosis is simply recognizing the signs and symptoms of disease, something all hygienists are required to do to take their licensing exam. Hygienists also must practice this in the clinical setting to provide care for patients. If a hygienist can’t tell the difference between health and disease, keeping a clinical position will be difficult.

Those who don’t want RDHs to “diagnose” must instead want a robot to simply “scale teeth.” Every dentist I’ve know wants the RDH employed in the practice to “actually have a brain,” to quote Dr. Michael Rethman. Providing dental hygiene care involves critical thinking to assess the health of each individual patient. A wide variety of information is gathered to determine health, disease and individual risk factors presented by each patient. With the identification of the dental hygiene diagnosis, the dental hygiene treatment plan can be devised and followed by the RDH. The dental hygiene diagnosis and treatment plan are part of the comprehensive dental diagnosis and treatment plan created by the dentist. Working as colleagues, the dentist and dental hygienist gather information necessary to accurately assess the health of each patient and provide the necessary treatment, prevention and maintenance care.

In this issue, Lori Frey presents the history of the periodontal probe and advice on effective technique. Information collected with the probe, plus the extra- and intra-oral examination and information gathered through interviewing the patient about eating habits, daily oral hygiene and medical history provides the basis for creating both the dental hygiene diagnosis and a dental hygiene treatment plan. These activities, including diagnosis, are all essential parts of the dental hygiene process of care.
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Many attempts at automating periodontal probing have been made over the years, however the manual probe is still the one used most often in practice today.

Since the manual probe is still the number-one choice of clinicians, researchers at the Tokyo Medical and Dental University in Japan modified a manual probe by attaching a fiber optic sensor to record probing depths. They compared the sensor probe to a standard manual probe for accuracy of measurements.

The fiber optic sensor mechanism is an external sheath that covers the manual probe, adding approximately 8mm of length. As the probe is inserted into a sulcus, the sheath is stopped by the gingival margin and slides back as the probe moves forward. A spring-loaded mechanism is used as the sheath slides back. The sliding distance is detected by the fiber optic sensor and transmitted by cable to a personal computer outside the mouth.

This pilot study compared probing and bleeding scores on six individuals with moderate to severe periodontitis. Six measurements per tooth were recorded around the first molar in each quadrant. Measurements were repeated one week later for comparison.

Averaging all probing scores together, the manual probe score was 3.03mm and the fiber optic probe was 3.08mm. In pockets 7mm or deeper, the fiber optic probe scores were not as deep as the manual probe. This may be due to pressure buildup on the gingival margin, pushing the margin down, thus giving a shallower reading.

Clinical Implications: New options might become available that modify manual probes rather than creating automated probes.


Gingival bleeding can be assessed between the teeth, professionally using a periodontal probe, or by the patient using a triangular-shaped wooden stick moved in and out from facial to lingual four times. Self-assessment by patients of their own gingival health provides them with feedback and a means of cleaning between the teeth.

Researchers at the University of Zürich in Switzerland compared periodontal probing to the use of an interdental brush to determine if the information about bleeding, plaque and gingivitis was similar. The test subjects were 64 consecutive patients being seen for their semi-annual periodontal maintenance visit with the dental hygienist. All had gingival inflammation with at least 50 percent papillary height and no pocket depths exceeding 4mm.

All four quadrants were tested, half with the probe inserted 2mm into the gingival sulcus and the other half with one pass through with an interdental brush. Rather than using the probe on one side of the mouth and the interdental brush on the other side of the mouth, contralateral quadrants were assigned. Randomly assigned quadrants were either the maxillary right and the mandibular left or the maxillary left and the mandibular right. The presence or absence of both plaque and bleeding were recorded.

Average bleeding scores were similar for the sites measured with the periodontal probe and the sites tested with the interdental brush. Scores were 47 percent for the periodontal probe and 46 percent for the interdental brush.

Clinical Implications: Correctly sized interdental brushes can be used as a reliable self-test for interproximal bleeding.

