SU

FACULTY OF DENTISTRY
SU

THE AGDP

LOG BOOK

19050

www.su.edu.eg

2023-2024

ADVANCED GENERAL DENTISTRY PROGRAM

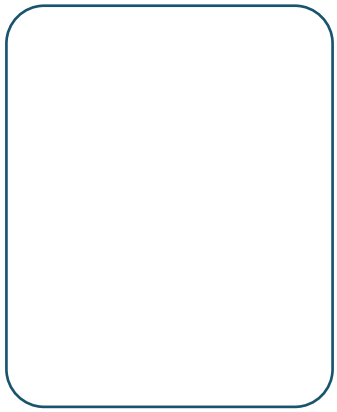
Proudly presented by
Sinai University Kantara Campus
2023-2024

Candidate Name: .....

ID: .....

Cell Phone: .....

E-Mail: .....



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Cell Phone: .....

E-Mail: .....

“If You Can’t Fly Then Run,
If You Can’t Run Then Walk,
If You Can’t Walk Then Crawl,
But Whatever You Do,
You Have To
Keep Moving Forward.”

Martin Luther King Jr.

WE SIMPLY NEVER GIVE UP

MESSAGE FROM THE DEAN

I have the honor to welcome you young dentists to the AGDP journey in our beloved faculty. It's really heart-warming to witness fresh students transform into fine graduates. The Sinai university family is proud of you. The AGDP is not the end of your learning journey, it's rather the beginning of your professional life. The more effort you put into the AGDP, the more your skills would sharpen and mature.

We are all students in life, and we will eagerly continue learning as long as we are breathing.

Worship god, love our country, be kind to people and never stop learning.

Dean of Faculty of Dentistry
Prof. Randa Hafez

THE TEAM

PROF. MOHAMMAD M. RAYYAN
Vice Dean for Postgraduate affairs,
Environmental Affairs and Community Service

DR. MOHAMMED DESOKY MOHAMED
Director of AGDP

MR. AHMED BUOMEY
AGDP Affairs Specialists

SU

FACULTY OF DENTISTRY SU

PROGRAM NAME

AGDP

ADVANCED
GENERAL
DENTISTRY
PROGRAM

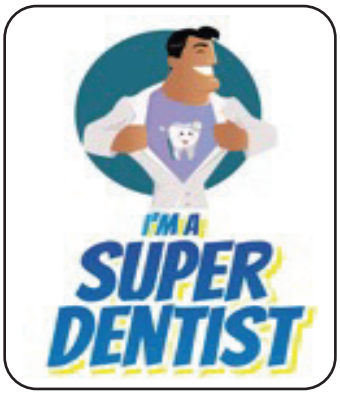
PROGRAM MISSION

To train, upgrade and update clinical, ethical and informative skills of each and every candidate to the program. Aiming to produce a new breed of skilled acquainted and well informative general dentists to dental market.

PROGRAM VISION

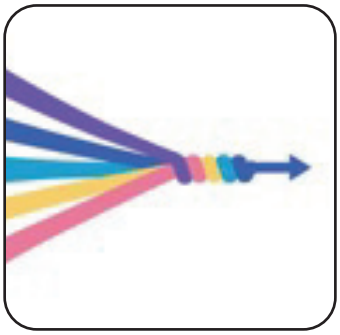
To upgrade dental graduates to better serve god, beloved Egypt, community and themselves.

PROGRAM GOALS



AIM

Produce a trained skillful super general dentist. And optimize his/her abilities, skill and knowledge to perfectly fit the dental market.



DESCRIPTION

The ADGP product should be able to deal with each case in a complete comprehensive manner. With all domains merging together in a sequential manner to formulate proper treatment care.

METHOD

The product will be continuously guided in clinics and nourished by continuous tips and tricks to optimally finishes cases. Advanced cases, Seminars, Discussion groups and lectures will be held weekly . Hands-on workshops will be held monthly.

PROGRAM DESCRIPTION

- It's a compulsory one year clinical training program. Its completion is obligatory for candidate to receive the Egyptian dental syndicate permission to practice dentistry on Egyptian soil.

- For SU ranked candidates: 6 months are spent in faculty clinics, and 6 months spent in Egyptian ministry of health hospital.

- For SU none-ranked candidates: 3 months are spent in faculty clinics and 9 months spent in Egyptian ministry of health hospitals.

- Candidates can apply to spend more months in faculty clinics.

- Due to space availability and logistics, only SU graduates are accepted in the program till now.

DEPARTEMENTAL ROTATIONS

- Ten selected motivated candidates will spend one month at a chosen department (Surgery, Operative, Fixed or removable prosthodontics)
- The candidate will be rewarded 15-20 points according to their achievements.
- Only selected teaching assistants from each department will be responsible for the AGDP candidates.
- Each candidate will be assigned to ONLY ONE DEPARTMENT during his/her 3 months spent in Sinai University.

CANDIDATE OBLIGATIONS

- Candidates should literally accept to perfectly represent faculty in behavior, appearance and attitude.
- Candidates should stick to strict sterilization and disinfection protocols implemented by the faculty.
- Candidates should use good materials , instruments and equipment for proper treatment. All material should be in their original packing and not a custom-packing so that material quality could be traced.
- Candidates should stick to clean and tidy uniform green scrubs (pants or skirts) and clogs- at all times their presence in the university. No sandals or slippers are allowed in clinics. Female candidates should have pony tail-do or white scarfs. No tall finger nails allowed.
- Candidates should score the base-line number of points in order to gradate the program (100).
- Candidate should follow the rules of the university.
- Candidates should maintain a professional attitudes towards patients, their fellow colleagues , nursing staff and workers and their instructors.
- Candidates should respect university property and leave their clinics clean and tidy at the end of their working day.

CANDIDATE RIGHTS

- Candidates would be assisted by professionals to be become better trained at various dental disciplines.
- Candidates would be treated professionally as fellow dentists.
- Candidates would find professional help support and guidance from all disciplines at their scheduled times.
- Candidates would actively participate in state-of-the-art workshops.
- Candidates would actively participate in open discussion in their CCCs.
- Active candidates would receive free workshop ,special certificates and various rewards.
- Two early leave permissions per month for 2 hours. All remaining days, candidates are not allowed to leave before end of clinical sessions.

CANDIDATE'S SCHEDULE

- Candidates are divided in two teams; blue and red. Blue will attend Saturday, Sunday and Monday. Red will attend Tuesday, Wednesday and Thursday.
- Each two candidates in any of the teams should register their names together in order to participate in the four-hand dentistry.
- In clinics; Fixed prosthodontics, Removable prosthodontics, operative dentistry, Endodontics and Pedodontics, are referred to as Restorative sciences. While Surgery and Periodontics are referred to as Surgical sciences.
- Each candidate will work as operator or assistant consecutively.
- The total number of cases for both candidate will be calculated.
- Candidates working alone, will have a deduction in the total points.

	9 AM -12 PM	2 PM - 5 PM
Saturday	Restorative Sciences	Surgical Sciences
Sunday	Restorative Sciences	Surgical Sciences
Monday	Complete Care Case	Restorative Sciences
Tuesday	Restorative Sciences	Surgical Sciences
Wednesday	Restorative Sciences	Surgical Sciences
Thursday	Complete Care Case	Restorative Sciences

FLEXIBLE REQUIREMENTS

- AGDP is not undergraduate “year 6”, as an extension to undergraduate method of Rigid requirements.
- The flexible requirements protocol is presented by the smart point system.
- Where the candidates can self-develop through concentrating on domains that he/she would choose, and fulfilling the minimum required cases in the rest of disciplines.

THE POINTS SYSTEM

What is it?

- It is a way to calculate overall cases done by the candidate.

How is it being calculated?

- Each point resembles one hour.
- The total time spent by each candidate in clinics are: 15 hours per week…. 60 per month….180 per 3 months

1/3 of the time was removed as lost during logistics (60 hours). The remaining time is 120 hours. To simplify things more for the candidate…... another 20 hours were deducted . The remaining are 100 point to pass the program.

- Each candidate should finish cases from all disciplines.
- For unlisted special procedures that need skill and authorized by clinic instructors, the candidate will receive extra points as advised.

THE POINTS SYSTEM

What happens if a candidate didn't score the 100 points?

- If the candidate scored 60-69 points, he/she will be requested a one-month remake.
- If the candidate scored 70-79 points, he/she will be requested a three-weeks remake.
- If the candidate scored 80-89 points, he/she will be requested a two-weeks remake.
- If the candidate scored 90-99 points, he/she will be requested a one-week remake.

THE POINTS SYSTEM

What happens if a candidate scored more than 100 points?

