



This guide
describes the
**PreViser® Clinical
Suite**

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HIPAA / HITECH

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Version History

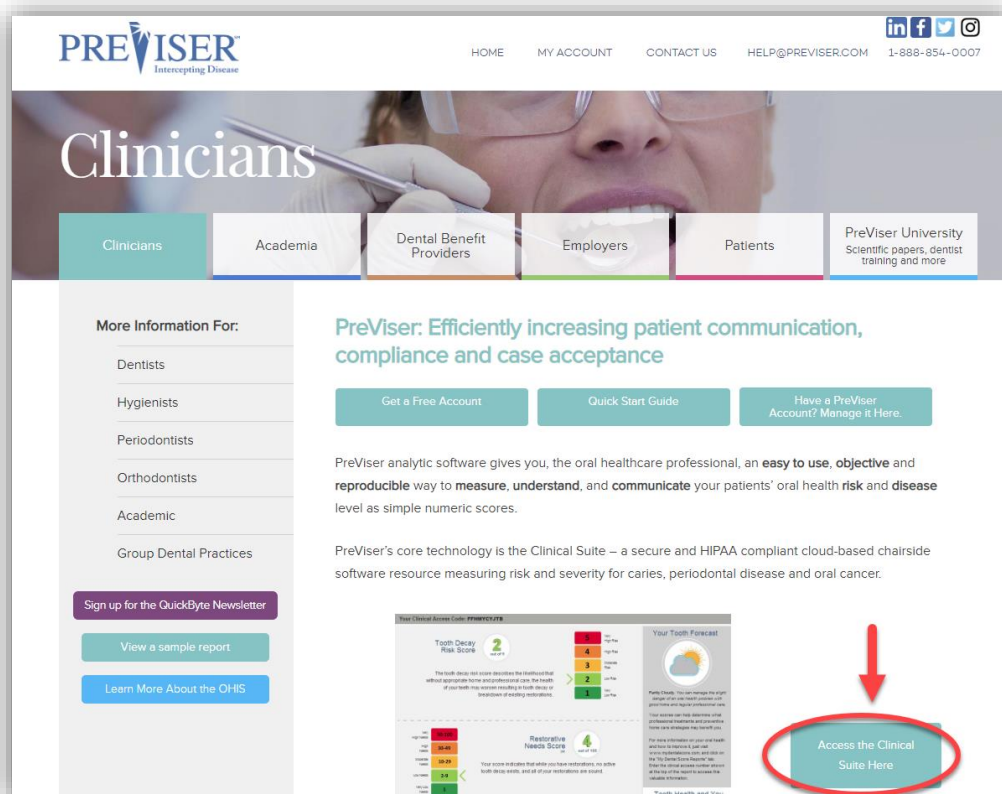
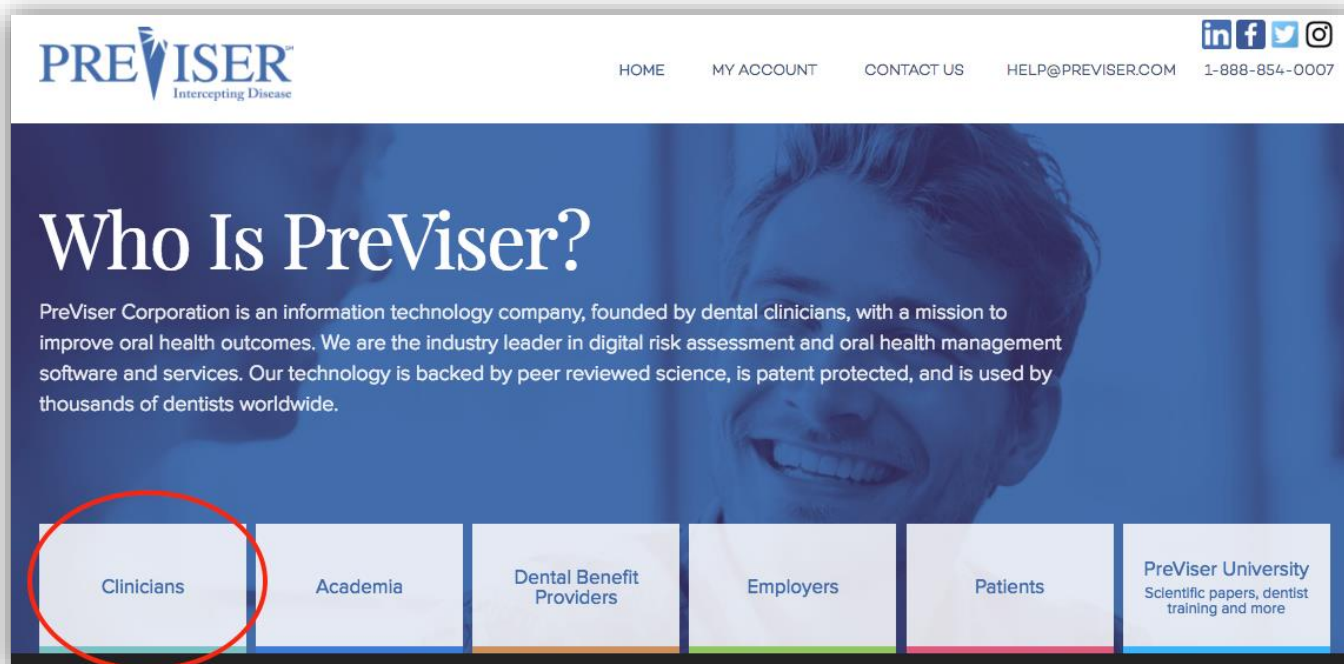
Revision Level	Date	Description
5.0	02/2020	Original
5.2	06/2020	Added mobile shortcut, assessment import, emailing reports, and submitted to insurer sections. Updated encryption key section. Updated all screenshots.

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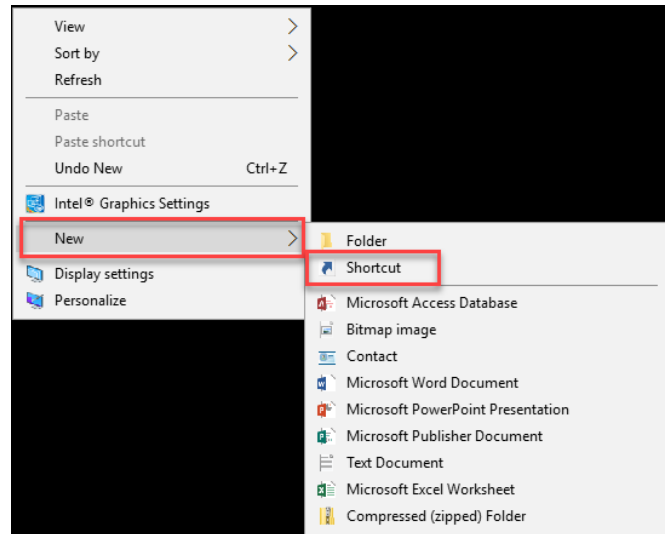
GETTING STARTED WITH THE CLINICAL SUITE

You can reach the Clinical Suite URL from www.previser.com here and navigating to the **Clinicians** tab and clicking on **Access PreViser Clinical Suite Here**, or directly by entering this URL into a browser: <https://secure.previser.com/clinical>

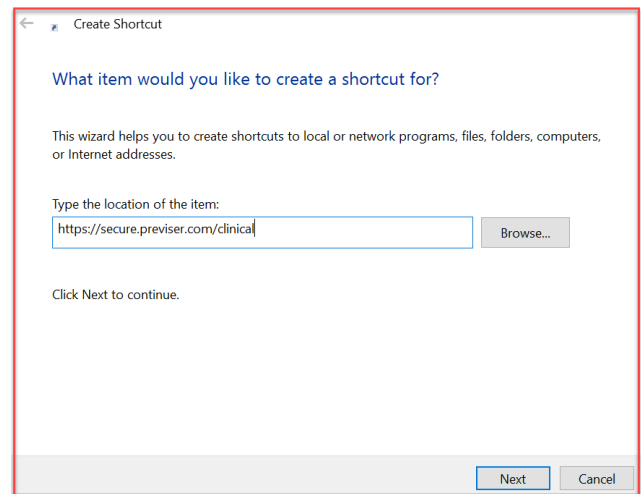


TO CREATE A SHORTCUT ON YOUR DESKTOP

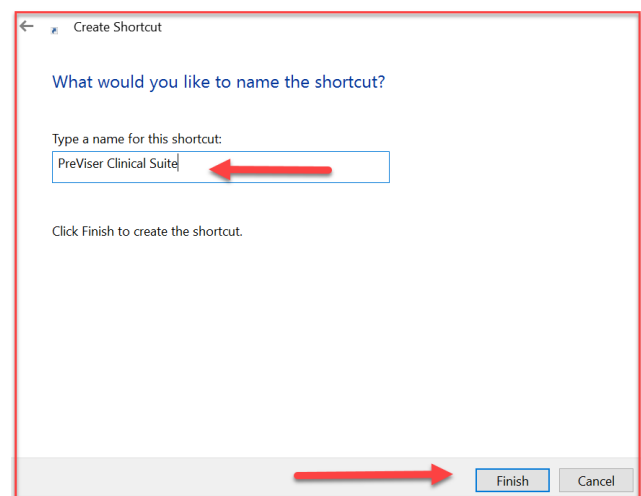
1. Right-click anywhere on your desktop.
2. Select **New** and then **Shortcut**.



3. Enter <https://secure.previser.com/clinical> into the Shortcut address box.
4. Click **Next**



5. Enter the name of the Shortcut (PreViser) into the box.
6. Click **Finish**.

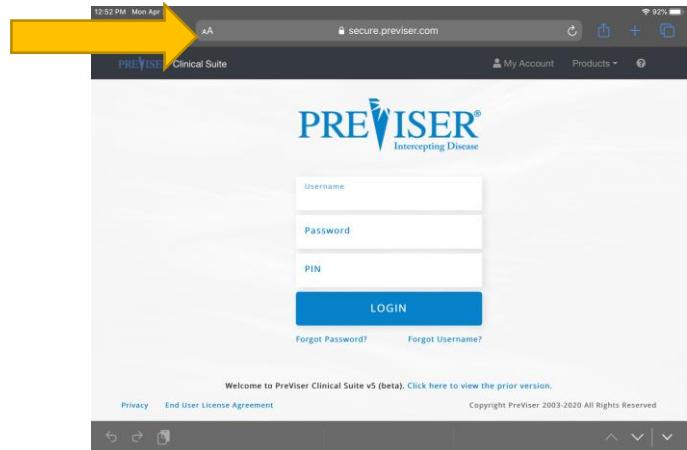
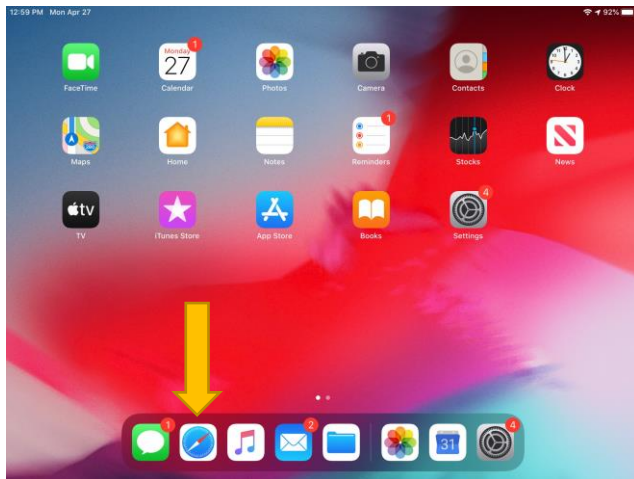


You will now have a shortcut displayed on your desktop labeled **PreViser Clinical Suite**.