Bacteria Cling to Periodontal Probes

In 1985 researchers reported the translocation of Actinobacillus actinomycetemcomitans (Aa) from infected sites to healthy sites. Although the bacteria were moved, they were unable to survive the ecology of the healthy sulcular environment. While inoculation is possible, suitable growth conditions are required for successful colonization.

Dental hygiene researchers at University of Missouri, Kansas City compared four probes in sites 3mm or less and sites 4mm or greater. A total of eight probes were tested, four in shallow sites and four in deep sites. The probes were inserted subgingivally, held there for two seconds and removed directly to a vial of transport medium and sealed with wax. Each probe was then processed for evaluation under a scanning electron microscope.

Microbial samples from 80 pockets were collected and cultured to compare shallow and deep pockets. As expected, shallow pockets had fewer bacteria than deep pockets. The researchers were surprised to see just how rough the probe surfaces were. Striations around the metal probes indicated use of a lathe in the manufacturing process. Roughness and barbed edges were typical of the cuts for millimeter markings. The plastic probes had smoother surfaces than the metal probes and were made of two identical halves sealed together. Excess plastic flashing around the ball tip of these probes was evident.

All probes tested retained bacteria and epithelial cells. No differences in bacteria retention were observed between probe types in either shallow or deep pockets.

Clinical Implications: Despite the fact that bacteria and epithelial cells cling to probe surfaces, clinical effects of bacterial translocation have not been shown.


The Future is Ultrasonic Probing

To diagnose periodontal disease, radiographs and periodontal probing are always used. Radiographs provide a two-dimensional image of three-dimensional structures and require ionizing radiation. Periodontal probing is an invasive procedure influenced by clinician technique, force used, probe size and topography of the pocket. Researchers are looking for a non-invasive approach to diagnosis that overcomes current sources of error. Ultrasonography may be the answer.

Researchers in London used a non-invasive 20MHz ultrasonic imaging system to determine bone and tissue levels from the facial surfaces of three teeth in each of three pig jaws. A fourth pig jaw was used for histological evaluation. A notch was made on each tooth as a landmark. An ultrasonic gel was used between the ultrasonic probe tip and the gingival tissues on the facial surface of the tooth. Measurements were taken through the gingival tissue and provided 15mm X 6.25mm images within one second. Images were captured in a computer and compared to actual measurements of the pig jaws. Trans-gingival measurements or “soundings” were done with a periodontal probe from the gingival margin through the attachment to the bone crest. Direct measurements were taken after surgical reflection of the tissue. Measurements and ultrasound images were repeated to determine accuracy.

Differences between ultrasonic images were only 0.44mm. This was less than the 1mm error found between sounding measurements and the 0.6mm difference between surgical measurements. Within a preset range of plus or minus 0.6mm there was good agreement between ultrasound measurements and direct surgical measurements.

Clinical Implications: The advantages of a non-invasive ultrasound diagnostic technique will be a welcome addition to clinical practice in the future.


continued on page 5
Painful probing might deter patients from continuing on for needed periodontal treatment. Based on published research, we know that probing the anterior region is more painful than the posterior. This is explained by anatomy, identifying a greater density of free nerve endings in the anterior gingiva compared to the posterior gingiva. Both manual and automated probes are associated with pain and discomfort. The level of inflammation can also influence pain experienced during probing.

This multi-center study in Belgium evaluated patients’ experience of pain and discomfort during probing, scaling and root planing (SRP) and maintenance therapy. Local anesthesia was provided in 90 percent of SRP cases, two percent of maintenance cases and not at all for probing. Patients completed a computer questionnaire following each clinic visit to measure pain and discomfort.

Less than 10 percent of patients undergoing probing reported severe pain, more than 20 percent reported moderate pain and approximately 60 percent reported mild pain. Just over 20 percent reported no pain on injections, while more than 70 percent reported some level of pain with the injections. Overall pain levels reported for SRP and maintenance were lower than those reported for probing. One third of the SRP group and two percent of maintenance patients reported taking pain medication after treatment.