- 175-199 one, candidate will receive free 1 workshop + golden certificate of appreciation.
- 200-249, candidate will receive free 2 workshops + diamond certificate of appreciate.
- 250- above, candidate will receive free 3 workshops + purple heart certificate of appreciate.
- At the end of each 3 months. One candidate would be selected for platinum certificate and extra bonus according to behavior attitude and work in clinics.

Volunteers: From the 20 candidates, some will be trained in different departments without pay and that will ensure his/her appointment in that department.

THE POINTS SYSTEM

Can points be deducted?

- For each breaking of rules or absent the candidate will receive immediate deduction of points.
- If the same negative behaviors was repeated for the 2nd time, double of penalty will be implemented . For 3rd time triple of penalty. 4th time a remake of one week will be enforced. 5th time, a 1-3 months will be remade according to the staff decision.
- Certain negative behaviors may cause an instant complete remake of expelling form program.

What happens if candidate finishes his/her point? Does she/he stop coming to the Program?

If the candidate completed his/her case, he/she continues working in clinics and adding more points till the end of his/her AGDP period.

What happens to the unfinished long cases?

If the candidate didn't complete his/her case . it's their duty to find a candidate to complete it and pass every record related to the case to this candidate. Dodging a patient is totally unethical and would be negatively rewarded.

THE POINTS SYSTEM

CROWN OR FIXED DENTAL PROSTHESIS	
STEP	Point/s
1ry impression/ study cast	0.5
Each abutment prep	1
2ry impression	1
Provisional	1
Try in	1
Cementation	0.5
Total	5

FIBER POST/CORE AND CROWN	
STEP	Point/s
Post space prep	0.5
Post cementation	0.5
Core construction/Prep	1
2ry impression	1
Provisional	1
Crown Try in	0.5
Crown Cementation	0.5
Total	5

CAST POST AND CROWN	
STEP	Point/s
Post space prep	0.5
Direct pattern construction	1
Post try in/cementation	1
2ry impression	1
Provisional	1
Crown Try in	0.5
Crown Cementation	0.5
Total	5.5

NAYYAR CORE AND CROWN	
STEP	Point/s
Pulp chamber cleaning	0.5
Core construction/ prep	1
2ry impression	1
Provisional	1
Crown Try in	0.5
Crown Cementation	0.5
Total	4.5

ENDO CROWN	
STEP	Point/s
Pulp chamber cleaning	0.5
2ry impression	1
Provisional	1
Crown Try in	0.5
Crown Cementation	0.5
Total	3.5

CERAMIC VENEER	
STEP	Point/s
1ry impression/ study cast	0.5
Each abutment prep	0.5
2ry impression	1
Provisional	1
Each abutment Try in/Cementation	0.5
Total	3.5

ONE ARCH VDO RAISING	
STEP	Point/s
1ry impression/ study cast	0.5
FWS determination/ bite registration	2
Mockups from diagnostic wax up	1
Each abutment prep	1
2ry impression	1
Provisional	2
Try in	1
Cementation	2
Total	10.5

CROWN/FDP OVER IMPLANT	
STEP	Point/s
Abutment selection	0.5
Implant level impression	1
Each implant temporization	1
Try in	1
Cementation	1
Total	4.5

CERAMIC INALY/ONLAY/OVERLAY	
STEP	Point/s
1ry impression/ study cast	0.5
Each tooth prep	0.5
2ry impression/provisional	1
Each tooth Try in/Cementation	1
Total	3

DIRECT COMPOSITE VENEER	
STEP	Point/s
Each tooth prep	1
Each tooth direct composite overlay	2
Each tooth finishing and polishing	1
Total	4

CLASS I / III/ V COMPOSITE	
STEP	Point/s
Cavity prep	0.5
Composite filling	1.5
Total	2

CLASS II / IV COMPOSITE	
STEP	Point/s
Cavity prep	1.5
Composite filling	1.5
Total	3

COMPOSITE INALY/ONLAY/OVERLAY	
STEP	Point/s
Each abutment prep	0.5
2ry impression/provisional	1
Each tooth Try in/Cementation	0.5
Total	2

SINGLE ROOTED ENDO TTT	
STEP	Point/s
Cleaning and shaping	1
Obturation	1
Total	2

MULTIPLE ROOTED ENDO TTT	
STEP	Point/s
Cleaning and shaping	2
Obturation	2
Total	4

SINGLE ROOTED ENDO RE TTY	
STEP	Point/s
Cleaning and shaping	2
Obturation	1
Total	3

MULTIPLE ROOTED ENDO RE TTT	
STEP	Point/s
Cleaning and shaping	4
Obturation	2
Total	6

PARTIAL DENTURE	
STEP	Point/s
1ry impression	2
Mouth prep	1
2ry impression	1
Metal try in	0.5
Jaw relationship	0.5
Try in waxed teeth	0.5
Final insertion	1
Total	6.5

COMPLETE / SINGLE DENTURE	
STEP	Point/s
1ry impression	2
2ry impression	2
Bite registration	2
Try in	1
Delivery	1
Total	8

TOOTH SUPPORTED OVERDENTURE	
STEP	Point/s
1ry impression	2
Abutments prep	1
2ry impression for coping	1
2ry impression	2
Bite registration	2
Try in	0.5
Delivery	0.5
Total	9

IMPLANT SUPPORTED OVERDENTURE	
STEP	Point/s
Implant placement	2
Healing Abutments	1
Abutment selection placements	1
2ry impression	2
Bite registration	2
Try in	0.5
Delivery	0.5
Total	9

OBTURATOR	
STEP	Point/s
1ry imp/prep	2
2ry impression	2
Bite registration	2
Try in	0.5
Delivery	0.5
Total	7

PROCEDURE	Point/s
Simple Extraction	0.5
Surgical Extraction/ Impaction	2
Closure of oroantral fistula	2
3-6 Teeth clearance and alveoloplasty	2
Apicectomy	2
Management of dry socket	1
Simple cyst removal	3
Cyst with critical size/ bone graft	3
Implant placement	2

PROCEDURE	Point/s
One arch scaling	1
One arch scaling, root planning and curettage	1
Depigmentation	2
Functional Crown lengthening	2
Esthetic Crown lengthening	3
Gingivectomy	3

PROCEDURE	Point/s
Class I,II Pedo	0.5
Stainless steel crown	0.5
Pulpotomy	1
Pulpectomy	1.5
Endodontic treatment for first permanent molar	2.5
Revascularization	2
Apexcification	2
Apexogenesis	2
Space maintainer	2
Extraction	0.5

THE COMPREHENSIVE CARE CASE

What is so special about it?

• As undergraduate, young dentist tend to deal with patients as requirements donor. They search the mouth looking for requirements, instead of treating the patient in a sequential manner.

What is it?

• It is a case containing more than two dental disciplines. i.e Fixed, operative and surgery.

• The candidate will learn: how to sequentially lay down the paper treatment plan (perio & surgery, then endo & operative then prosthodontics). To answer the big question FROM WHERE WOULD I START? WHERE TO END?. To know the big mystery of life; that patients are actually humans. To know about treatment time frame.

• The more complicated the case, the more the candidate will learn from it. Extra points COULD be earned from such a case. Depending on recommendation of clinical instructors. Not the personal request of the candidate.

• If the case was not completed. It should be passed along with its all its records to a fellow candidate.