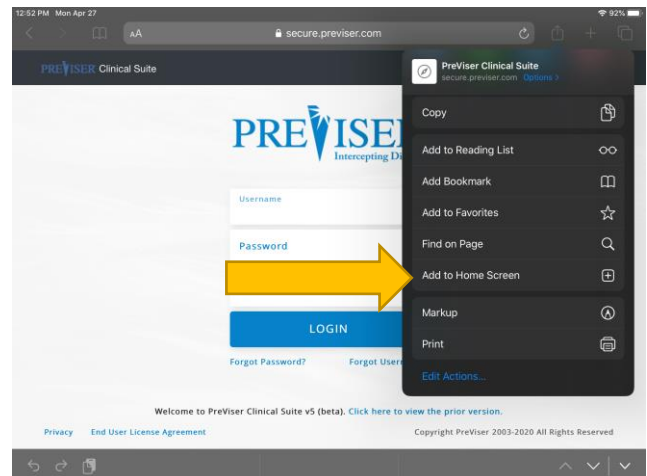


TO CREATE A SHORTCUT ON YOUR IPAD

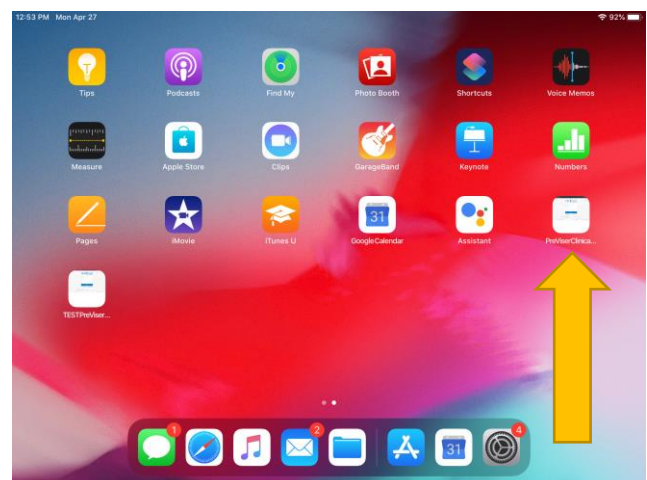
1. Open Safari on your home screen and enter <https://secure.previser.com/clinical> in the navigation bar:



2. Tap the Share Icon and tap **Add to Home Screen**.
3. Enter the name PreViser Clinical Suite and tap **Add**.

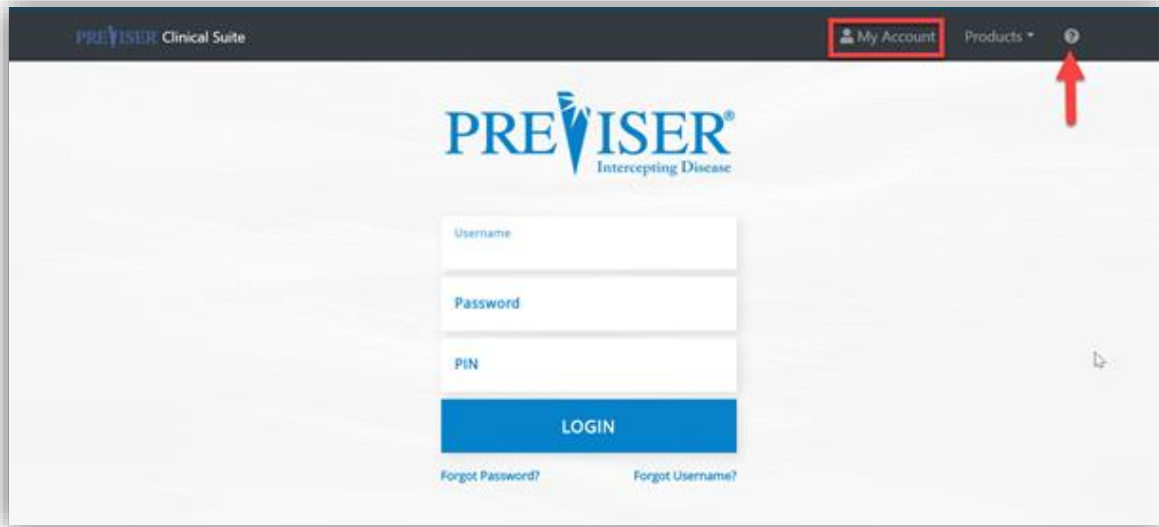


4. You can now easily access PreViser Clinical Suite on your Home Screen!

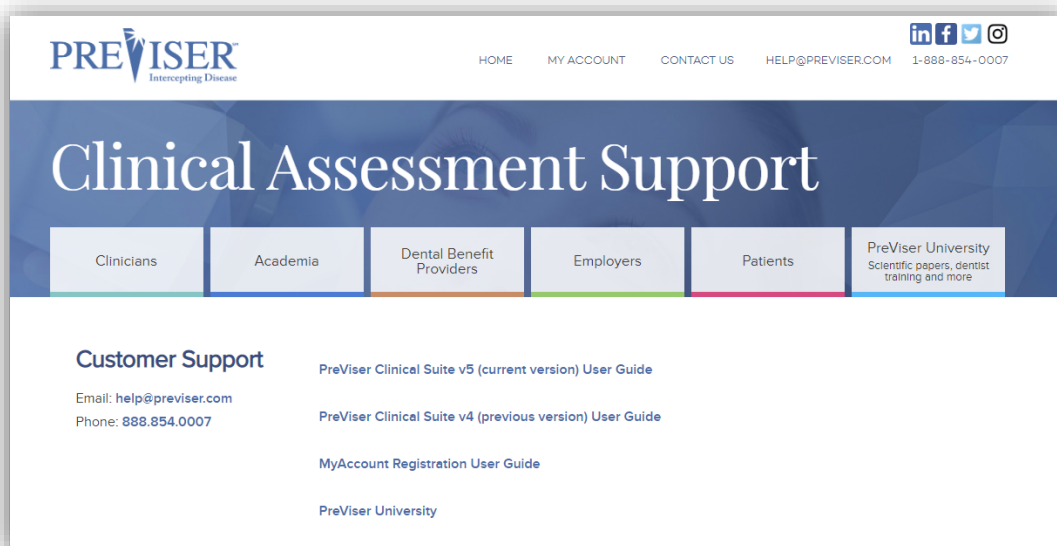


ACCESSING THE CLINICAL SUITE

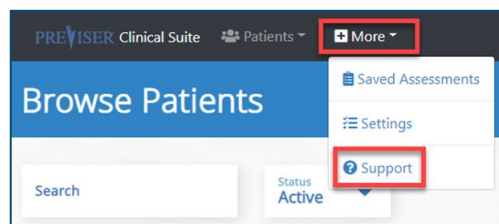
When you launch the Clinical Suite for the first time from <https://secure.previser.com/clinical> you will be prompted for the username and password you created when you registered. Additionally, you will be prompted for your individual pin number. Enter those values, and click **Login**.



Clicking on **MyAccount** will redirect you to the MyAccount application for account management. Clicking on the question mark (?) will reroute you to the PreViser website with support links to documentation and phone and email to contact for support at <https://www.previser.com/clinical-assessment-support/>.



Note: Once you are logged in, another way to reach the Support Page is to click **More** and slide down and click **Support**.

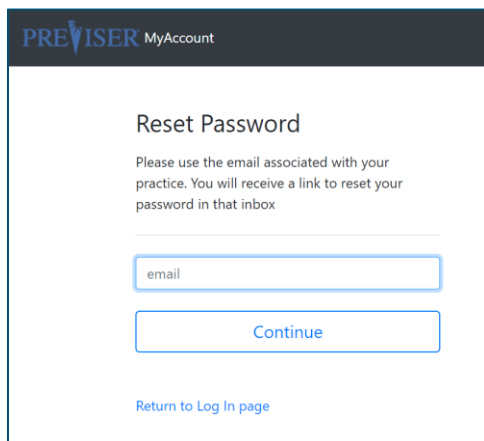


LOST USERNAME OR PASSWORD

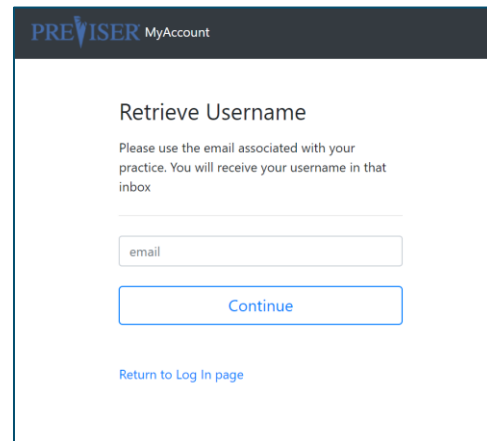
You can reset your password or retrieve your account username by entering the email address associated with your account.



The image shows the PreViser login interface. At the top is the PreViser logo with the tagline "Intercepting Disease". Below the logo are three input fields labeled "Username", "Password", and "PIN". A blue "LOGIN" button is positioned below these fields. At the bottom of the login area, there are two links: "Forgot Password?" and "Forgot Username?". The "Forgot Username?" link is highlighted with a red rectangular border.



The image shows the "Reset Password" screen within the PreViser MyAccount section. The header includes the PreViser logo and "MyAccount". The main heading is "Reset Password". Below this, a message states: "Please use the email associated with your practice. You will receive a link to reset your password in that inbox". There is an input field labeled "email" and a blue "Continue" button. At the bottom, there is a link that says "Return to Log In page".

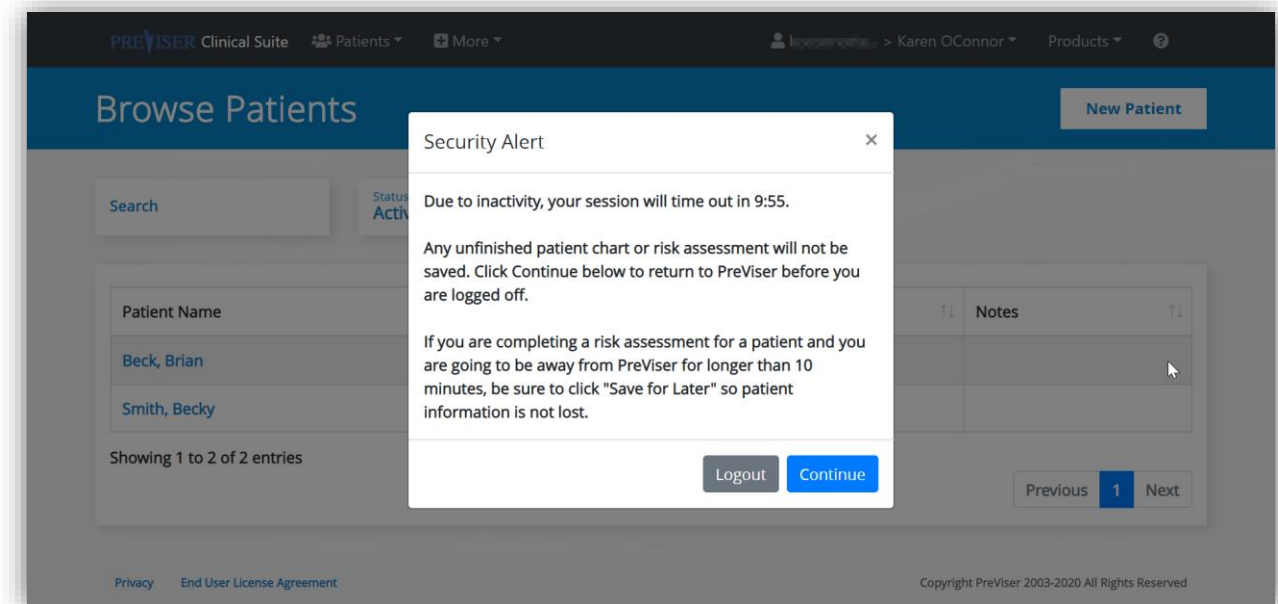


The image shows the "Retrieve Username" screen within the PreViser MyAccount section. The header includes the PreViser logo and "MyAccount". The main heading is "Retrieve Username". Below this, a message states: "Please use the email associated with your practice. You will receive your username in that inbox". There is an input field labeled "email" and a blue "Continue" button. At the bottom, there is a link that says "Return to Log In page".