This study was funded by the original developers of Oraqix, a topical local anesthetic used in place of injections, as justification for an alternative to anesthetic injections to control pain associated with probing, SRP and maintenance therapy.

**Clinical Implications: Pain control options should be considered for probing and subgingival instrumentation.**


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**Pain on Probing Varies by Site**

Depending on the amount of pressure used, probing can be painful for some patients and some areas of the mouth seem to be more sensitive than others.

Researchers at the University of Florida evaluated probing pain associated with varying probing pressures using a Florida Probe. Patients listened to an audio tape explaining what sensations they would feel when the probe was inserted into the sulcus. There would be the initial touch, followed by the pressure and then the transition from pressure to pain. It was this transition point they wanted to identify. Patients were given a control switch to indicate when the pressure became pain. The goal was not to see how much pain they could endure, but rather the point at which pain began.

The 10 test subjects were periodontally healthy. Midfacial and mid-lingual surfaces were measured for all maxillary first molars and maxillary central incisors. Probing was repeated weekly for three weeks. Scores for each of the three visits for each person were similar and were combined to give a single mean for each surface for each patient. Scores ranged from 14 to 182 grams of pressure. The pain tolerance was more than four times greater for some patients than others.

It is apparent from this small pilot study that setting an average probing pressure for all patients will not take into consideration the variations between patients, nor the variations between sites within the same mouth. No reasons for these differences were given.

**Clinical Implications: When probing, incisors are more sensitive than molars and facial surfaces are more sensitive than lingual surfaces.**

Probing Techniques
Hygienists talk about what works and what doesn’t in perio.

What is your favorite probe? Do you actually look at the exact measurement on the probe or do you estimate the measurement through experience and feel? Just curious. I mostly do a combination of the two depending on the depth of the pocket. Also, do you angle the probe into furcations or straight along the long axis until you feel tissue? Once upon a time long, long ago when I was in school, we were taught to use a light touch, but sometimes I miss deeper pockets until I see the X-rays or start scaling or using the Cavitron.

My favorite is the Michigan probe, 3-6-9-12. Finding I am better with color-coded these days. I see docs, sometimes probing the line angle which is wrong. Col is the place to probe. Dr. Sam Low corroborated that this spring. Angle the probe into the col area.

Thanks for your response. I was just wondering because sometimes when the doc comes in and does a spot probe, he gets deeper numbers than I do, but his probe is angled into the interproximal space. Of course, that will give a higher number. It seems to me that probing isn’t really an exact science. I see a lot of variables and inconsistencies between operators. Any thoughts?

I use the colored probe yellow with a black line at 3-5-7, with exact measurements. Neighbors probe for furcations. I find with both of these probes it is easy to compare at future visits.

I hate it when they probe the line angles! I think that’s probably why they taught us to “walk the probe around!” My rule is: On the buccal insert the probe, walk it MB B DB, then take it out of the pocket. Get the three probing depths and then completely remove the probe. Same for the lingual.

After the initial scan of soft tissue, I probe throughout the mouth. Once a year I record probing depths for every tooth. On the other visits I chart changes only. The reason I do this is anything above 3mm needs to be Sc/RP. If probing is not done, how would you know where Sc/RP would be needed?
Abstract

New technology has transformed the practice of modern dentistry over the past few decades. Digital radiography, lasers, improved materials for enhanced aesthetics, magnification loupes with illumination and computerized systems that now provide for a “paperless” practice are just some of the many examples of how dentistry has evolved. However, the method for obtaining periodontal health data has largely remained unchanged over these same decades. To date, the periodontal probe is still the most relied upon instrument utilized for obtaining the information necessary to make an accurate and comprehensive diagnosis with regard to periodontal health status.

Educational Objectives

At the end of this program, participants will be able to:

- Recognize the value of the periodontal probe for diagnosis.
- List the five generations of periodontal probe development.
- Describe the clinical features the periodontal probe is used to measure.
- Describe the col area anatomy and correct probing angles in this area.
- List the factors that contribute to accurate probing measurements.