THE COMPREHENSIVE CARE CASE

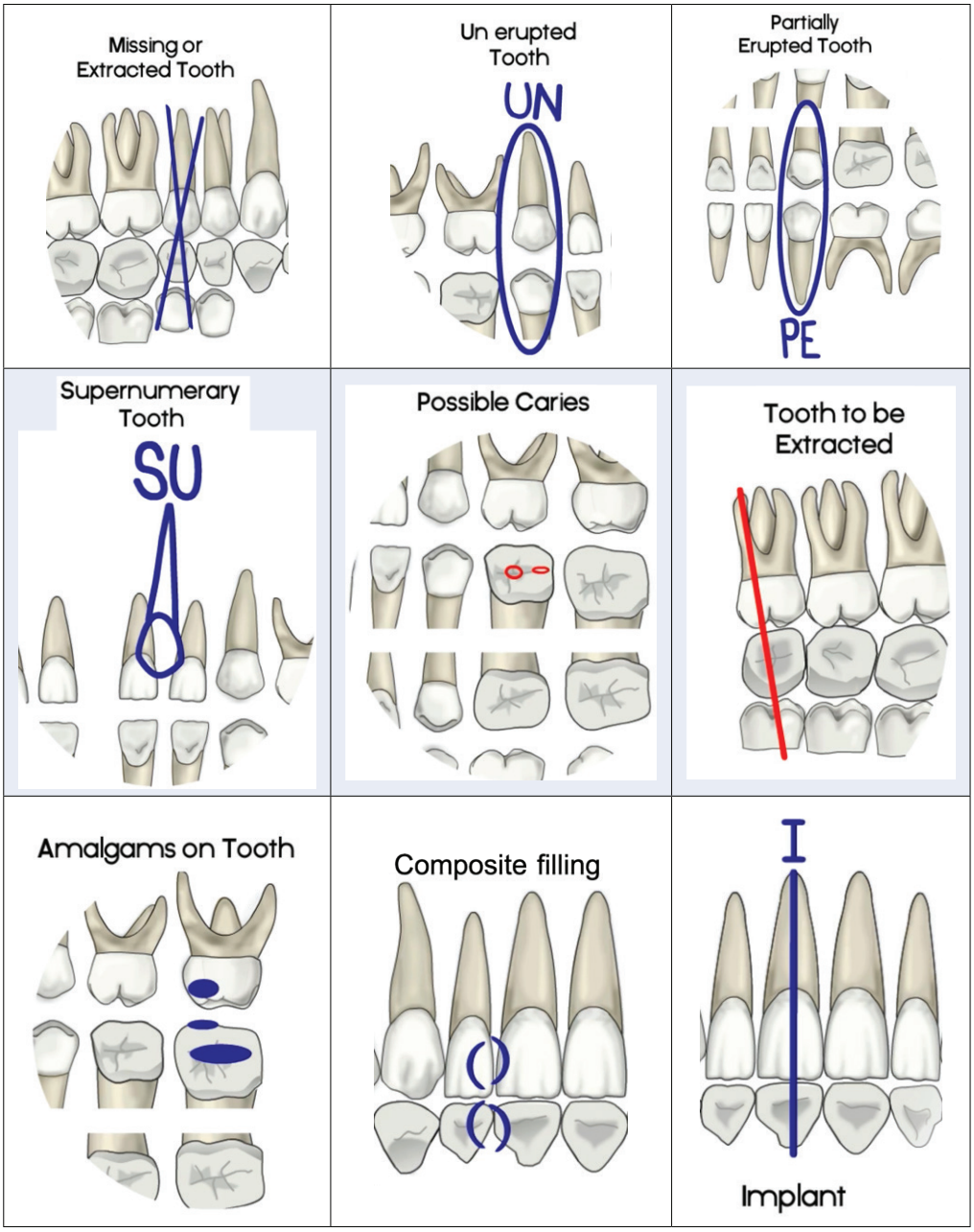
How to document it?

- After taking FULL medical ,dental and social history, diagnostic models , Panoramic x-ray, extra and intraoral radiographs, dental chart coding , one for existing dental condition and the other for the tentative treatment plan.
- Each step taken in the treatment will be documented I its proper post chart.

What is chart coding?

- They are special codes for each existing dental situation and for each dental treatment.
- Candidates should learn the codes and use them in the existing dental situation chart and in tentative treatment plan chart.

CHARTING CODES



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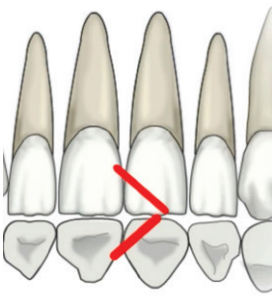
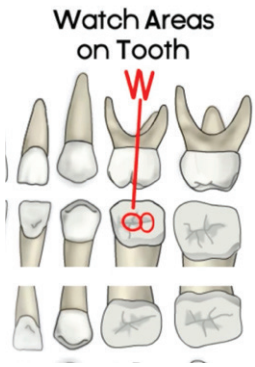
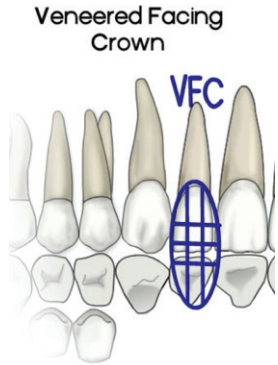
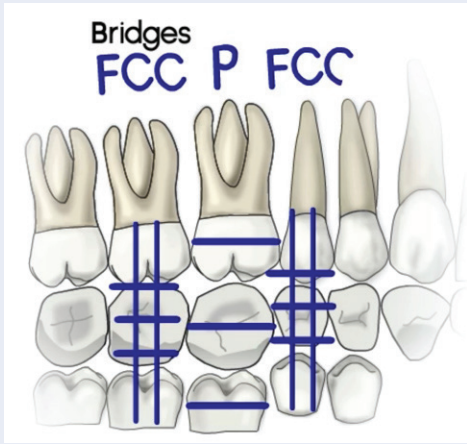
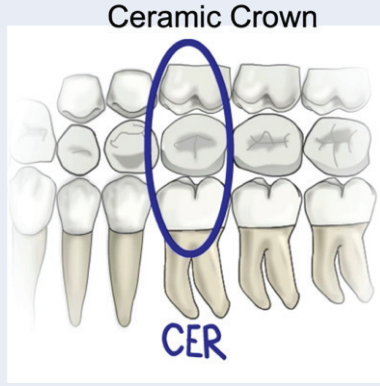


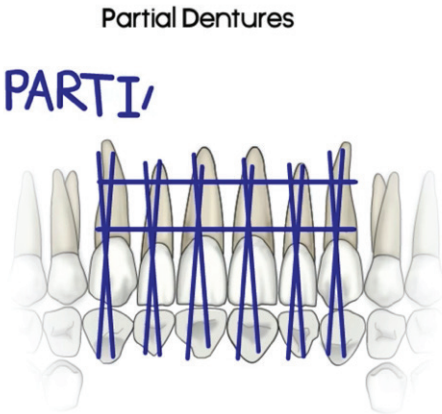
Fractured Tooth

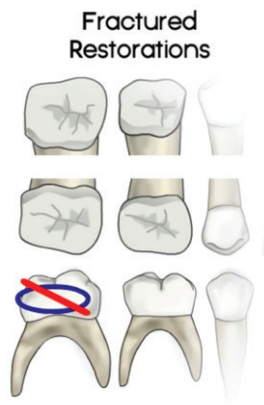












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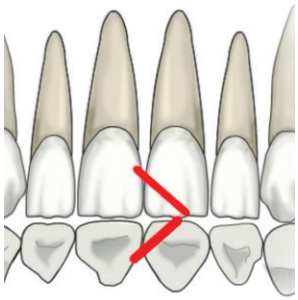

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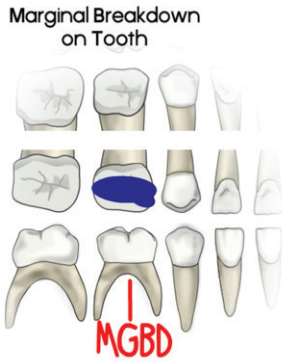

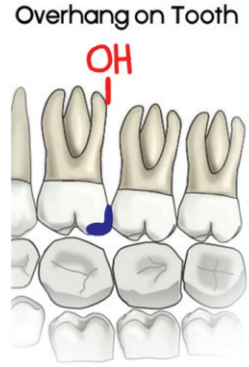

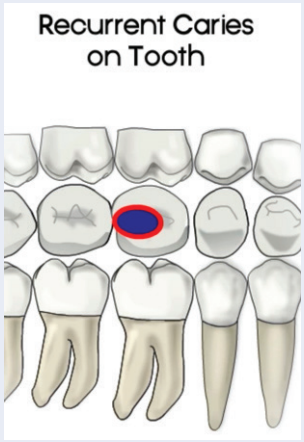

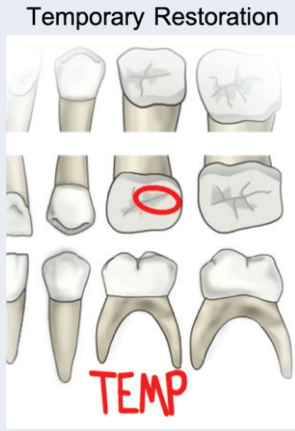

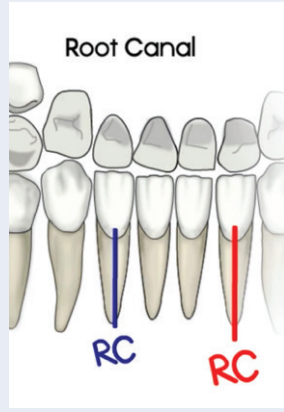

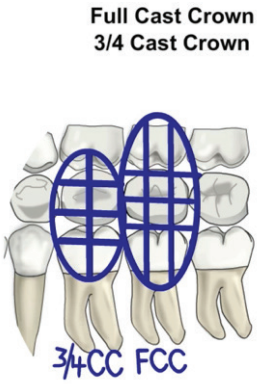

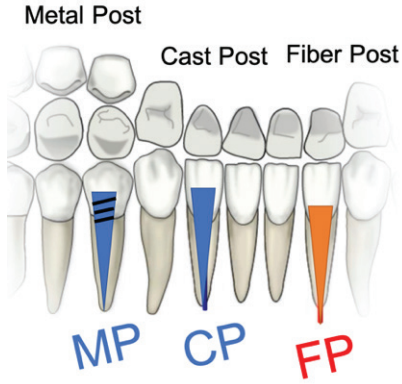

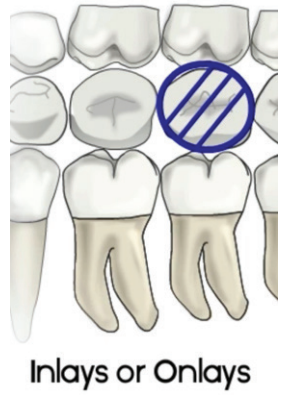

Inlays or Onlays

CCC NO:

Patient Information

Patient's Name: .....