TIME OUT FEATURE

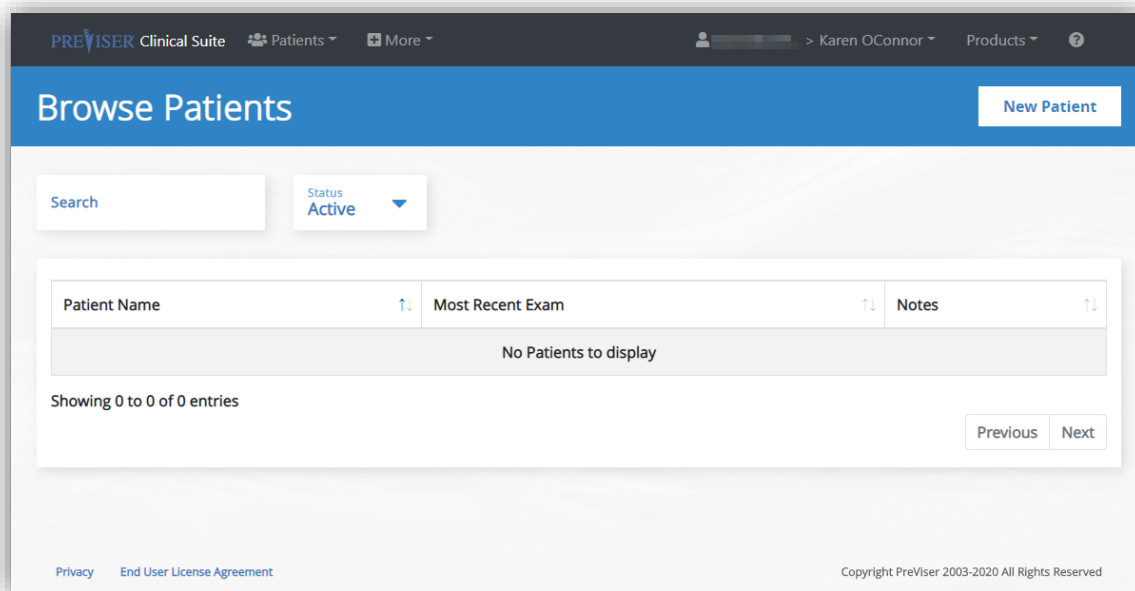
To ensure compliance with HIPAA IT security requirements, users of the PreViser Clinical Suite will see a new pop-up appear after 10 minutes of data entry inactivity. If you do not click the **Continue** button, 10 minutes after that you will be automatically logged off the system.

- ! If you are automatically logged off, **any unsaved data will be lost** and will need to be re-entered to complete the assessment. If you believe you are going to be longer than 10 minutes away from data entry, be sure to click **Save for Later** so you do not lose any unsaved clinical data entered.



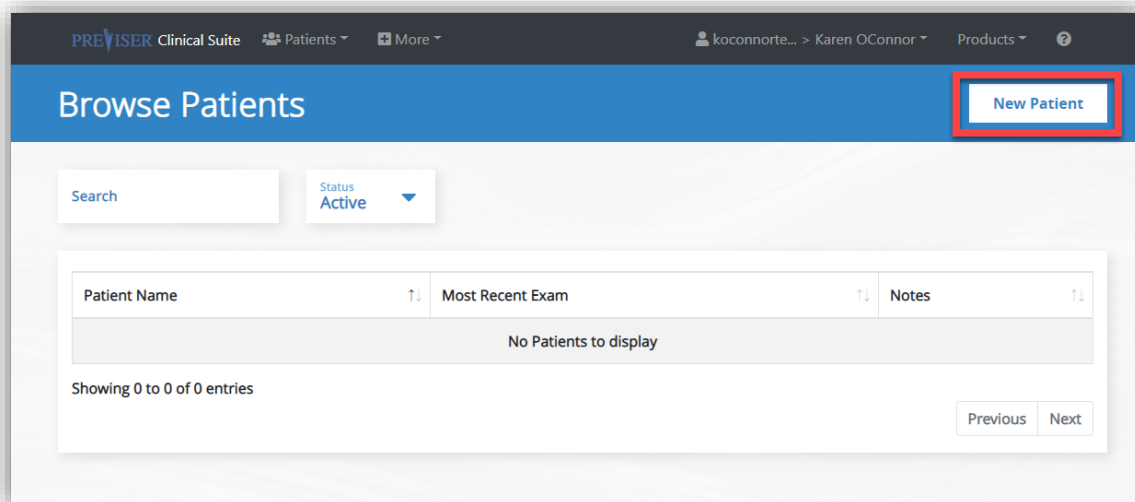
USING PREVISER'S CLINICAL ASSESSMENT

Once you are logged in successfully, the Browse Patients page displays:

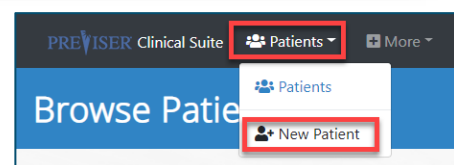


Creating Patients

In order to assess a patient, a PreViser patient record must be created. Click on the **New Patient** button on the Home Page:



Or click the **Patients** tab at the top, then click the **New Patient** option:



The following **Patient Information** page will display:

Fill in the fields as described on the following table:

Patient Information Fields		
<div><div><div></div><div></div></div><div>It is important to note that fields without an asterisk are not submitted to the insurance carrier, i.e., any notes added to the Patient Notes section are not viewable by the insurance carrier.</div></div>	First Name*	Required field.
	Last Name*	Required field.
	Gender patient identifies as	Required field. Dropdown menu
	Patient's Date of Birth*	Required field, mmddyyyy format
	Phone Number	Optional field.
	Email (Parents if under 18)	Optional field.
	Patient Notes	Optional field.

Once this page is filled out, select the **Insurer Information** page and select the insurer of that patient from the dropdown list.

PREVISER Clinical Suite Patients More Karen OConnor Products ?

Creating Patient Save Patient

Patient Information Insurer Information

Select Patient Insurance Company
PV - PreViserTest

Subscriber Number

Group Number

Relationship Code

Email (Parent's if under 18)

Patient Engagement
Entering the patient's e-mail address and checking the authorization box will allow your patient to receive oral wellness messaging that will increase their compliance with your recommended treatment plan.

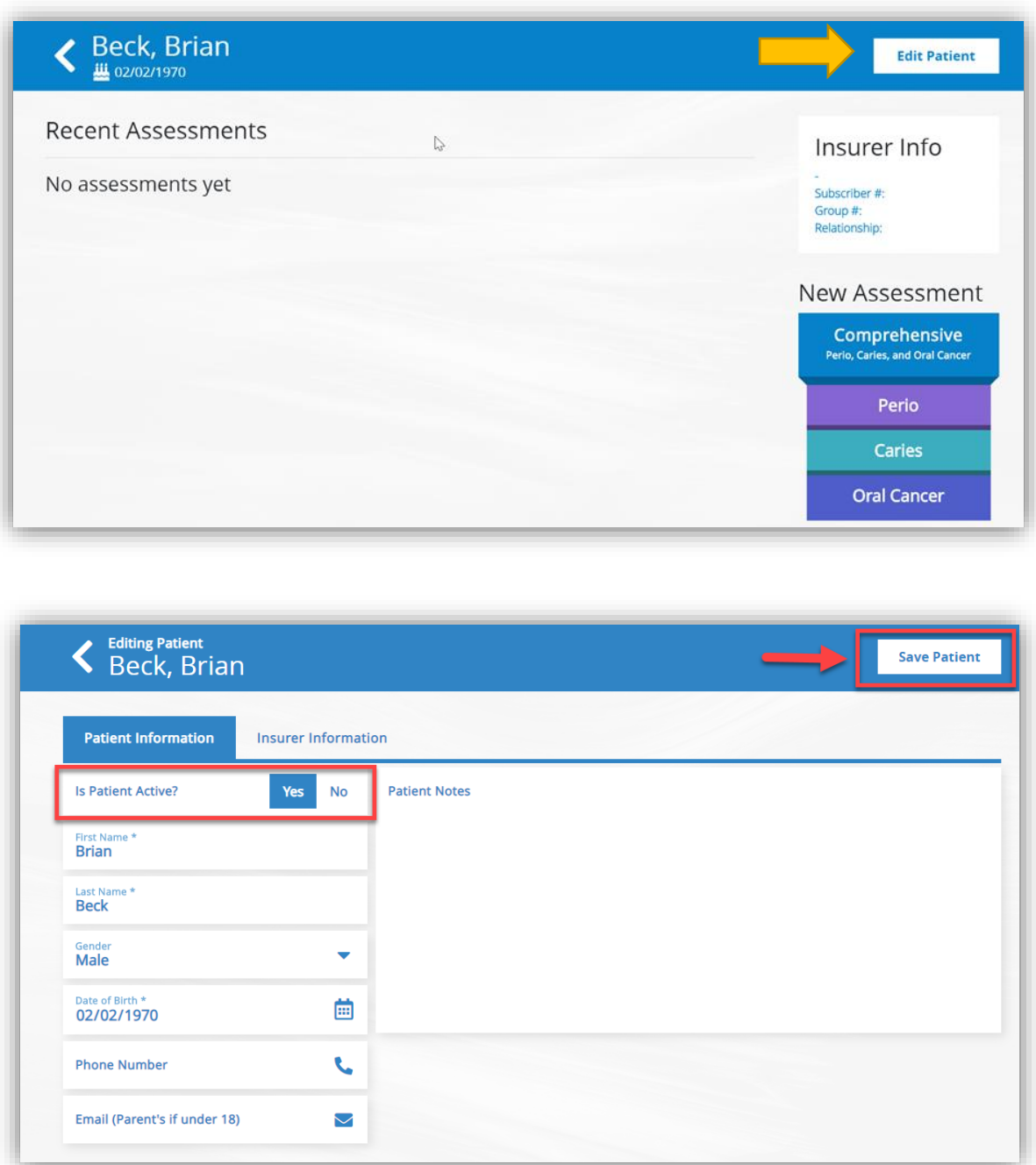
☐ I have confirmed that this patient wishes to receive additional information about their oral health.

If you do not see the insurer of the patient listed, or if the patient is uninsured, select **None** from the dropdown list.

Click the **Save Patient** button at the top right corner after all information is filled out.

Edit Patient Information

If you need to update the patient’s demographic information, or make them inactive in the Clinical Suite, you can do so by clicking **Edit Patient**, making the update, and clicking **Save**.



Patient Engagement

If the provider selects an insurance company from the dropdown list, the provider has an opportunity to collect the patient's email address. This will allow the insurance company to send targeted messages to the patient based on the patient's risk and severity scores. To enable this feature, you must check the box to confirm that the "patient wishes to receive additional information about their oral health," and enter the patient's email address:

Patient Engagement

Entering the patient's e-mail address and checking the authorization box will allow your patient to receive oral wellness messaging that will increase their compliance with your recommended treatment plan.

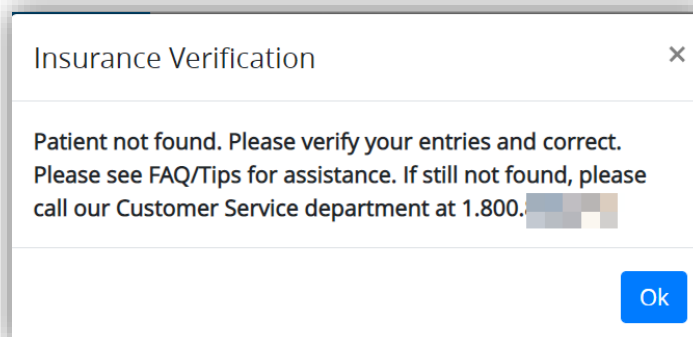
☐

I have confirmed that this patient wishes to receive additional information about their oral health.