The Latin word *probo* means “to test.” The history of diagnosis dates back to the time of Hippocrates, and the premise that a proper diagnosis is required before treatment may be prescribed is commonly understood today. In 1882, an American dentist, John W. Riggs, was very interested in diseases of the gingiva and was the first to limit his practice to periodontics. Riggs was also the first to describe the periodontal probe as a tool in the diagnosis of periodontal disease. Prior to Riggs, there was no mention of periodontal probes in the literature; diagnosis of periodontal disease, or “Rigg’s disease,” as it was called then, was based on tooth mobility and suppuration. Riggs developed the concept of oral prophylaxis and prevention and was a true pioneer of conservative periodontal therapy, noting that “teeth with their accretions and roughened surfaces are the existing cause of the disease.”

In 1925, the periodontal probe and its use were described by F. V. Simonton of the University of California, San Francisco. Simonton noted something very significant, saying that “the only way to determine the existence and extent of pyorrhea was by the measurement of the pockets.” Orban (1958) described the periodontal probe as “the eye of the operator beneath the gingival tissue.”

margin” and it stands today that a comprehensive dental examination cannot be accomplished without the use of the periodontal probe.

Interestingly, the periodontal probe is remarkably similar to its original designs dating back to the early 1900s. Hanford and Patten’s design of a periodontal probe, then called a Periodontometer and made of silver, is nearly the same in appearance as the probes that are routinely used in clinical practice today. Differences in probes currently used include a variety of materials, various incremental markings designated by lines and/or colors, and variable thicknesses and shapes, depending upon the probe’s particular intended area of use. The working end can be some combination of flat or round, and straight or curved.

In 1992, B. L. Pihlstrom created a classification of periodontal probes. The classification system included three generations of probes: first, second and third generations. In 2000, Watts extended the classification system to include a fourth and fifth generation of probes.6

First-generation probes are manual, handheld instruments, also called conventional probes. These probes are typically made of stainless steel, although titanium and plastic (polymeric material) are used as well, and are dependent upon the clinician’s manual pressure. In 1936, Charles H. M. Williams, a periodontist, designed a prototype for first-generation probes.7 The Williams’ probe is a straight probe, 13 millimeters in length and one millimeter in diameter, with demarcation lines at 1, 2, 3, 5, 7, 8, 9 and 10 millimeters, and is still widely used in clinical practice today. Other examples of conventional probes include the color-coded Marquis’ probe, the University of Carolina-15 (UNC-15) probe and the Naber’s probe (Fig. 1). The Marquis probe, first available in 1965, was the first color-coded probe and was designed for patient comfort and ease of reading. It is available in both straight and curved designs, has the slimmest tip on the market, and is designed with alternating black and silver incremental markings at 3, 6, 9 and 12 millimeters (Marquis Dental). The University of Carolina-15 (UNC-15) probe is a straight probe with black incremental markings at every millimeter from 1 through 15 and is particularly favored for use in research. The Naber’s probe is a curved probe, used for detecting and measuring horizontal periodontal furcation involvement in multi-rooted teeth. These first-generation probes are still used by the majority of dental hygienists, periodontists and dentists today.

Second-generation probes, also called Constant Pressure probes, are manual probes designed to provide for the standardization of controlled probing pressure. Invented by Frank Hunter in 1994, the TPS (True Pressure Sensitive) probe was designed to obtain accurate and reliable measurements utilizing the same 20 grams of force every time it’s used.8 When the probe encounters resistance and the indicator lines coincide, a constant pressure of 20 grams has been reached, and the reading is then taken. It is designed to obtain consistent results, even when utilized by different clinicians. Constant pressure probes, like conventional probes, do not require computerization to record the collected data.

Third-generation probes refer to automated probing systems. Software integrates with existing computer systems to provide computerized periodontal charting and the data is collected and stored electronically. Automated probing systems are designed to streamline the periodontal charting examination by using a computerized probe handpiece and foot switch to record probing measurements, eliminating the need for an assistant to record data. The Florida Probe, first available in 1987, is one such automated probing system that efficiently allows for hands-free charting and generates a detailed, computerized periodontal chart. The Florida Probe has a constant pressure of 15 grams and a precision of 0.2 millimeters, providing a highly accurate periodontal examination.