Marital Status: .....

Birthdate (not age) : .....

Occupation: .....

Address: .....

City: .....

Home Phone: .....

Work Phone: .....

Cell Phone: .....

E-Mail: .....

Notes: .....

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Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Last First Middle | Home Phone: Include area code ( ) | Business/Cell Phone: Include area code ( )

Address: Mailing address | City: | State: | Zip:

Occupation: | Height: | Weight: | Date of Birth: | Sex: M F

SS# or Patient ID: | Emergency Contact: | Relationship: | Home Phone: Include area code ( ) | Cell Phone: Include area code ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name | Relationship

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *Please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐

If yes, how often? *(Check one:)* DAILY ☐ / WEEKLY ☐ / OCCASIONALLY ☐

Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?
Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: Include area code ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

Form S500

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?			
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?			
Date: ____ If yes, have you had any complications? ____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?			
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?			
Date Treatment began:			

	Yes	No	DK
Do you use controlled substances (drugs)?			
Do you use tobacco (smoking, snuff, chew, bidis)?			
If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?			
If yes, how much alcohol did you drink in the last 24 hours? ____			
If yes, how much do you typically drink i n a week? ____			
WOMEN ONLY Are you:			
Pregnant?			
Number of weeks: ____			
Taking birth control pills or hormonal replacement?			
Nursing?			

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics ____			
Aspirin ____			
Penicillin or other antibiotics ____			
Barbiturates, sedatives, or sleeping pills ____			
Sulfa drugs ____			
Codeine or other narcotics ____			
Metals ____			
Latex (rubber) ____			
Iodine ____			
Hay fever/seasonal ____			
Animals ____			
Food ____			
Other ____			

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve			
Previous infective endocarditis			
Damaged valves in transplanted heart			
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD			
Repaired (completely) in last 6 months			
Repaired CHD with residual defects			

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease			
Angina			
Arteriosclerosis			
Congestive heart failure			
Damaged heart valves			
Heart attack			
Heart murmur			
Low blood pressure			
High blood pressure			
Other congenital heart defects			
Mitral valve prolapse			
Pacemaker			
Rheumatic fever			
Rheumatic heart disease			
Abnormal bleeding			
Anemia			
Blood transfusion If yes, date: ____			
Hemophilia			
AIDS or HIV infection			
Arthritis			
Autoimmune disease			
Rheumatoid arthritis			
Systemic lupus erythematosus			
Asthma			
Bronchitis			
Emphysema			
Sinus trouble			
Tuberculosis			
Cancer/Chemotherapy/ Radiation Treatment			
Chest pain upon exertion			
Chronic pain			
Diabetes Type I or II			
Eating disorder			
Malnutrition			
Gastrointestinal disease			
G.E. Reflux/persistent heartburn			
Ulcers			
Thyroid problems			
Stroke			
Glaucoma			
Hepatitis, jaundice or liver disease			
Epilepsy			
Fainting spells or seizures			
Neurological disorders If yes, specify: ____			
Sleep disorder			
Do you snore?			
Mental health disorders Specify: ____			
Recurrent Infections Type of infection: ____			
Kidney problems			
Night sweats			
Osteoporosis			
Persistent swollen glands in neck			
Severe headaches/ migraines			
Severe or rapid weight loss			
Sexually transmitted disease			
Excessive urination			

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?			

Name of physician or dentist making recommendation: ____ Phone: *Include area code* ( ) ____

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about?			

Please explain: ____

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: ____ Date: ____

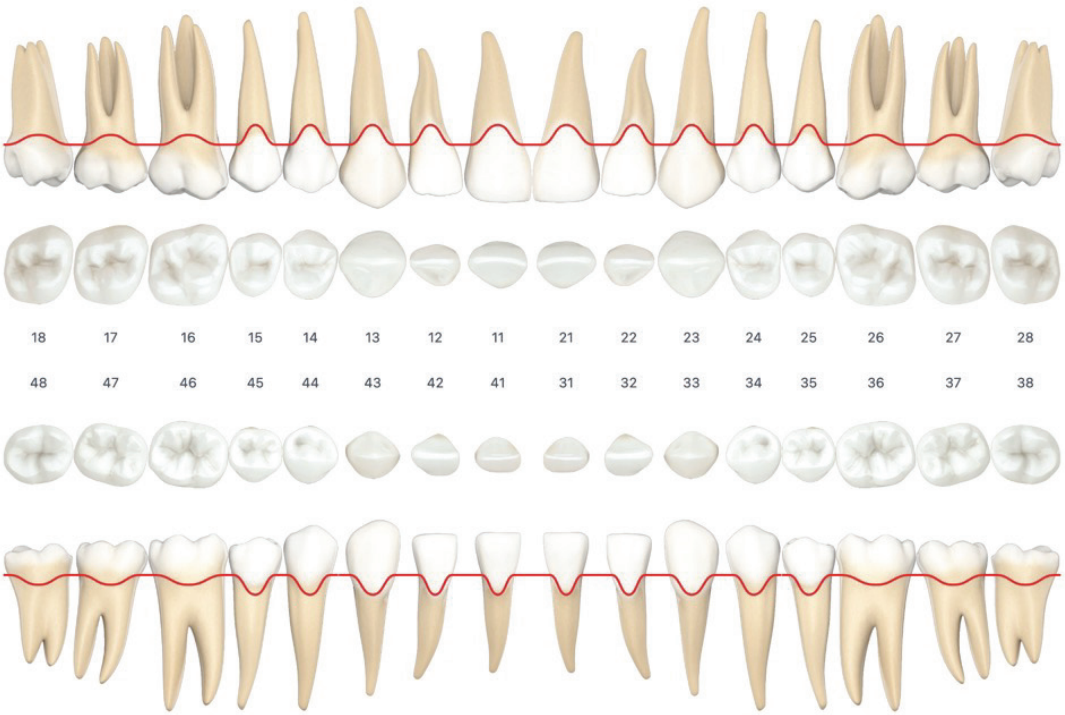
Signature of Dentist: ____ Date: ____

FOR COMPLETION BY DENTIST

Comments: ____

CCC NO:

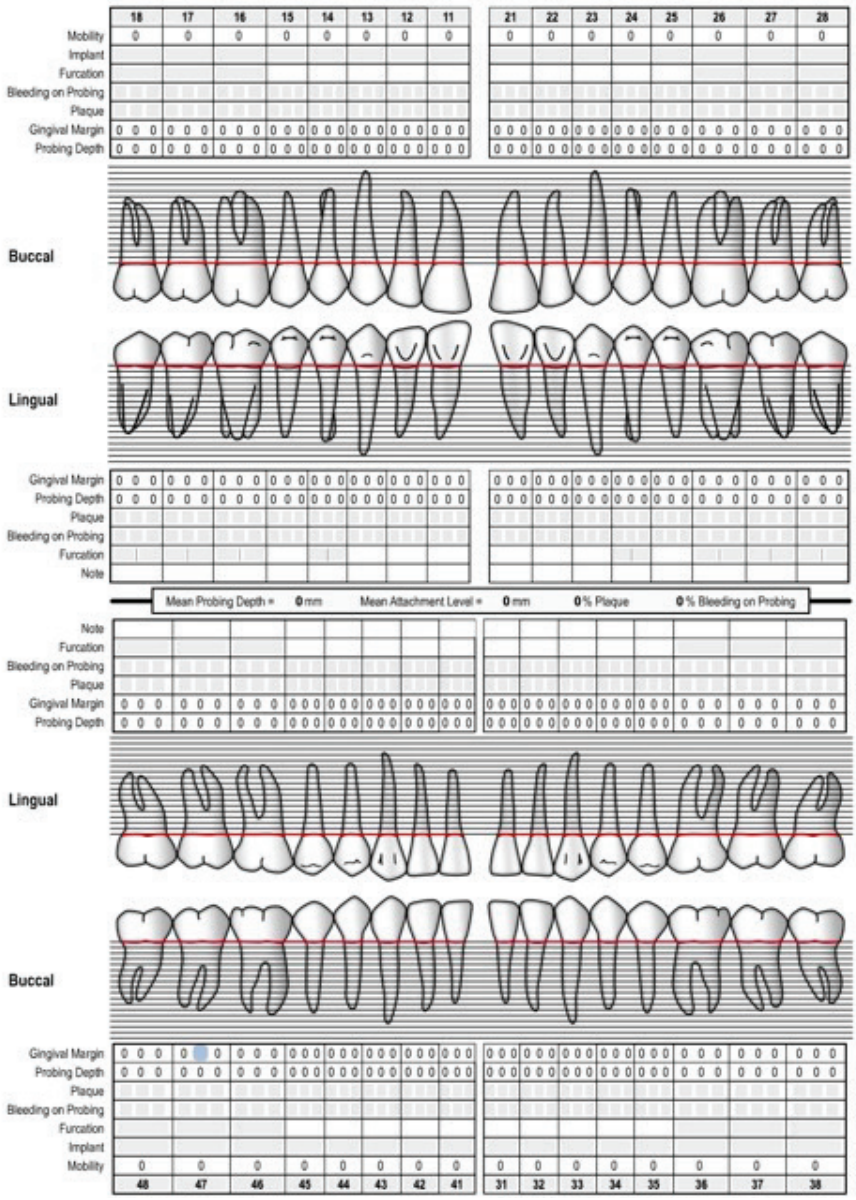
PRESENT DENTAL CONDITION



CCC NO:

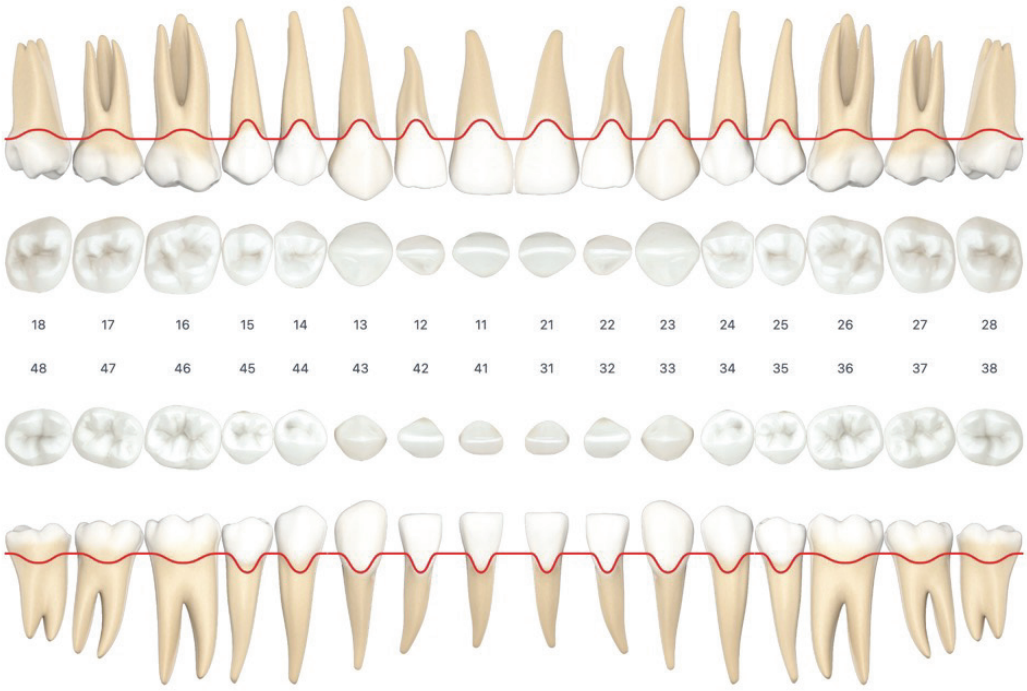
CCC NO:

PRESENT DENTAL CONDITION



CCC NO:

TENTATIVE CARE PLAN



CCC NO:

CCC NO:

Patient Name	

PROCEDURE	Point/s	Signature/Date
One arch scaling	1	
One arch scaling, root planning and curettage	1	
Depigmentation	2	
Functional Crown lengthening	2	
Esthetic Crown lengthening	3	
Gingivectomy	3	

Patient Name	

PROCEDURE	Point/s	Signature/Date
One arch scaling	1	
One arch scaling, root planning and curettage	1	
Depigmentation	2	
Functional Crown lengthening	2	
Esthetic Crown lengthening	3	
Gingivectomy	3	

CCC NO:

Patient Name	

PROCEDURE	Point/s	Signature/Date
One arch scaling	1	
One arch scaling, root planning and curettage	1	
Depigmentation	2	
Functional Crown lengthening	2	
Esthetic Crown lengthening	3	
Gingivectomy	3	

Patient Name	

PROCEDURE	Point/s	Signature/Date
One arch scaling	1	
One arch scaling, root planning and curettage	1	
Depigmentation	2	
Functional Crown lengthening	2	
Esthetic Crown lengthening	3	
Gingivectomy	3	

CCC NO:

Patient Name	

PROCEDURE	Point/s	Signature/Date
One arch scaling	1	
One arch scaling, root planning and curettage	1	
Depigmentation	2	
Functional Crown lengthening	2	
Esthetic Crown lengthening	3	
Gingivectomy	3	

Patient Name	

PROCEDURE	Point/s	Signature/Date
One arch scaling	1	
One arch scaling, root planning and curettage	1	
Depigmentation	2	
Functional Crown lengthening	2	
Esthetic Crown lengthening	3	
Gingivectomy	3	

CCC NO:

Patient Name	

PROCEDURE	Point/s	Signature/Date
Simple extraction	0.5	
Surgical extraction/ Impaction	2	
Closure of oroantral fistula	2	
Apicectomy	2	
Management of dry socket	1	
Implant placement	2	

Patient Name	

PROCEDURE	Point/s	Signature/Date
Simple extraction	0.5	
Surgical extraction/ Impaction	2	
Closure of oroantral fistula	2	
Apicectomy	2	
Management of dry socket	1	
Implant placement	2	

CCC NO:

Patient Name	

PROCEDURE	Point/s	Signature/Date
Simple extraction	0.5	
Surgical extraction/ Impaction	2	
Closure of oroantral fistula	2	
Apicectomy	2	
Management of dry socket	1	
Implant placement	2	

Patient Name	

PROCEDURE	Point/s	Signature/Date
Simple extraction	0.5	
Surgical extraction/ Impaction	2	
Closure of oroantral fistula	2	
Apicectomy	2	
Management of dry socket	1	
Implant placement	2	

CCC NO:

SINGLE ROOTED ENDO TTT

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	1	
Obturation	1	
TOTAL	2	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	1	
Obturation	1	
TOTAL	2	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	1	
Obturation	1	
TOTAL	2	

CCC NO:

SINGLE ROOTED ENDO TTT

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	1	
Obturation	1	
TOTAL	2	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	1	
Obturation	1	
TOTAL	2	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	1	
Obturation	1	
TOTAL	2	

CCC NO:

MULTIPLE ROOTED ENDO TTT

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	2	
TOTAL	4	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	2	
TOTAL	4	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	2	
TOTAL	4	

CCC NO:

MULTIPLE ROOTED ENDO TTT

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	2	
TOTAL	4	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	2	
TOTAL	4	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	2	
TOTAL	4	

CCC NO:

MULTIPLE ROOTED ENDO TTT

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	2	
TOTAL	4	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	2	
TOTAL	4	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	2	
TOTAL	4	

CCC NO:

MULTIPLE ROOTED ENDO TTT

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	2	
TOTAL	4	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	2	
TOTAL	4	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	2	
TOTAL	4	

CCC NO:

MULTIPLE ROOTED ENDO TTT

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	2	
TOTAL	4	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	2	
TOTAL	4	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	2	
TOTAL	4	

CCC NO:

SINGLE ROOTED ENDO RE TT

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	1	
TOTAL	3	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	1	
TOTAL	3	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	1	
TOTAL	3	

CCC NO:

SINGLE ROOTED ENDO RE TT

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	1	
TOTAL	3	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	1	
TOTAL	3	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	1	
TOTAL	3	

CCC NO:

SINGLE ROOTED ENDO RE TT

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	1	
TOTAL	3	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	1	
TOTAL	3	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	1	
TOTAL	3	

CCC NO:

SINGLE ROOTED ENDO RE TT

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	1	
TOTAL	3	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	1	
TOTAL	3	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	1	
TOTAL	3	