Patient Verification

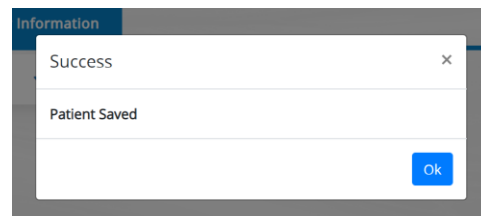
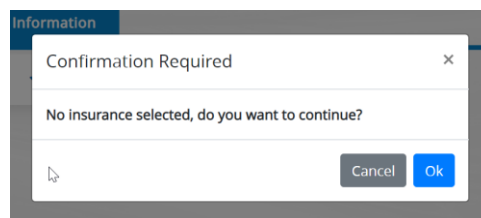
When an insurance company is selected, the Clinical Suite can verify the data that you enter with the information the insurance company has on file, if the insurer has established the necessary connection to the Clinical Suite. This can vary from one insurance company to another.

If you enter information that does not match what is in the insurance company's records, a message will display with information about what to do next:



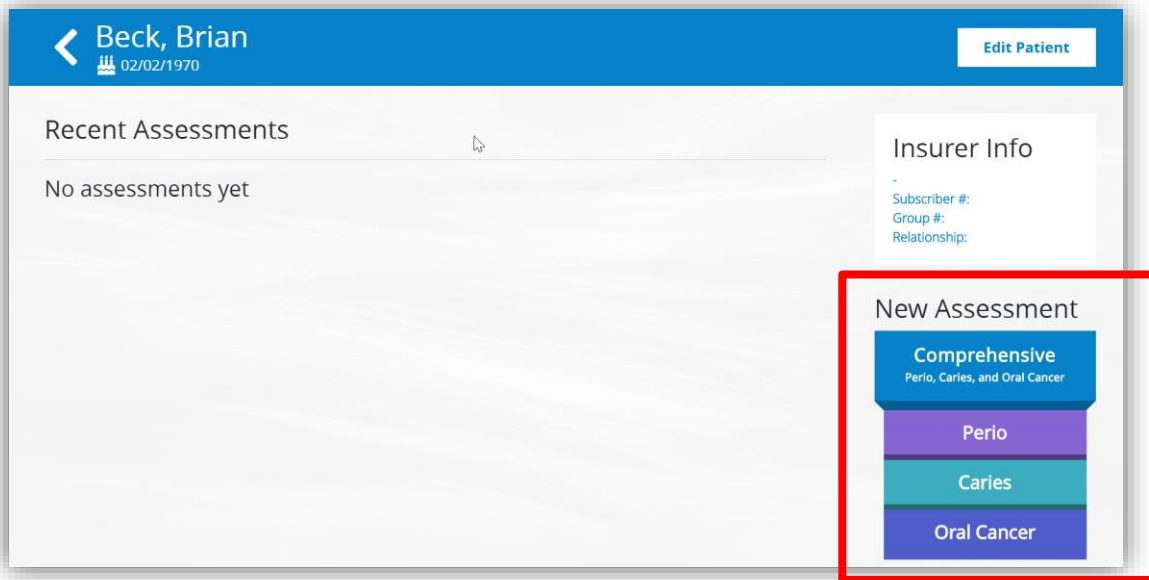
Once the patient details page has been populated, click **Save**. If you selected **None** for the insurance status of the patient, you will be prompted to verify the patient is uninsured:

Once you confirm this status, an alert message will confirm that your patient was created successfully and saved:



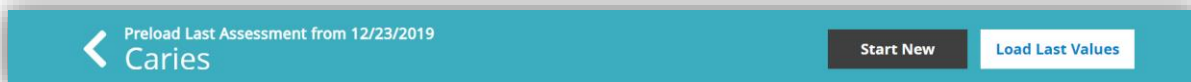
OVERALL ASSESSMENT INFORMATION

Select a patient you created and click one of the New Assessment choices to open and start a new **Comprehensive**, **Periodontal**, **Caries**, or **Oral Cancer** Assessment:



Pre-loading Values from Prior Assessments

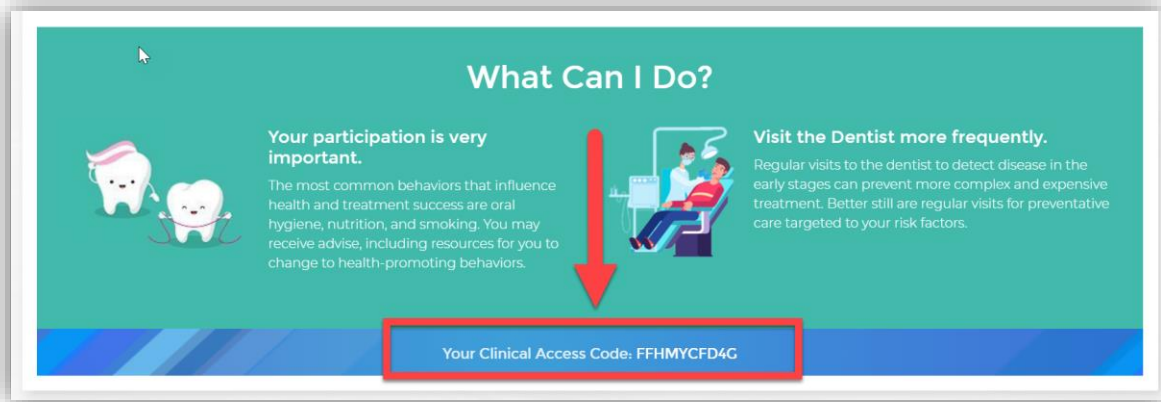
After the first risk/restorative needs assessment has been done for any of the assessment types, the Clinical Suite allows you to pre-load prior entered values from a previous assessment. This saves a great deal of time as it allows you to only address clinical conditions that have changed since the last assessment. This will appear as follows (Caries is used as the example below):



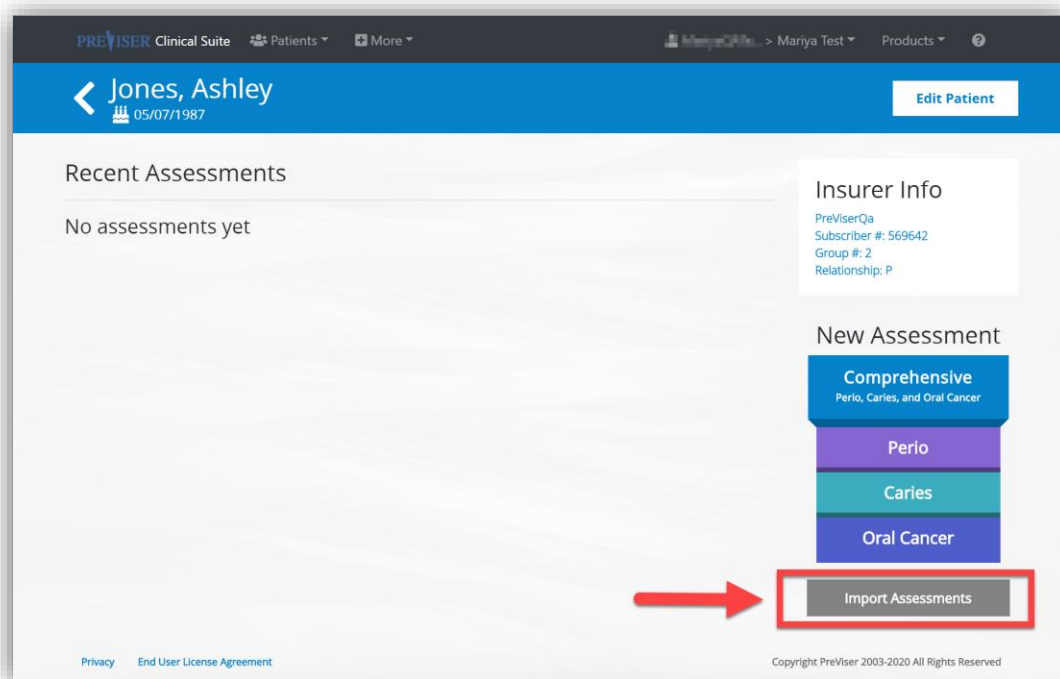
If you wish to pre-load prior examination values, just click the **Load Last Values** and then just update those observations that have changed. Alternately, you can begin an entirely new assessment by clicking **Start New**.

Importing Assessments from Other Practices

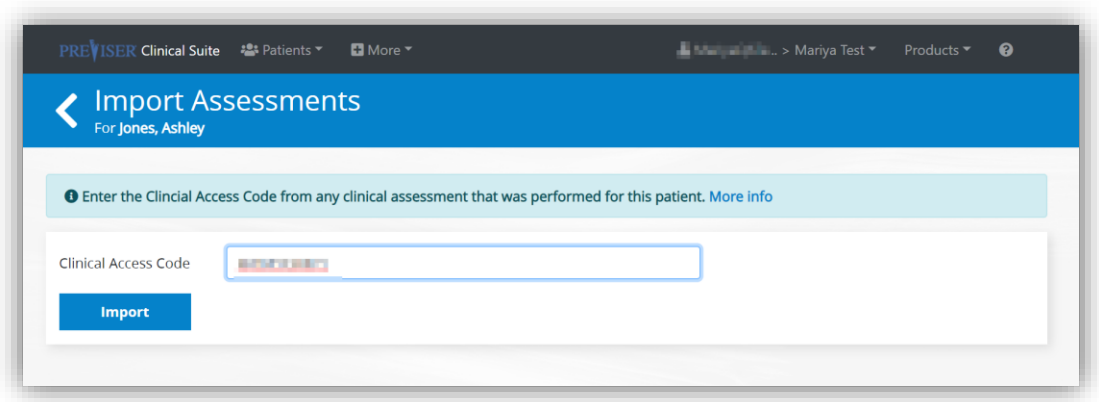
If a new patient came from an office that utilized PreViser and has had PreViser assessments performed in the past, you are able to use that previous data. You will need to reach out to the patient's previous dental provider and ask for a clinical access code found at the bottom of any of that patient's assessments. The clinical access code is found after the "What Can I Do?" section:



Once you receive that access code, select 'Import Assessments' on the patient page.

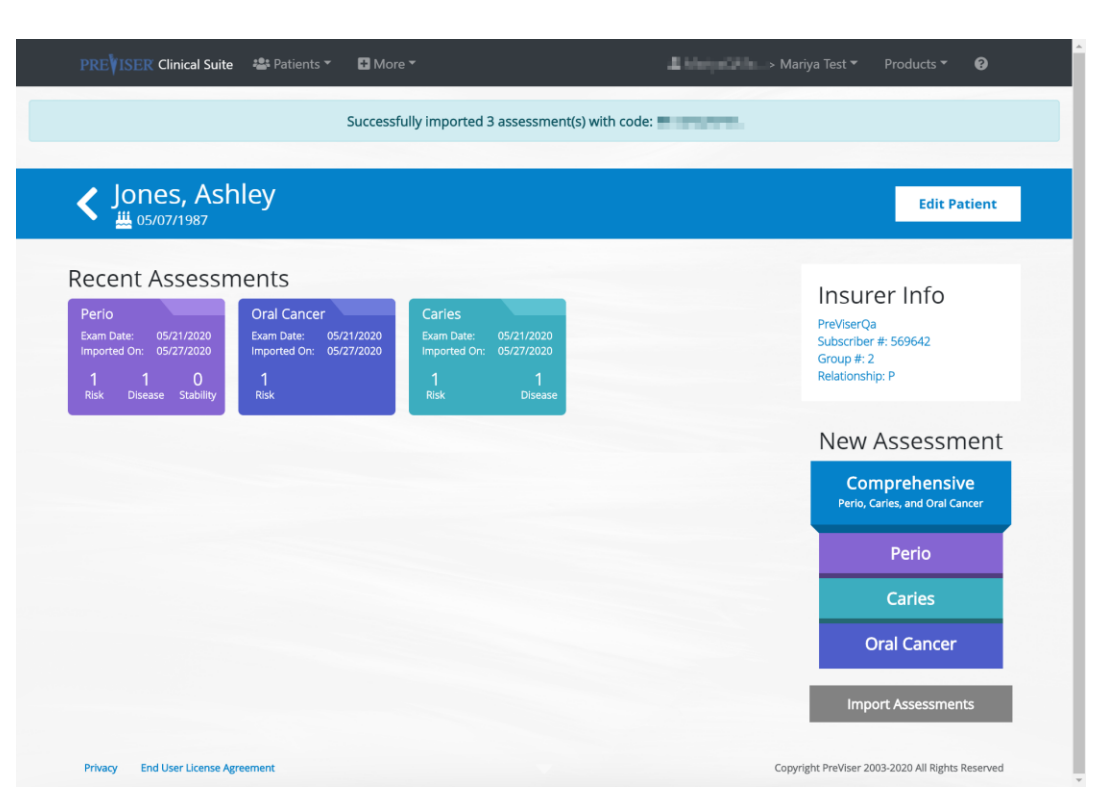


You will then be taken to the following page:



Type in or copy and paste the clinical access code and click 'Import'.