Fourth-generation probes refer specifically to 3D technology, with the goal of obtaining a precise and continuous reading of the base of the sulcus or pocket. Fifth-generation probes are designed to utilize ultrasound, in addition to 3D. These probes aim to accurately measure attachment levels without penetrating the junctional epithelium, as conventional probes often do, providing for a more comfortable examination and a precise mapping of the base of the sulcus or pocket. While not currently used in conventional practice, the development of these fourth- and fifth-generation probes offers the potential for error-free probing measurements, particularly in the very early stages of periodontal disease. Earlier screening is becoming even more important, now that periodontal disease is associated with systemic conditions such as diabetes and heart disease.

Comprehensive periodontal charting involves the measurements of sulcus or pocket depth around a tooth. However, probing depths alone are not reliable enough to indicate the degree of bone support present. Because the position of the gingival margin can change with such factors as gingival hyperplasia or

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Fig. 1: Williams probe with Williams markings (left) and Naber’s probe with Marquis markings (right)
Fig. 2: http://www.ehuman.com/BHI/Periodontal%20Morphology.pdf, p. 20
recession, the clinical attachment level (CAL) is a critical measurement to obtain. The clinical attachment level is measured from the fixed position of the cemento-enamel junction (CEJ), whereas probing depths are measured from the gingival margin. Also referred to as clinical attachment loss, the clinical attachment level indicates “the extent of periodontal support that has been destroyed around a tooth” and is the “gold standard” for the measurement of periodontal disease activity.

While the primary purpose of periodontal probing is to measure both sulcus/pocket depth and clinical attachment levels, more information is needed to enable a complete periodontal diagnosis. A complete periodontal examination also includes the measurement and recording of gingival recession, mobility, furcation involvement, bleeding and suppuration. The probe is used to measure intra-oral lesions of the hard and/or soft tissues, and other existing factors such as calculus, plaque and changes in the dentition should also be noted. Failure to obtain all these criteria results in the inability to make a thorough and comprehensive periodontal diagnosis.

Typically, the periodontal examination begins with the recording of six-point probing depth measurements, measuring the distal, direct and mesial aspects of both the buccal and the lingual surfaces of each tooth. A systematic routine is usually established by the clinician, often beginning with the distofacial aspect of the most posterior maxillary tooth and working forward and around the arch, then probing the same way maxillary lingually. The mandibular arch is probed in the same fashion. While this is a perfectly acceptable routine, another routine used to enhance patient education is to first systematically measure all the direct surfaces, buccally and lingually, followed by measuring the distal and mesial aspects of the buccal and lingual surfaces. Reading the measurements out loud in this way can help patients more easily distinguish between areas of the teeth that are brushed vs. flossed, and help them make the connection that periodontal disease often begins in the interproximal areas.

Periodontal probing technique is critical to obtaining accurate measurements. Probing involves moving the probe along the perimeter of the base of the sulcus or pocket, called a walking stroke. The entire circumference of the sulcus/pocket base is “walked” to determine the topography of the junctional epithelium. It is not uncommon for depth differences to exist in the same sulcus/pocket, so the walking stroke is carefully performed to accurately record the deepest existing depth measurements.

The probe is inserted into the sulcus/pocket while maintaining the probe tip against the tooth surface. When the probe encounters resistance at the epithelial attachment, the probe is then gently “walked” or “bobbed” up and down, keeping strokes close together and moving forward along the base of the sulcus/pocket. This walking stroke is performed without removing the probe tip from the sulcus/pocket, and maintaining contact with the base of the epithelial attachment on each downstroke. The deepest reading is recorded for each of the six aspects: distofacial, direct facial, mesiofacial, mesiolingual, direct lingual and distolingual.