CCC NO:

SINGLE ROOTED ENDO RE TT

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	1	
TOTAL	3	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	1	
TOTAL	3	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	2	
Obturation	1	
TOTAL	3	

CCC NO:

MULTIPLE ROOTED ENDO RE TTT

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	4	
Obturation	2	
TOTAL	6	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	4	
Obturation	2	
TOTAL	6	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	4	
Obturation	2	
TOTAL	6	

CCC NO:

MULTIPLE ROOTED ENDO RE TTT

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	4	
Obturation	2	
TOTAL	6	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	4	
Obturation	2	
TOTAL	6	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	4	
Obturation	2	
TOTAL	6	

CCC NO:

MULTIPLE ROOTED ENDO RE TTT

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	4	
Obturation	2	
TOTAL	6	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	4	
Obturation	2	
TOTAL	6	

Patient Name	

STEP	Point/s	Signature/date
Cleaning and shaping	4	
Obturation	2	
TOTAL	6	

CCC NO:

MULTIPLE ROOTED ENDO RE TTT

Patient Name		

STEP	Point/s	Signature/date
Cleaning and shaping	4	
Obturation	2	
TOTAL	6	

Patient Name		

STEP	Point/s	Signature/date
Cleaning and shaping	4	
Obturation	2	
TOTAL	6	

Patient Name		

STEP	Point/s	Signature/date
Cleaning and shaping	4	
Obturation	2	
TOTAL	6	

CCC NO:

MULTIPLE ROOTED ENDO RE TTT

Patient Name		

STEP	Point/s	Signature/date
Cleaning and shaping	4	
Obturation	2	
TOTAL	6	

Patient Name		

STEP	Point/s	Signature/date
Cleaning and shaping	4	
Obturation	2	
TOTAL	6	

Patient Name		

STEP	Point/s	Signature/date
Cleaning and shaping	4	
Obturation	2	
TOTAL	6	

CCC NO:

DIRECT COMPOSITE VENEER

Patient Name	

STEP	Point/s	Signature/date
Each tooth prep	1	
Each tooth direct composite overlay	2	
Each tooth finishing and polishing	1	
TOTAL	4	

Patient Name	

STEP	Point/s	Signature/date
Each tooth prep	1	
Each tooth direct composite overlay	2	
Each tooth finishing and polishing	1	
TOTAL	4	

Patient Name	

STEP	Point/s	Signature/date
Each tooth prep	1	
Each tooth direct composite overlay	2	
Each tooth finishing and polishing	1	
TOTAL	4	

CCC NO:

DIRECT COMPOSITE VENEER

Patient Name	

STEP	Point/s	Signature/date
Each tooth prep	1	
Each tooth direct composite overlay	2	
Each tooth finishing and polishing	1	
TOTAL	4	

Patient Name	

STEP	Point/s	Signature/date
Each tooth prep	1	
Each tooth direct composite overlay	2	
Each tooth finishing and polishing	1	
TOTAL	4	

Patient Name	

STEP	Point/s	Signature/date
Each tooth prep	1	
Each tooth direct composite overlay	2	
Each tooth finishing and polishing	1	
TOTAL	4	

CCC NO:

DIRECT COMPOSITE VENEER

Patient Name	

STEP	Point/s	Signature/date
Each tooth prep	1	
Each tooth direct composite overlay	2	
Each tooth finishing and polishing	1	
TOTAL	4	

Patient Name	

STEP	Point/s	Signature/date
Each tooth prep	1	
Each tooth direct composite overlay	2	
Each tooth finishing and polishing	1	
TOTAL	4	

Patient Name	

STEP	Point/s	Signature/date
Each tooth prep	1	
Each tooth direct composite overlay	2	
Each tooth finishing and polishing	1	
TOTAL	4	

SU

FACULTY OF DENTISTRY SU

CCC NO:

DIRECT COMPOSITE VENEER

Patient Name	

STEP	Point/s	Signature/date
Each tooth prep	1	
Each tooth direct composite overlay	2	
Each tooth finishing and polishing	1	
TOTAL	4	

Patient Name	

STEP	Point/s	Signature/date
Each tooth prep	1	
Each tooth direct composite overlay	2	
Each tooth finishing and polishing	1	
TOTAL	4	

Patient Name	

STEP	Point/s	Signature/date
Each tooth prep	1	
Each tooth direct composite overlay	2	
Each tooth finishing and polishing	1	
TOTAL	4	

CCC NO:

DIRECT COMPOSITE VENEER

Patient Name		

STEP	Point/s	Signature/date
Each tooth prep	1	
Each tooth direct composite overlay	2	
Each tooth finishing and polishing	1	
TOTAL	4	

Patient Name		

STEP	Point/s	Signature/date
Each tooth prep	1	
Each tooth direct composite overlay	2	
Each tooth finishing and polishing	1	
TOTAL	4	

Patient Name		

STEP	Point/s	Signature/date
Each tooth prep	1	
Each tooth direct composite overlay	2	
Each tooth finishing and polishing	1	
TOTAL	4	

CCC NO:

CLASS I / III/ V COMPOSITE

Patient Name	

STEP	Point/s	Signature/date
Cavity prep	0.5	
Composite filling	1.5	
TOTAL	2	

Patient Name	

STEP	Point/s	Signature/date
Cavity prep	0.5	
Composite filling	1.5	
TOTAL	2	

Patient Name	

STEP	Point/s	Signature/date
Cavity prep	0.5	
Composite filling	1.5	
TOTAL	2	

CCC NO:

CLASS I / III/ V COMPOSITE

Patient Name	

STEP	Point/s	Signature/date
Cavity prep	0.5	
Composite filling	1.5	
TOTAL	2	

Patient Name	

STEP	Point/s	Signature/date
Cavity prep	0.5	
Composite filling	1.5	
TOTAL	2	

Patient Name	

STEP	Point/s	Signature/date
Cavity prep	0.5	
Composite filling	1.5	
TOTAL	2	

CCC NO:

CLASS I / III/ V COMPOSITE

Patient Name	

STEP	Point/s	Signature/date
Cavity prep	0.5	
Composite filling	1.5	
TOTAL	2	

Patient Name	

STEP	Point/s	Signature/date
Cavity prep	0.5	
Composite filling	1.5	
TOTAL	2	

Patient Name	

STEP	Point/s	Signature/date
Cavity prep	0.5	
Composite filling	1.5	
TOTAL	2	

CCC NO:

CLASS I / III/ V COMPOSITE

Patient Name	

STEP	Point/s	Signature/date
Cavity prep	0.5	
Composite filling	1.5	
TOTAL	2	

Patient Name	

STEP	Point/s	Signature/date
Cavity prep	0.5	
Composite filling	1.5	
TOTAL	2	

Patient Name	

STEP	Point/s	Signature/date
Cavity prep	0.5	
Composite filling	1.5	
TOTAL	2	

CCC NO:

CLASS II / IV COMPOSITE

Patient Name	

STEP	Point/s	Signature/date
Cavity prep	1.5	
Composite filling	1.5	
TOTAL	3	

Patient Name	

STEP	Point/s	Signature/date
Cavity prep	1.5	
Composite filling	1.5	
TOTAL	3	

Patient Name	

STEP	Point/s	Signature/date
Cavity prep	1.5	
Composite filling	1.5	
TOTAL	3	

CCC NO:

CLASS II / IV COMPOSITE

Patient Name	

STEP	Point/s	Signature/date
Cavity prep	1.5	
Composite filling	1.5	
TOTAL	3	

Patient Name	

STEP	Point/s	Signature/date
Cavity prep	1.5	
Composite filling	1.5	
TOTAL	3	

Patient Name	

STEP	Point/s	Signature/date
Cavity prep	1.5	
Composite filling	1.5	
TOTAL	3	

CCC NO:

CLASS II / IV COMPOSITE

Patient Name	

STEP	Point/s	Signature/date
Cavity prep	1.5	
Composite filling	1.5	
TOTAL	3	

Patient Name	

STEP	Point/s	Signature/date
Cavity prep	1.5	
Composite filling	1.5	
TOTAL	3	

Patient Name	

STEP	Point/s	Signature/date
Cavity prep	1.5	
Composite filling	1.5	
TOTAL	3	

CCC NO:

CLASS II / IV COMPOSITE

Patient Name	

STEP	Point/s	Signature/date
Cavity prep	1.5	
Composite filling	1.5	
TOTAL	3	

Patient Name	

STEP	Point/s	Signature/date
Cavity prep	1.5	
Composite filling	1.5	
TOTAL	3	

Patient Name	

STEP	Point/s	Signature/date
Cavity prep	1.5	
Composite filling	1.5	
TOTAL	3	

CCC NO:

CLASS II / IV COMPOSITE

Patient Name	

STEP	Point/s	Signature/date
Cavity prep	1.5	
Composite filling	1.5	
TOTAL	3	

Patient Name	

STEP	Point/s	Signature/date
Cavity prep	1.5	
Composite filling	1.5	
TOTAL	3	

Patient Name	

STEP	Point/s	Signature/date
Cavity prep	1.5	
Composite filling	1.5	
TOTAL	3	

CCC NO:

COMPOSITE INALY/ONLAY/OVERLAY

Patient Name	

STEP	Point/s	Signature/date
Each abutment prep	0.5	
2ry impression/provisional	1	
Each tooth Try in/Cementation	0.5	
TOTAL	2	

Patient Name	

STEP	Point/s	Signature/date
Each abutment prep	0.5	
2ry impression/provisional	1	
Each tooth Try in/Cementation	0.5	
TOTAL	2	

Patient Name	

STEP	Point/s	Signature/date
Each abutment prep	0.5	
2ry impression/provisional	1	
Each tooth Try in/Cementation	0.5	
TOTAL	2	

CCC NO:

COMPOSITE INALY/ONLAY/OVERLAY

Patient Name	

STEP	Point/s	Signature/date
Each abutment prep	0.5	
2ry impression/provisional	1	
Each tooth Try in/Cementation	0.5	
TOTAL	2	

Patient Name	

STEP	Point/s	Signature/date
Each abutment prep	0.5	
2ry impression/provisional	1	
Each tooth Try in/Cementation	0.5	
TOTAL	2	

Patient Name	

STEP	Point/s	Signature/date
Each abutment prep	0.5	
2ry impression/provisional	1	
Each tooth Try in/Cementation	0.5	
TOTAL	2	

CCC NO:

CROWN OR FIXED DENTAL PROSTHESIS

Patient Name	

PROCEDURE	Point/s	Signature/Date
1ry impression/ study cast	0.5	
Each abutment prep	1	
2ry impression	1	
Provisional	1	
Try in	1	
Cementation	0.5	
TOTAL	5	

Patient Name	

PROCEDURE	Point/s	Signature/Date
1ry impression/ study cast	0.5	
Each abutment prep	1	
2ry impression	1	
Provisional	1	
Try in	1	
Cementation	0.5	
TOTAL	5	

CCC NO:

CROWN OR FIXED DENTAL PROSTHESIS

Patient Name	

PROCEDURE	Point/s	Signature/Date
1ry impression/ study cast	0.5	
Each abutment prep	1	
2ry impression	1	
Provisional	1	
Try in	1	
Cementation	0.5	
TOTAL	5	

Patient Name	

PROCEDURE	Point/s	Signature/Date
1ry impression/ study cast	0.5	
Each abutment prep	1	
2ry impression	1	
Provisional	1	
Try in	1	
Cementation	0.5	
TOTAL	5	

CCC NO:

CROWN OR FIXED DENTAL PROSTHESIS

Patient Name	

PROCEDURE	Point/s	Signature/Date
1ry impression/ study cast	0.5	
Each abutment prep	1	
2ry impression	1	
Provisional	1	
Try in	1	
Cementation	0.5	
TOTAL	5	

Patient Name	

PROCEDURE	Point/s	Signature/Date
1ry impression/ study cast	0.5	
Each abutment prep	1	
2ry impression	1	
Provisional	1	
Try in	1	
Cementation	0.5	
TOTAL	5	

CCC NO:

FIBER POST/CORE AND CROWN

Patient Name	

PROCEDURE	Point/s	Signature/Date
Post space prep	0.5	
Post cementation	0.5	
Core construction/Prep	1	
2ry impression	1	
Provisional	1	
Crown Try in	0.5	
Crown Cementation	0.5	
TOTAL	5	

Patient Name	

PROCEDURE	Point/s	Signature/Date
Post space prep	0.5	
Post cementation	0.5	
Core construction/Prep	1	
2ry impression	1	
Provisional	1	
Crown Try in	0.5	
Crown Cementation	0.5	
TOTAL	5	

CCC NO:

FIBER POST/CORE AND CROWN

Patient Name	

PROCEDURE	Point/s	Signature/Date
Post space prep	0.5	
Post cementation	0.5	
Core construction/Prep	1	
2ry impression	1	
Provisional	1	
Crown Try in	0.5	
Crown Cementation	0.5	
TOTAL	5	

Patient Name	

PROCEDURE	Point/s	Signature/Date
Post space prep	0.5	
Post cementation	0.5	
Core construction/Prep	1	
2ry impression	1	
Provisional	1	
Crown Try in	0.5	
Crown Cementation	0.5	
TOTAL	5	

CCC NO:

FIBER POST/CORE AND CROWN

Patient Name	

PROCEDURE	Point/s	Signature/Date
Post space prep	0.5	
Post cementation	0.5	
Core construction/Prep	1	
2ry impression	1	
Provisional	1	
Crown Try in	0.5	
Crown Cementation	0.5	
TOTAL	5	

Patient Name	

PROCEDURE	Point/s	Signature/Date
Post space prep	0.5	
Post cementation	0.5	
Core construction/Prep	1	
2ry impression	1	
Provisional	1	
Crown Try in	0.5	
Crown Cementation	0.5	
TOTAL	5	

CCC NO:

FIBER POST/CORE AND CROWN

Patient Name	

PROCEDURE	Point/s	Signature/Date
Post space prep	0.5	
Post cementation	0.5	
Core construction/Prep	1	
2ry impression	1	
Provisional	1	
Crown Try in	0.5	
Crown Cementation	0.5	
TOTAL	5	

Patient Name	

PROCEDURE	Point/s	Signature/Date
Post space prep	0.5	
Post cementation	0.5	
Core construction/Prep	1	
2ry impression	1	
Provisional	1	
Crown Try in	0.5	
Crown Cementation	0.5	
TOTAL	5	

CCC NO:

NAYYAR CORE AND CROWN

Patient Name	

PROCEDURE	Point/s	Signature/Date
Pulp chamber cleaning	0.5	
Core construction/ prep	1	
2ry impression	1	
Provisional	1	
Crown Try in	0.5	
Crown Cementation	0.5	
TOTAL	4.5	

Patient Name	

PROCEDURE	Point/s	Signature/Date
Pulp chamber cleaning	0.5	
Core construction/ prep	1	
2ry impression	1	
Provisional	1	
Crown Try in	0.5	
Crown Cementation	0.5	
TOTAL	4.5	

CCC NO:

NAYYAR CORE AND CROWN

Patient Name	

PROCEDURE	Point/s	Signature/Date
Pulp chamber cleaning	0.5	
Core construction/ prep	1	
2ry impression	1	
Provisional	1	
Crown Try in	0.5	
Crown Cementation	0.5	
TOTAL	4.5	

Patient Name	

PROCEDURE	Point/s	Signature/Date
Pulp chamber cleaning	0.5	
Core construction/ prep	1	
2ry impression	1	
Provisional	1	
Crown Try in	0.5	
Crown Cementation	0.5	
TOTAL	4.5	

CCC NO:

NAYYAR CORE AND CROWN

Patient Name	

PROCEDURE	Point/s	Signature/Date
Pulp chamber cleaning	0.5	
Core construction/ prep	1	
2ry impression	1	
Provisional	1	
Crown Try in	0.5	
Crown Cementation	0.5	
TOTAL	4.5	

Patient Name	

PROCEDURE	Point/s	Signature/Date
Pulp chamber cleaning	0.5	
Core construction/ prep	1	
2ry impression	1	
Provisional	1	
Crown Try in	0.5	
Crown Cementation	0.5	
TOTAL	4.5	

CCC NO:

NAYYAR CORE AND CROWN

Patient Name	

PROCEDURE	Point/s	Signature/Date
Pulp chamber cleaning	0.5	
Core construction/ prep	1	
2ry impression	1	
Provisional	1	
Crown Try in	0.5	
Crown Cementation	0.5	
TOTAL	4.5	

Patient Name	

PROCEDURE	Point/s	Signature/Date
Pulp chamber cleaning	0.5	
Core construction/ prep	1	
2ry impression	1	
Provisional	1	
Crown Try in	0.5	
Crown Cementation	0.5	
TOTAL	4.5	

CCC NO:

ENDO CROWN

Patient Name	

PROCEDURE	Point/s	Signature/Date
Pulp chamber cleaning	0.5	
2ry impression	1	
Provisional	1	
Crown Try in	0.5	
Crown Cementation	0.5	
TOTAL	3.5	

Patient Name	

PROCEDURE	Point/s	Signature/Date
Pulp chamber cleaning	0.5	
2ry impression	1	
Provisional	1	
Crown Try in	0.5	
Crown Cementation	0.5	
TOTAL	3.5	