You should see the following screen with that patient’s previous PreViser Assessments and the top of the screen should tell you how many assessments imported successfully:



Performing an Assessment

If any of the assessments are selected (Caries is used as the example below) and you begin the assessment, the following page will display:

The screenshot shows a web interface for a 'New Assessment for Brian Beck' with the 'Caries' assessment selected. At the top, there are three buttons: 'Model This Patient', 'Save for Later', and 'Submit'. Below these, there are three main input areas: 'Exam Date' set to 12/23/2019 with a calendar icon, 'Prepared By' set to Karen OConnor, and 'Responsible Clinician' set to Karen OConnor with a dropdown arrow. A blue instruction box below the clinician field says 'Please select the dentist responsible for this patient's care from the list'.

Exam Date	<p>This is the date the assessment was performed. The current date is the default date for this field. Generally this is going to be within a day or so of when the assessment data is entered. However, clinicians may wish to create a record of the patient's PreViser scores by entering data from prior examinations. You can adjust the exam date to reflect the prior dates with corresponding clinical information for those dates.</p> <p>Note: <i>that if the exam date is more than 90 days in the past for a finished assessment, the Correct function is disabled.</i></p>
Prepared By	<p>This is the person who is doing the assessment, which will match the clinician logged in to the Clinical Suite with their PIN.</p>
Responsible Clinician	<p>This is the clinician who is ultimately responsible for the care of the patient, typically a dentist or independent practicing hygienist.</p>
Submit	<p>If this option is selected, the data you have recorded will be submitted to the PreViser web service and a patient report will be returned including the Report Settings you have indicated. If an insurance company has been entered and successfully saved, the scores will also be sent to the patient's dental insurance company.</p>
Save for Later	<p>This option allows for the unfinished assessment to be saved for later and for the clinician to come back to it at a later time.</p>
Model this Patient	<p>This is a hypothetical option and when this is selected, the assessment is not saved. This is used to demonstrate to patients on what they can do differently to improve their scores.</p>

Recent Assessments

Once a patient has been assessed and you return to the patient page for that person, a new section will appear on this page that shows all prior assessments. Example:



The type, date, and scores for the assessment are shown, where:

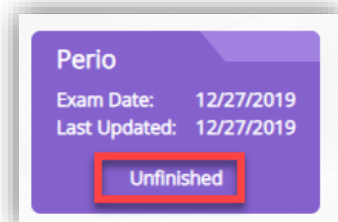
Risk = the risk of the patient for the disease type; and

Disease = the restorative needs or periodontal disease severity scores;

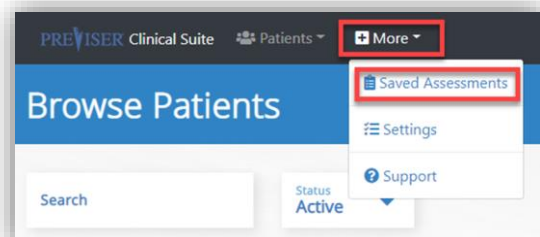
Stability = is the periodontal disease stability score for the patient.

Where **Unfinished** appears instead of scores, this will be an assessment that was not completed but saved to complete later.

Note: If you select to **Model This Patient**, the assessment will not appear in this section because modeled assessments are not recorded in the PreViser database and disappear once you close the modeled patient report.



Accessed through the top navigation bar, the **Saved Assessments** link gives access to all assessments you elected to **Save for Later** rather than Modeling or Submitting the assessment. Example:



continued

Assessment Date	Patient Name	Prepared By	Type	
12/27/2019	Beck, Brian	Karen OConnor	Caries	Delete
12/27/2019	Smith, Becky	Karen OConnor	Perio	Delete

By clicking on the assessment date, the data input page for the unfinished assessment will open and you can then provide the missing information prior to submitting the assessment by clicking **Submit**. Alternately, you can delete the assessment by clicking the **Delete** button.

Report Overview

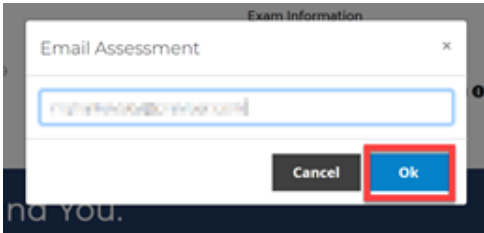
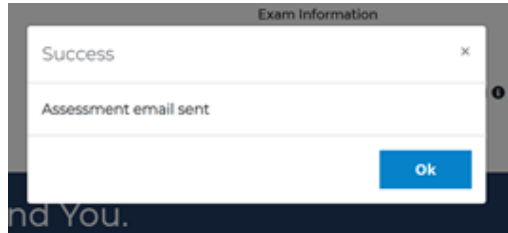
After any assessments have been performed, the clinicians are able to view the reports anytime, whether the assessment was just performed or an older one selected from the 'Recent Assessments' list.

Assessment Report Header

The top of the report includes the assessment type (Caries is used as the example below) and name of the patient as well as other information and functionality:

The screenshot shows the top section of a report. On the left, there is a back arrow and the text 'Assessment for Sally Moore' and 'Caries'. A red arrow points to the 'Caries' text. On the right, there are two buttons: 'Correct' and 'Share'. Below this, on the left, is a placeholder for a patient picture. To its right is the patient's name 'Mariya Test Test', phone number '(567) 678-7753', address '56 Test St. Concord, NH 01899', and a 'Correct' button. To the right of the patient information is the 'Exam Information' section, which includes 'Prepared For: Sally Moore', 'Prepared By: Mariya Test', 'Exam Date: 04/15/2020', and 'Submitted To: PreViser Test 04/15/2020 12:49 PM'.

This screenshot shows a close-up of the 'Share' button from the previous image. The button is labeled 'Share' with a dropdown arrow. The dropdown menu is open, showing two options: 'Print' and 'Email'.

Patient Name	Click this link at the top of the report to return to the Patient Details page for the patient being assessed.
Picture	An image meeting specifications will display on the patient report. Generally, this will be an image of the dentist, staff, or the office.
Correct	Click this to return to the data collection form for the inputs that generated the report. You would use this if you think you made an error in entering the clinical observations. If you wish to correct a report, click this link and make whatever changes you need to, then click Submit to resubmit the assessment. A corrected report will replace the incorrect report when the data is being sent to an insurance company for oral health communication or benefit determination.
Print	Click choice to direct the report to a printer.
Email	<p>Clinicians have the capability to email reports to the patients instantly. Enter the patient's email and press Ok:</p> <div style="display: flex; justify-content: space-around;">   </div>

PERIODONTAL DISEASE ASSESSMENT

From the Patient Details page, you can perform a periodontal disease risk and severity assessment by clicking the **Perio** link:



Fill out the information required to perform a periodontal disease risk and severity assessment.

Cigarette Smoking

Has the patient smoked cigarettes?

Never SmokedHave/Has Smoked

Diabetic Status

	Good Control	Fair Control	Poor Control
HbA1c (%)	Less than 6.5	6.5 - 7.5	Greater than 7.5
AM fasting plasma glucose (mg/dl)	90 - 104	105-130	Greater than 130

Not diabetic or unknownGood diabetic controlFair diabetic controlPoor diabetic control

Check all that apply

☐ Oral hygiene improvement is needed

☐ Scaling and root planing for any tooth has been done

☐ Furcation involvements exist

☐ Vertical bone lesions exist

☐ Dental care frequency is NOT regular as advised

☐ Periodontal surgery for pockets has been done

☐ Subgingival restorations are present

☐ Subgingival calculus detected by x-ray or exam

Deepest Pocket Per Sextant from the Gingival Margin to the Base of the Sulcus

Upper Right

Less than 5 mm5-7 mmGreater than 7 mmNo teeth

☐ Bleeding

Upper Anterior

Less than 5 mm5-7 mmGreater than 7 mmNo teeth

☐ Bleeding

Upper Left

Less than 5 mm5-7 mmGreater than 7 mmNo teeth

☐ Bleeding

Lower Right

Less than 5 mm5-7 mmGreater than 7 mmNo teeth

☐ Bleeding

Lower Anterior

Less than 5 mm5-7 mmGreater than 7 mmNo teeth

☐ Bleeding

Lower Left

Less than 5 mm5-7 mmGreater than 7 mmNo teeth

☐ Bleeding

Upper Right

Less than 5 mm5-7 mmGreater than 7 mmNo teeth

☐ Bleeding

Upper Anterior

Less than 5 mm5-7 mmGreater than 7 mmNo teeth

☐ Bleeding

Upper Left

Less than 5 mm5-7 mmGreater than 7 mmNo teeth

☐ Bleeding

Lower Right

Less than 5 mm5-7 mmGreater than 7 mmNo teeth

☐ Bleeding

Lower Anterior

Less than 5 mm5-7 mmGreater than 7 mmNo teeth

☐ Bleeding

Lower Left

Less than 5 mm5-7 mmGreater than 7 mmNo teeth

☐ Bleeding

Xray Distance from CEJ to Bone Crest

Measured	Visual
Less than 2 mm	Normal bone height
2-4 mm	Between normal and excessive
Greater than 4 mm	Excessive bone loss

Upper Right

Less than 2 mm2-4 mmGreater than 4 mmNo Teeth

Upper Anterior

Less than 2 mm2-4 mmGreater than 4 mmNo TeethNo X-Ray

Upper Left

Less than 2 mm2-4 mmGreater than 4 mmNo Teeth

Lower Right

Less than 2 mm2-4 mmGreater than 4 mmNo Teeth

Lower Anterior

Less than 2 mm2-4 mmGreater than 4 mmNo TeethNo X-Ray

Lower Left

Less than 2 mm2-4 mmGreater than 4 mmNo Teeth

Report Options - Perio

Once the data input form for the Perio risk assessment is completed select from the following options to be included in the report:

Report Settings



Treatment Options



Do you wish to indicate the use of laser therapy?

Treatment Options

This is a selectable feature and if the box is checked suggested treatments will be included in the report.

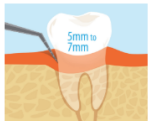
To help maintain or improve the health of your gums:

Pockets less than 5mm



Pockets that are less than 5mm deep can have the most thorough removal of bacteria and calculus. However, all deep pockets were at one time less than 5mm with the optimal probing depth being 3mm or less.

Pockets 5-7mm



Pockets in the 5 to 7 depth range cannot be cleaned with a toothbrush and floss, and professional cleaning instruments don't always reach the bottom of the pocket. Incomplete removal of plaque and calculus results in deeper pockets and tooth loss.

As noted on the report, these possible therapeutic recommendations will apply unless the patient is “stable and without inflammation.” This exception is noted since a patient may have residual pocketing or bone loss but lack current inflammation, so active intervention is not needed in preference to maintenance procedures.

Do you wish to indicate the use of laser therapy?

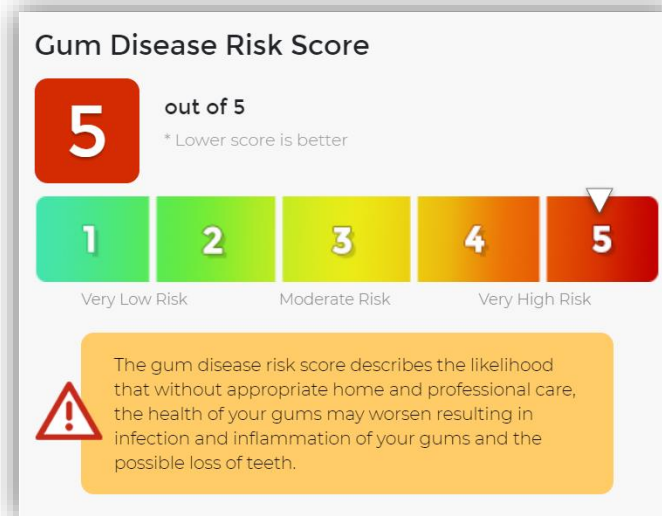
If lasers are part of your armamentarium, you can check this box and an additional message will appear in the Treatment Recommendations section. Example:

Our office uses the latest in laser technology to ensure the best outcome for our patients. The use of lasers may influence which therapy is the most suitable for you.