It is commonly taught to position the probe parallel to the long axis of the tooth. When probing the faciolingual dimension, parallel positioning is easy to achieve. However, when probing interproximally, some adaptation is necessary, as maintaining the probe parallel to the long axis is difficult, if not impossible at times, and can result in an inaccurate measurement. In figure 5, the diagram on the left demonstrates how positioning the probe parallel to the long axis misses a deep interproximal defect as it encounters the contact.

When probing interproximally, particularly with adjacent teeth in contact and no gingival recession, inserting the probe at the line angle and tilting the probe slightly into the col, the depression in the interdental tissues just below the interproximal contact, to reach under the contact area, then walking the probe interproximally to drop into the depths of the mesial or distal pocket, can provide a more accurate reading. In figure 5, the diagram on the right demonstrates how tilting the probe slightly and walking it interproximally, from either the buccal or lingual aspect, can better enable detection of interproximal bony defects. On the other hand, using too much angulation can also result in missing interproximal defects. This is where the skill and expertise of the clinician is paramount to obtaining accurate periodontal probing measurements.

Probing accuracy can also be influenced by other factors. Calculus, especially subgingival calculus located at the line angles, can make probing particularly difficult. And, a patient’s unmanaged pain or discomfort can interfere with obtaining accurate measurements. While local anesthesia is not typically given for a periodontal examination, it can be advantageous if a patient’s discomfort prevents obtaining accurate measurements. In the case of patients requiring periodontal therapy, it is good practice to reprobe at the initial SRP appointment, after local anesthesia is given, to confirm probing measurements obtained during examination.

Until technology delivers a more accurate and reliable way to measure periodontal disease, the periodontal probe is still the most valuable instrument we have to gather clinical data involving the periodontium. With respect to accurately diagnosing periodontal disease, one thing remains unchanged – periodontal probing accuracy is completely dependent upon the clinician’s knowledge of root morphology and skilled technique. Ultimately, and most importantly, the single factor critical to obtaining excellent diagnostic information has always been, and still is, the skill and expertise of the clinician.


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1. The periodontal probe is designed to:
   a. measure sulcus or pocket depths.
   b. measure clinical attachment levels.
   c. locate and measure furcation involvement of multi-rooted teeth.
   d. measure the size of intra-oral lesions.
   e. All of the above

2. The first to describe the periodontal probe as a tool in the diagnosis of periodontal disease was:
   a. Hippocrates.
   b. Riggs.
   c. Simonton.
   d. Williams.
   e. Hunter.

3. All periodontal probes utilize one standardized demarcation system for consistency.
   a. True
   b. False

4. A periodontal probe designed to detect and measure furcation involvement in multi-rooted teeth is the Naber's probe.
   a. True
   b. False

5. Automated probing systems such as the Florida Probe:
   a. utilize constant pressure.
   b. have a variable calibrated precision between 0.2 and 0.8 millimeters.
   c. generate a computerized periodontal chart and store data electronically.
   d. Both a and c.
   e. All of the above

6. Periodontal probes utilizing ultrasound technology:
   a. are currently used only in research studies.
   b. provide more accurate results than 3D technology.

7. Earlier periodontal screening is becoming even more important because:
   a. of the association with systemic diseases such as diabetes and heart disease.
   b. insurance coverage may be adversely affected by delaying treatment.
   c. of the availability of in-office diagnostic laboratory testing.
   d. patient compliance with treatment usually declines with advanced disease.

8. The col is:
   a. another name for the junctional epithelium.
   b. a defect often observed in the furcations of molars.
   c. a depression in the interdental tissues just below the interproximal contact area.
   d. the point of attachment between the handle and working end of a periodontal probe.
   e. None of the above

9. The factor(s) that can contribute to inaccurate probing measurements is/are:
   a. subgingival calculus.
   b. incorrect probe positioning.
   c. a patient’s unmanaged pain or discomfort during probing.
   d. Both a and b.
   e. All of the above

10. Probing accuracy is dependent upon:
    a. the clinician's choice of probing system.
    b. the clinician's knowledge of root morphology.
    c. the clinician's skilled technique.
    d. Both b and c.
    e. All of the above.

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