CCC NO:

ENDO CROWN

Patient Name	

PROCEDURE	Point/s	Signature/Date
Pulp chamber cleaning	0.5	
2ry impression	1	
Provisional	1	
Crown Try in	0.5	
Crown Cementation	0.5	
TOTAL	3.5	

Patient Name	

PROCEDURE	Point/s	Signature/Date
Pulp chamber cleaning	0.5	
2ry impression	1	
Provisional	1	
Crown Try in	0.5	
Crown Cementation	0.5	
TOTAL	3.5	

CCC NO:

ENDO CROWN

Patient Name	

PROCEDURE	Point/s	Signature/Date
Pulp chamber cleaning	0.5	
2ry impression	1	
Provisional	1	
Crown Try in	0.5	
Crown Cementation	0.5	
TOTAL	3.5	

Patient Name	

PROCEDURE	Point/s	Signature/Date
Pulp chamber cleaning	0.5	
2ry impression	1	
Provisional	1	
Crown Try in	0.5	
Crown Cementation	0.5	
TOTAL	3.5	

CCC NO:

CERAMIC VENEER

Patient Name	

PROCEDURE	Point/s	Signature/Date
1ry impression/ study cast	0.5	
Each abutment prep	0.5	
2ry impression	1	
Provisional	1	
Each abutment Try in/ Cementation	0.5	
TOTAL	3.5	

Patient Name	

PROCEDURE	Point/s	Signature/Date
1ry impression/ study cast	0.5	
Each abutment prep	0.5	
2ry impression	1	
Provisional	1	
Each abutment Try in/ Cementation	0.5	
TOTAL	3.5	

CCC NO:

CROWN/FDP OVER IMPLANT

Patient Name	

PROCEDURE	Point/s	Signature/Date
Abutment selection	0.5	
Implant level impression	1	
Each implant temporization	1	
Try in	1	
Cementation	1	
TOTAL	4.5	

Patient Name	

PROCEDURE	Point/s	Signature/Date
Abutment selection	0.5	
Implant level impression	1	
Each implant temporization	1	
Try in	1	
Cementation	1	
TOTAL	4.5	

CCC NO:

CERAMIC INALY/ONLAY/OVERLAY

Patient Name	

PROCEDURE	Point/s	Signature/Date
1ry impression/ study cast	0.5	
Each tooth prep	0.5	
2ry impression/provisional	1	
Each tooth Try in/Cementation	1	
TOTAL	3	

Patient Name	

PROCEDURE	Point/s	Signature/Date
1ry impression/ study cast	0.5	
Each tooth prep	0.5	
2ry impression/provisional	1	
Each tooth Try in/Cementation	1	
TOTAL	3	

CCC NO:

PARTIAL DENTURE

Patient Name	

PROCEDURE	Point/s	Signature/Date
1ry impression	2	
Mouth prep	1	
2ry impression	1	
Metal try in	0.5	
Jaw relationship	0.5	
Try in waxed teeth	0.5	
Final insertion	1	
TOTAL	6.5	

Patient Name	

PROCEDURE	Point/s	Signature/Date
1ry impression	2	
Mouth prep	1	
2ry impression	1	
Metal try in	0.5	
Jaw relationship	0.5	
Try in waxed teeth	0.5	
Final insertion	1	
TOTAL	6.5	

CCC NO:

COMPLETE / SINGLE DENTURE

Patient Name	

PROCEDURE	Point/s	Signature/Date
1ry impression	2	
2ry impression	2	
Bite registration	2	
Try in	1	
Delivery	1	
TOTAL	8	

Patient Name	

PROCEDURE	Point/s	Signature/Date
1ry impression	2	
2ry impression	2	
Bite registration	2	
Try in	1	
Delivery	1	
TOTAL	8	

CCC NO:

TOOTH SUPPORTED OVERDENTURE

Patient Name	

PROCEDURE	Point/s	Signature/Date
1ry impression	2	
Abutments prep	1	
2ry impression for coping	1	
2ry impression	2	
Bite registration	2	
Try in	0.5	
Delivery	0.5	
TOTAL	9	

Patient Name	

PROCEDURE	Point/s	Signature/Date
1ry impression	2	
Abutments prep	1	
2ry impression for coping	1	
2ry impression	2	
Bite registration	2	
Try in	0.5	
Delivery	0.5	
TOTAL	9	

CCC NO:

IMPLANT SUPPORTED OVERDENTURE

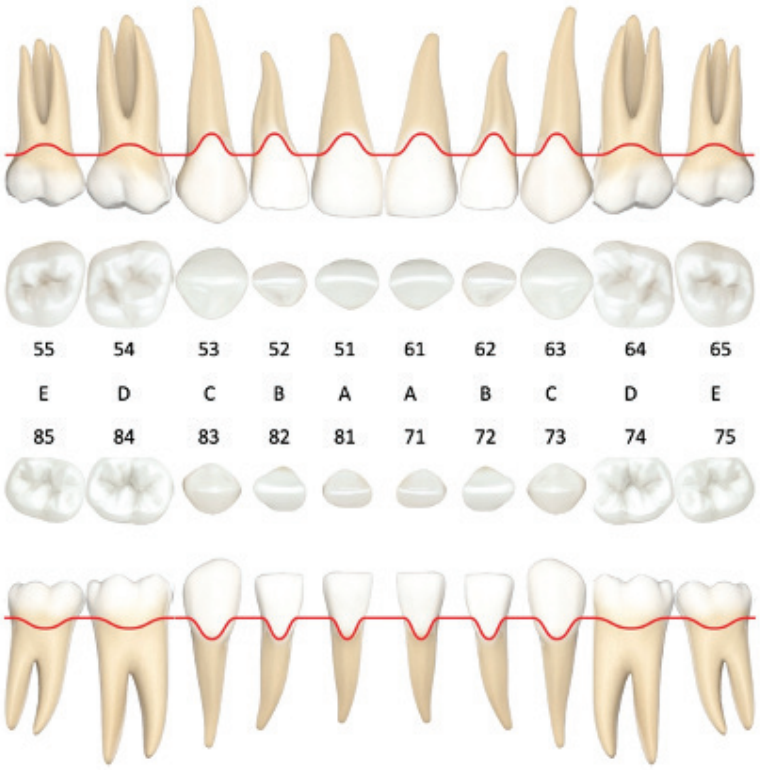
Patient Name	

PROCEDURE	Point/s	Signature/Date
Implant placement	2	
Healing Abutments	1	
Abutment selection placements	1	
2ry impression	2	
Bite registration	2	
Try in	0.5	
Delivery	0.5	
TOTAL	9	

Patient Name	

PROCEDURE	Point/s	Signature/Date
Implant placement	2	
Healing Abutments	1	
Abutment selection placements	1	
2ry impression	2	
Bite registration	2	
Try in	0.5	
Delivery	0.5	
TOTAL	9	

PEDO CASE NO: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E D C B A A B C D E
85 84 83 82 81 71 72 73 74 75

PEDO CASE NO:

PEDO CASE NO:

PEDO CASE NO:

Patient Name	

PROCEDURE	Point/s	Signature/Date
Class I,II Pedo	0.5	
Stainless steel crown	0.5	
Pulpotomy	1	
Pulpectomy	1.5	
Endodontic treatment For first permanent molar	2.5	
Revascularization	2	
Apexcification	2	
Apexogenesis	2	
Space maintainer	2	
Extraction	0.5	

PEDO CASE NO:

Patient Name	

PROCEDURE	Point/s	Signature/Date
Class I,II Pedo	0.5	
Stainless steel crown	0.5	
Pulpotomy	1	
Pulpectomy	1.5	
Endodontic treatment For first permanent molar	2.5	
Revascularization	2	
Apexcification	2	
Apexogenesis	2	
Space maintainer	2	
Extraction	0.5	

PEDO CASE NO:

Patient Name	

PROCEDURE	Point/s	Signature/Date
Class I,II Pedo	0.5	
Stainless steel crown	0.5	
Pulpotomy	1	
Pulpectomy	1.5	
Endodontic treatment For first permanent molar	2.5	
Revascularization	2	
Apexcification	2	
Apexogenesis	2	
Space maintainer	2	
Extraction	0.5	

PEDO CASE NO:

Patient Name	

PROCEDURE	Point/s	Signature/Date
Class I,II Pedo	0.5	
Stainless steel crown	0.5	
Pulpotomy	1	
Pulpectomy	1.5	
Endodontic treatment For first permanent molar	2.5	
Revascularization	2	
Apexcification	2	
Apexogenesis	2	
Space maintainer	2	
Extraction	0.5	


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