The Perio Patient Report

Periodontal Disease Risk

The PreViser patient reports are designed to give the patient clear scores for oral disease risk and severity. For periodontitis, the report delivers a [scientifically validated](#) 1 to 5 score for perio risk. This score is a reflection of the likelihood that the patient will develop periodontitis, or that existing perio severity will worsen. Example:

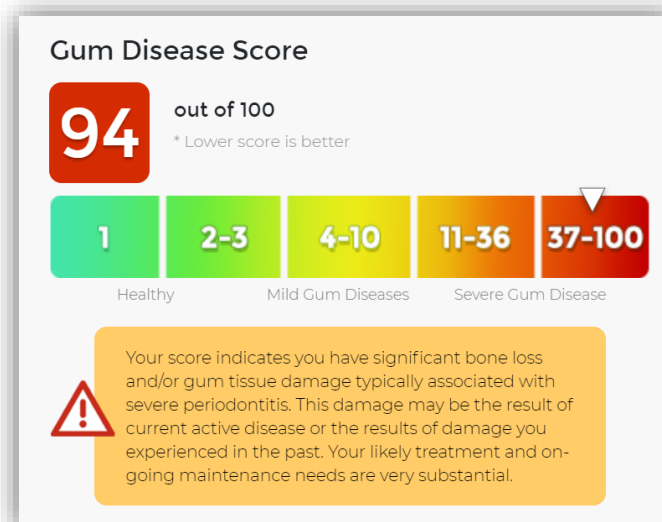


Periodontal Disease Severity

This score is a reflection of current perio severity on a 1 to 100 scale where:

- A score of 1 is perfectly healthy mouth without bleeding, pocketing or bone loss;
- A score between 2 and 3 indicates sextant bleeding on probing (gingivitis) but no pocketing or bone loss;
- A score between 4 - 10 indicates mild periodontitis;
- A score between 11 - 36 indicates moderate periodontitis;
- A score between 37 - 100 indicates severe periodontitis.

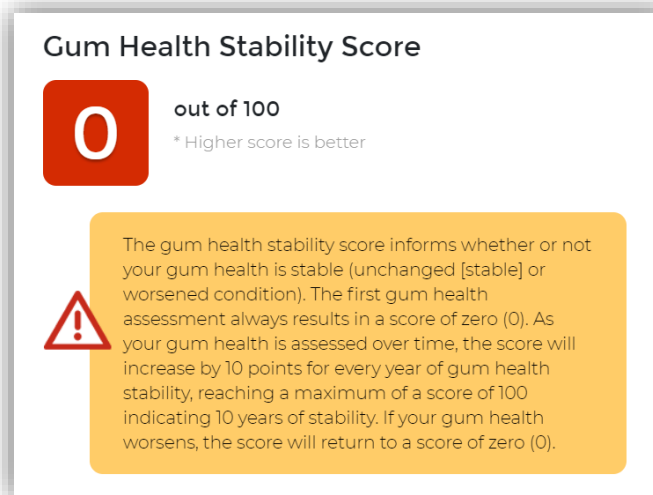
Within each of these ranges the condition varies between localized to generalized, and each increment in the score represents a measurable improvement or deterioration in periodontal status. Example:



Hint: A patient who has experienced periodontitis and bone loss won't grow back that bone, so their score can never return to a score of "1." However, without inflammation, the patient can be considered to be "Stable" in the sense that they are not suffering from continuing deterioration or current inflammation.

Periodontal Disease Stability

This score is a reflection of how long the patient has been stable with unchanged scores. The purpose of this score is to "reward" and motivate patients whose risk and severity scores are constant by having their stability continue to climb. The score will always start at a baseline of zero, and continue to rise at a maximum of 10 points per year, not exceeding 100 points which represents 10 full years of periodontal stability. The graphic below indicates that the patients' periodontal status has remained stable for 4 years. If the patient was stable for 4.5 years, the patient's score would be 45. If the patient's periodontal status regresses, or the patient's exhibits periodontal bone loss, the gum health stability score would reset to zero. Example:



Below is a brief guide on how to improve one's periodontal health:

Gum Disease and You.

Knowing your gum health scores is the first step in improving, or maintaining the health of your gums. Here are other simple steps you can take:

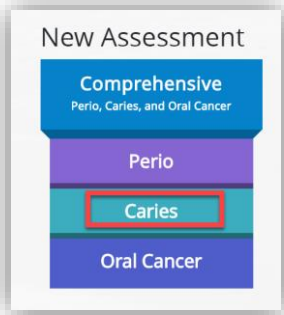
- Talk to your dentist about managing any factors that contribute to elevated risk of disease.
- Ask your dentist how gum disease may impact other serious health ailments such as heart disease, Alzheimer's, strokes and diabetes.

If Treatment Options were indicated to be included in Report Settings before the data was submitted to PreViser, those print, followed by the Clinical Inputs you provided that generated the scores shown on the report.

An example of the full Periodontal Disease Patient Report can be found in [Appendix A](#).

CARIES ASSESSMENT

From the Patient Details page, you can perform a caries risk and severity assessment by clicking the **Caries** link:



Fill out the information required to perform a caries risk and severity assessment.

1 or more teeth have an exposed root
☐ Yes ☒ No

How many months has the patient been without primary caries or an incipient carious lesion?
☒ 36 or more ☐ 24-35 ☐ 12-23 ☐ 1 or more teeth has had caries in the last 12 months

Bacteria culture includes elevated MS and/or LB level?
☐ Yes ☐ No ☒ No culture or test is available

Please answer the following questions (exclude third molars)
How many erupted teeth are present in the oral cavity?
28
of teeth

How many natural teeth have any type of restoration, including crowns and veneers?
0 (None)
of teeth

How many natural teeth currently require treatment because of caries or a defective restoration?
0 (None)
of teeth

How many natural teeth have primary caries or an incipient caries lesion?
0 (None)

Check all that apply

Clinical Conditions

☐ Oral hygiene improvement is needed

☐ Dry mouth or inadequate saliva flow

Treatment History and Considerations

☐ Dental care frequency is NOT as regular as advised

☐ Development problems or special health care needs

☐ Teeth have been extracted due to caries in last 36 months

☐ Fluoride varnish applied in last 6 months

☐ Has orthodontic appliance, space maintainer, or obturator

Questions the patient can answer

☐ Snacks or beverages containing sugar are consumed between meals 4 or more times per day

☒ Patient drinks fluoridated water

☐ Nonprescription or prescription fluoride products other than water are used

☐ Chlorhexidine used for at least 1 week per month for last 6 months

☐ Xylitol products have been used 4 times daily for last 6 months

☐ Calcium & phosphate toothpaste have been used during last 6 months

☐ Recreational drug/alcohol use

☐ Has had a major change in health (heart attack, stroke, etc.) during the past 12 months

Report Options - Caries

Once the data input form for the caries risk assessment is completed select from the following options to be included in the report:

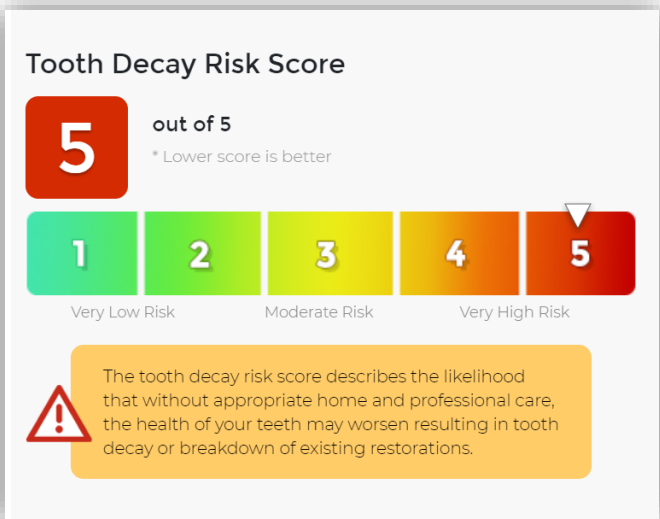
Report Settings

☒ Treatment Options

Caries Risk

The PreViser patient reports are designed to give the patient clear scores for oral disease risk and severity. For caries, the report delivers a 1 to 5 score for caries risk based on the Caries Management by Risk Assessment (CAMBRA) approach to risk determination. This score is a reflection of the likelihood that the patient will experience new caries, or that existing restorations will become defective. The Clinical Suite caries risk method expands the concept of CAMBRA, which predicts primary caries, to include secondary caries. Example:

In this example, the patient presents with a High risk of new defects and would then be a prime candidate for adult sealants, fluoride treatments and regular dental care. This score can be used to help the patient understand why professional oral care is so important.

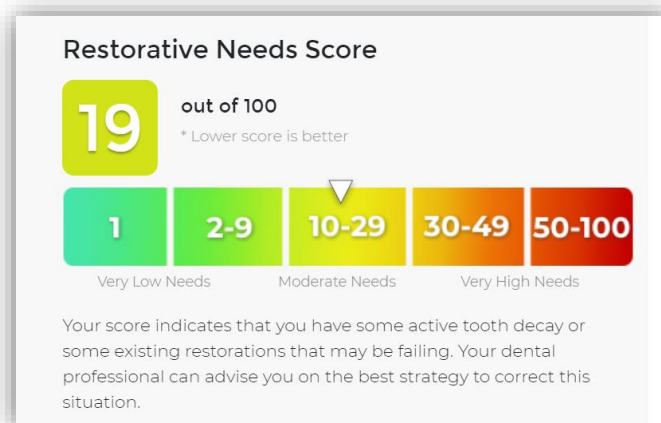


Restorative Needs Score

This score is a reflection of the current status of the dentition on a 1 to 100 scale where:

- A score of 1 is a pristine dentition without carious lesions or any restorations.
- A score between 2 and 9 is a sound dentition with no current defects but with an increasing percentage of the total dentition in a restored state as the score increases from 2 to 9.
- A score between 10 and 100 represents a dentition with current active treatment needs, either due to a new carious lesion or because an existing restoration is defective. As the score becomes greater, a greater percentage of the total dentition is affected by a defect. A score of 100 would indicate that all teeth in the dentition have a defect.
 - Example: If a patient has only one tooth remaining, and that tooth had a lesion, the restorative needs score would be 100. When restored, the score would drop to 9.
 - Example: If a patient has a full dentition, and one tooth had a lesion the restorative needs score would be 10. When restored, the score would drop to 2. Example:

In this example, the patient presents with Moderate Needs as indicated by a restorative needs score of 19. This equates to up to three defects that require therapeutic intervention.



In addition to a risk and restorative needs score, the caries patient report includes other elements of interest.

Tooth Health and You

This section gives the patient a quick summary of strategies that can help improve their oral health. Example:

Tooth Health and You.

Knowing your risk of tooth decay and the current health of your teeth is the first step in maintaining or improving the health of your teeth. Here are the other simple steps you can take

- Talk to your dentist about managing the risk factors that may contribute to tooth decay
- Brush twice a day with fluoride toothpaste
- Clean between your teeth daily with floss or an interdental cleaner

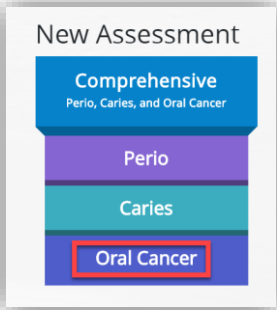
Treatment Options

As discussed above, this section of the report describes the preventive activities that may be helpful to improving the patient's oral health. It can be optionally printed by checking the box in the Report Settings section.

An example of the full Caries Patient Report can be found in [Appendix A](#).

ORAL CANCER RISK ASSESSMENT

From the Patient Details page, you can perform oral cancer risk assessment by clicking **Oral Cancer**:



Fill out the information required to perform an oral cancer risk and severity assessment:

☐ Has history of oral cancer

Cigarette Smoking

Has the patient smoked cigarettes?

Never SmokedHave/Has Smoked

Pipes/Cigars

Has the patient smoked pipes or cigars?

Never SmokedHave/Has Smoked

Smokeless (Chewing) Tobacco

Has the patient used smokeless (chewing) tobacco?

Never UsedHave/Has Used

Alcohol Use

Note: 1 drink equals

Beer	12 ounces or 355 milliliters	5% alcohol
Wine	5 ounces or 150 milliliters	12% alcohol
Spirits	1.5 ounces or 45 milliliters	40% alcohol

Number of drinks consumed in the past year

None1 or more

Report Options – Oral Cancer

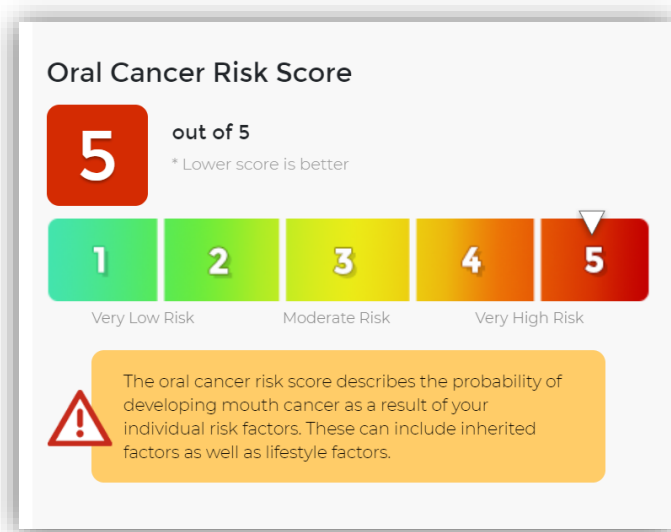
Once the data input form for the Perio risk assessment is completed select from the following options to be included in the report:

Report Settings

☒ Treatment Options

Oral (Mouth) Cancer Disease Risk

The PreViser patient reports are designed to give the patient clear scores for oral disease risk and severity. For oral cancer, the report delivers a risk score from 1 to 5. This score is a reflection of the possibility that the patient will experience an oral cancer lesion. Example:



Note: Because a person has elevated risk for mouth cancer does not mean they are likely to experience this terrible, if infrequent disease. Rather it means that they have exhibited risk factors that increase the possibility of developing the disease. It is helpful to explain to a patient that just because your home is at elevated risk for catching on fire due to the proximity of flammable brush or trees surrounding the home it doesn't mean the house will catch on fire - just that the risk factors increase that possibility. The oral (mouth) cancer risk score is designed to encourage the patient to reduce the risk factors associated with the disease, like the use of smokeless tobacco or alcohol.

A brief discussion of Oral Cancer and You is provided. Example:

Oral Cancer and You.

Am I at risk?

Anyone can get oral cancer. The most common factors for oral cancer are:

- Over 40 years of age
- Use of any type of tobacco product
- Regularly drink alcohol
- Exposure to the HPV virus

How do I reduce my risk?

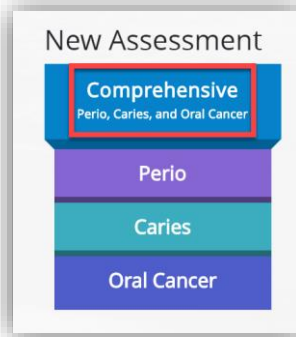
Lifestyle factors like tobacco, alcohol use and poor dental hygiene can be managed with a subsequent reduction in the risk of mouth cancer. In addition, recent research has indicated that exposure to the HPV 16 virus that can be sexually transmitted is a significant risk factor for oral cancer, and may be responsible for the increasing incidence of mouth cancers in younger populations.

If you select **Treatment Options** in **Report Settings** before submitting the clinical data to generate the report, those recommendations will be included. **Clinical Inputs** will also display and can be printed optionally to help guide the patient on what risk factors may be elevating their risk scores.

An example of the full Oral Cancer Patient Report can be found in [Appendix A](#).

COMPREHENSIVE ASSESSMENT

The comprehensive assessment includes the questions from all three assessments (caries, perio, and oral cancer). It would typically be done as the first PreViser assessment on a patient; or when a patient first presents for services; or on request from an insurer. It combines the caries, perio and oral cancer assessments into one document, and while it takes time to complete, provides a comprehensive guide to the complete treatment plan a new or existing patient will benefit from.



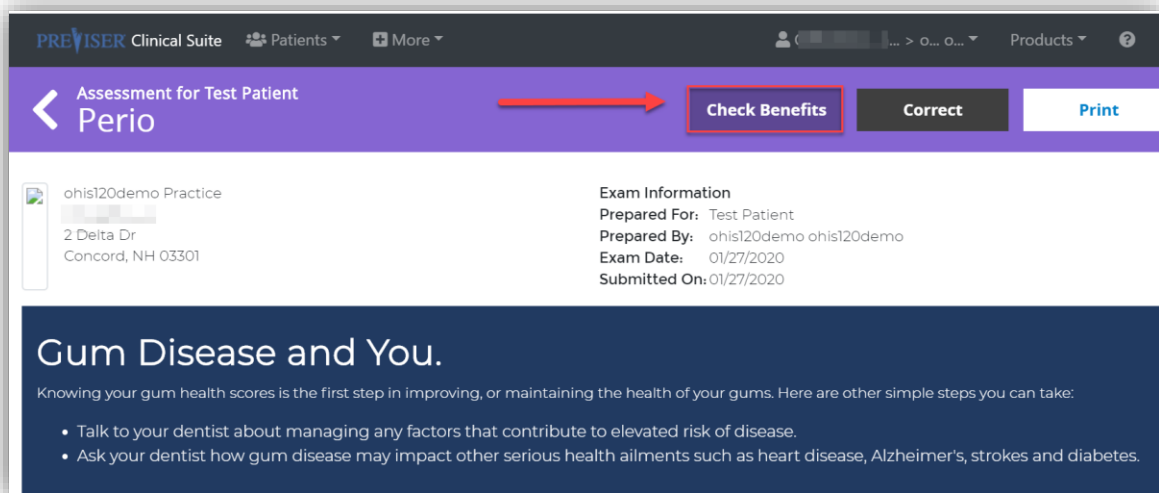
An example of the full Comprehensive Patient Report can be found in [Appendix A](#).

RETURN OF BENEFITS

Some insurance carriers offer a return of benefits after an assessment has been completed for a verified patient. This feature offers the dental office and clinician chair side return of benefits which includes maximum allowance, remaining allowance, limitations and enhanced benefits if a patient qualifies for additional benefits based on the patient's Clinical Suite scores, to name a few.

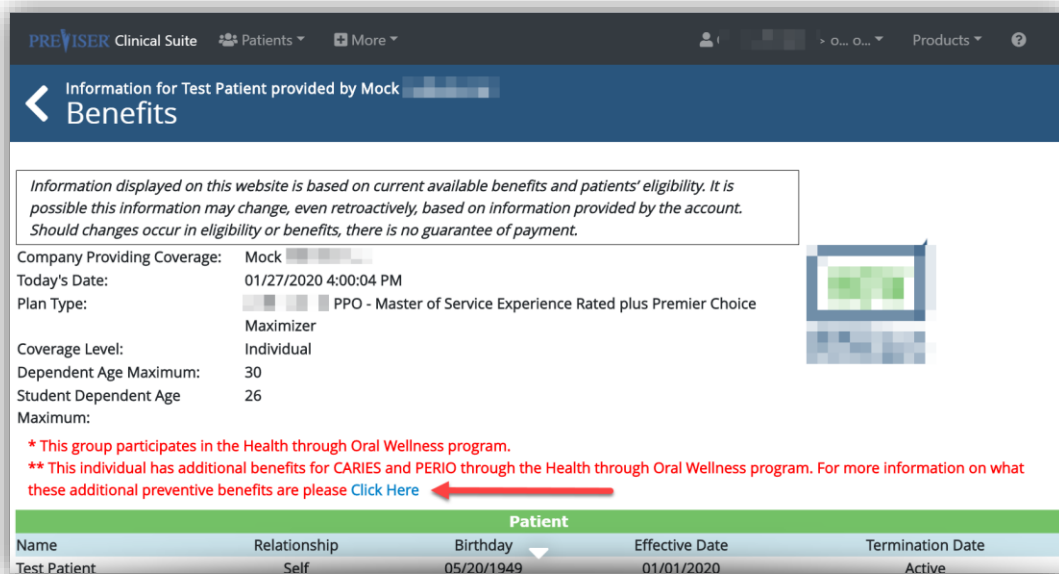
Check Benefits

After the Clinical Suite has been "Submitted," the Clinical Suite report will display with a **Check Benefits** button for a verified patient. This button will not display for a patient with no insurance, or a patient who has an insurance carrier who does not support this feature. In order to access the benefits of the patient, you have to click the **Check Benefits** button at the time the report is generated. The **Check Benefits** button will not display on previous assessment reports.



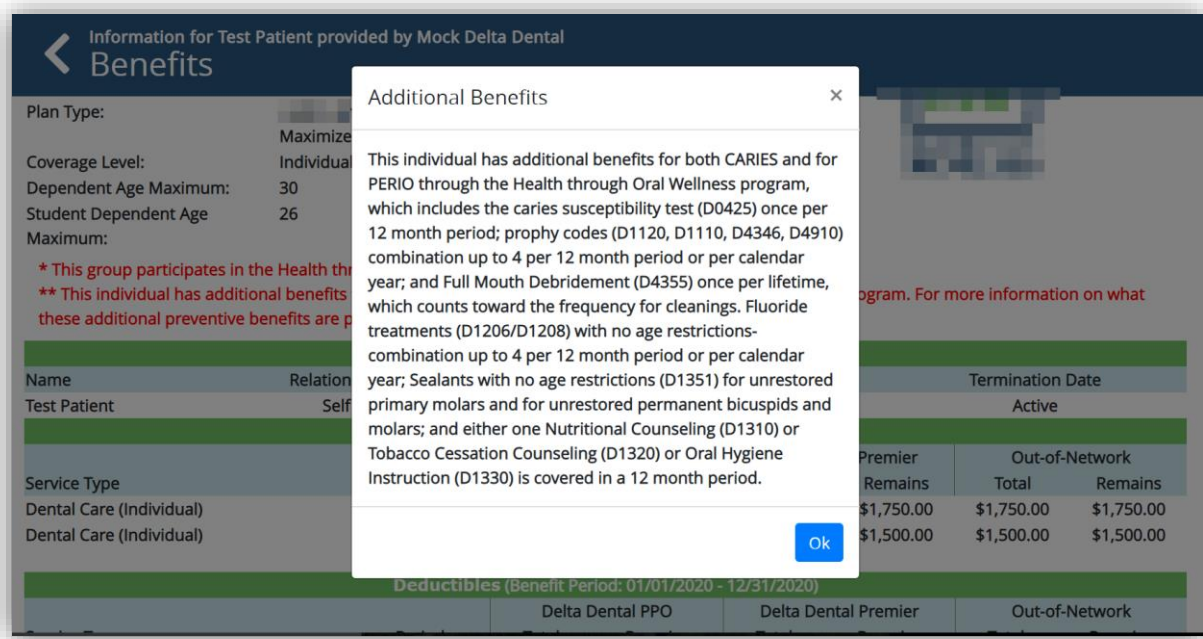
Benefit Return Display:

When you click **Check Benefits**, the current benefits of the verified patient displays:



Additional Enhanced Benefits Information:

After the benefit return displays, you also have the option to expand on the enhanced benefit plan design for the patient, by clicking **Click Here**, as seen below:



The return of benefits can only be accessed at the time the finished report has been completed and the Clinical Suite report displays. In other words, you cannot access the return of benefits on any saved reports, because the benefits may not be current.

Submitted to Insurer Status:

This reports the insurance company the assessment was submitted to, as well as the date and time.

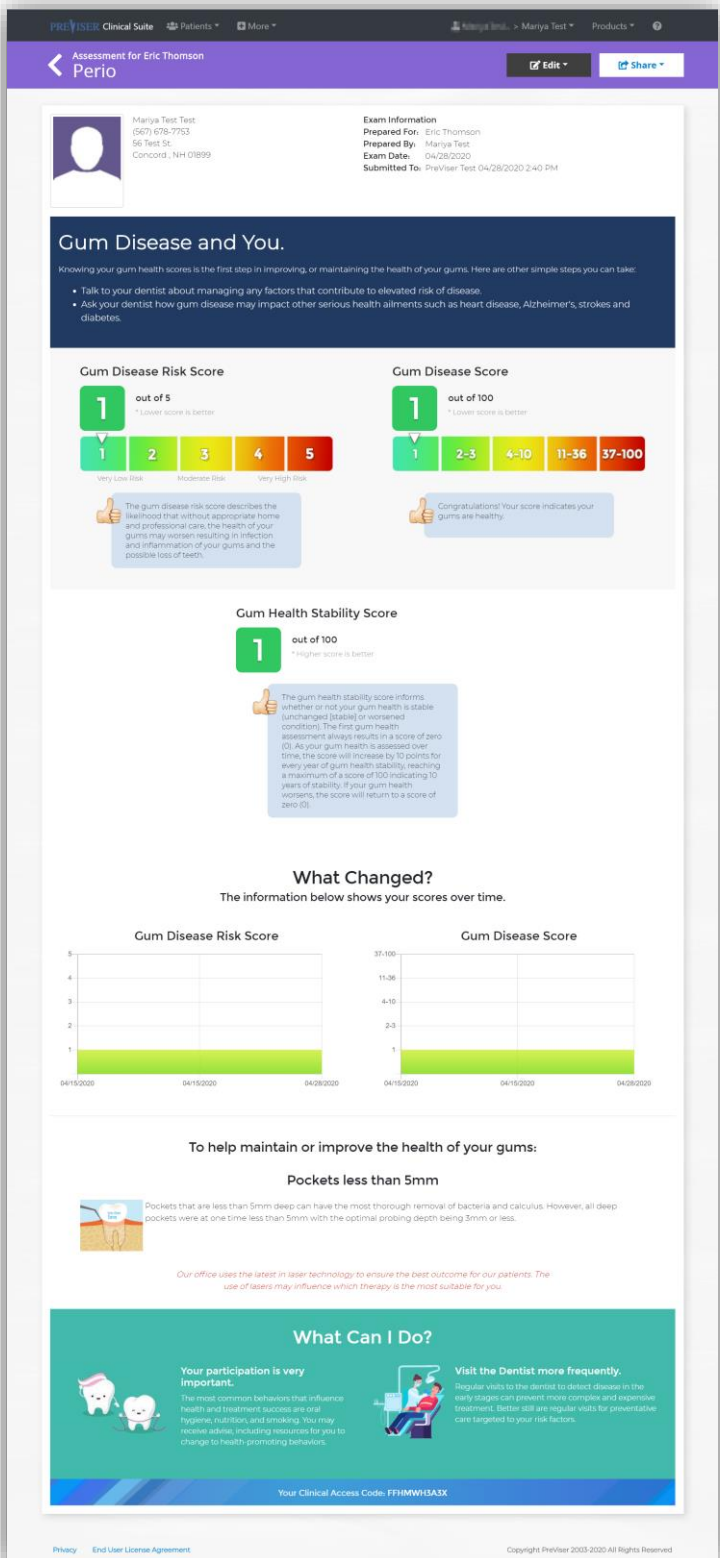
The screenshot shows a form titled "Assessment for Sally Moore" with a purple header. Below the header, there is a patient profile section on the left with a placeholder image and text: "Mariya Test Test (567) 678-7753 56 Test St. Concord, NH 01899". To the right of the profile is the "Exam Information" section, which includes "Prepared For: Sally Moore", "Prepared By: Mariya Test", "Exam Date: 04/08/2020", and "Submitted To: PreViser Test 04/08/2020 9:44 AM". The "Submitted To" field is highlighted with a red rectangular box. At the top right of the form, there are "Edit" and "Share" buttons.

If no insurance for that patient is selected, it should state "no insurer selected."

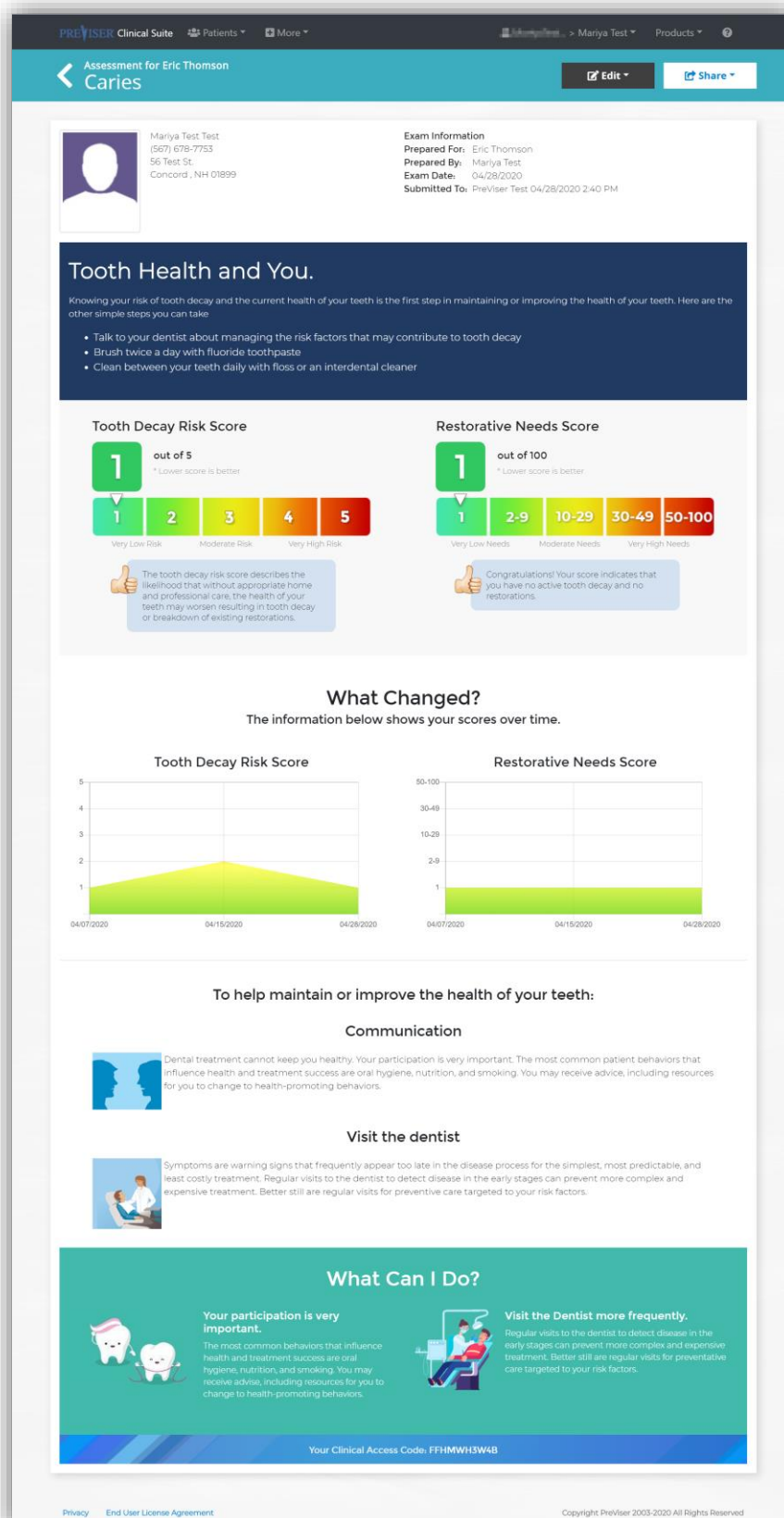
The screenshot shows a form titled "Assessment for Neil Strong" with a teal header. Below the header, there is a patient profile section on the left with a placeholder image and text: "Mariya Test Test (567) 678-7753 56 Test St. Concord, NH 01899". To the right of the profile is the "Exam Information" section, which includes "Prepared For: Neil Strong", "Prepared By: Mariya Test", "Exam Date: 04/13/2020", and "Submitted To: No Insurer Selected 04/13/2020 6:20 PM". The "Submitted To" field is highlighted with a red rectangular box. At the top right of the form, there are "Edit" and "Share" buttons.

APPENDIX A – REPORTS

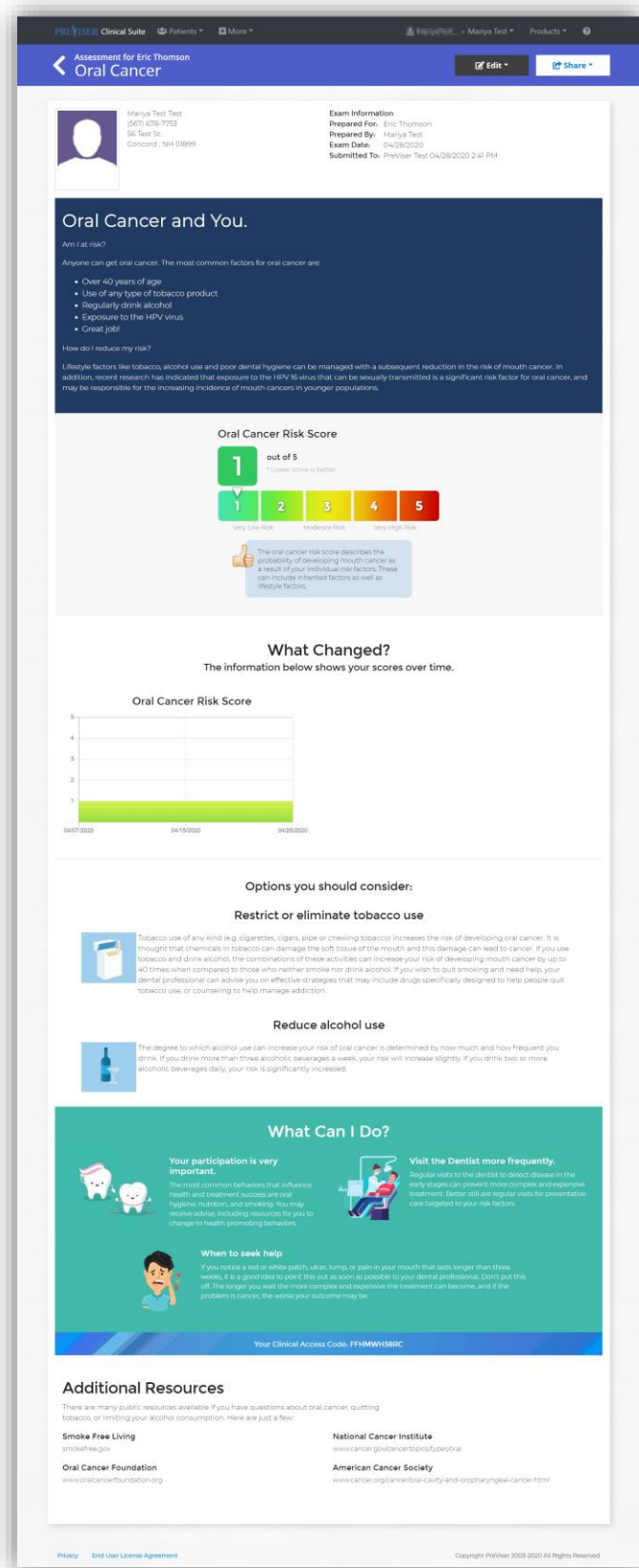
Perio Report



Caries Report



Oral Cancer Report



Comprehensive Report

