



DENTAL CLINIC

Policy and Procedure Oral Health Records Management

Responsible Party: Director of Dental Support Services

Policy: The oral health record is one of the most important documents in dental clinic. It must be accurately and concisely completed. In order to ensure uniformity of content and patient treatment data, it will be completed as described below.

Procedure:

- I. The oral health record will be marked
 - A. Front outside cover will be marked with a medical alert sticker, if indicated.
 - B. Back far right border will be designated from the top down.
 - 1) Latest year seen
 - 2) Alphabetic stickers corresponding to the patient's first three letters of their last name.

- II. The left inside contents of the oral health record in ascending order (as applicable):
 - A. Miscellaneous documents.
 - B. Patient registration / Medicaid forms
 - C. Medical consult forms / medication lists / other allied medical documents
 - D. Health history/dental screening.

- III. The right inside contents of the oral health record in ascending order (as applicable):
 - A. X-ray envelope.
 - B. Dental referral form /vouchers
 - C. Request letters.
 - D. Dental claim form/ superbill
 - E. Informed consent – most current on top.
 - F. Treatment planning form.
 - G. Chronological record of dental care.

- IV. The Chronological record of dental care will be completed as follows:
 - A. The side with the patient's name on the bottom will be designated page 1.
 - B. The restorations and treatments section: During the initial examination, all existing restorations, treatments, and missing teeth will be noted in ink. All subsequent restorations, treatment, and extraction of teeth will also be noted in ink. The remarks blank will be used to annotate permanent anomalies and other significant findings.
 - C. The disease and abnormalities section will be completed in pencil. It will designate required treatment. Once treatment is completed, the entry will be erased and annotated in the restoration and treatment section. The remarks/treatment plan

block will also be completed in pencil. It will be used to clarify patient management.

D. The dental progress notes section will address the following items as applicable. Refer to record keeping checklist for additional considerations.

- 1) Chief complaint (C.C.)
- 2) Health history taken/reviewed (HHT/HHR).
- 3) Reason for visit (type of examination).
 - a) Comprehensive oral evaluation (COE)
 - b) Periodic oral evaluation (POE)
 - c) Limited oral evaluation (LOE) – problem focused
 - d) Post operative treatment (POT)
 - e) Continuation of treatment (CT)
 - f) Restorative appointment (RES Appt)
- 4) Diagnostic tests and results
 - A) X – Ray (Bite-wings – BWX, peripheral – PAX)
 - B) Percussion
 - C) Thermal
 - D) Electronic pulp test (EPT)
- 5) Diagnosis/treatment plan formulated
 - a) Caries (CAR)
 - b) Defective(DEF)
 - c) Fractured (FRAC)
 - d) Irreversible pulpitis
 - e) Etc.
- 6) Treatment rendered
 - a) Tooth number/area of the mouth
 - b) Tooth surface
 - c) Specific materials and medication used
 - d) Local anesthesia (LA) site and close
 - e) Prescriptions
 - f) Patient instructions
- 7) Preventive comments
- 8) Next visit (NV)/treatment episode status/disposition
- 9) Signature

Approved: _____

Date Initiated: _____

Date Reviewed/Revised: _____

Date Reviewed/Revised: _____

Date Reviewed/Revised: _____



DENTAL CLINIC

Attachment 1 to:

Policy and Procedure Oral Health Records Management

POLICY: The dental health record will be annotated with a “medical alert sticker” whenever there is a significant health related condition that may affect patient treatment and / or the administration of medications. The final decision as to the placement of the “medical alert sticker” rests with the professional judgement of the provider.

PROCEDURE:

- I. The provider/assistant rendering the initial care to a patient will be the focal point to review the patient’s medical history and insure, when indicated, that the dental health record is properly annotated with a “medical alert sticker”.
- II. The “medical alert sticker” will be attached to the upper right hand corner of the front cover of the patient’s dental health record. Do not list the specific problem on the sticker.
- III. With reference to the “Dental Clinic Medical History Form” the following conditions require placement of a “medical alert sticker”;
 - A. Line item 6a. – relating to coronary valvular conditions.
 - B. Line item 6b. – relating to congenital heart lesions.
 - C. Line item 6c. – relating to cardiovascular disease.
 - D. Line item 6i. – relating to Diabetes.
 - E. Line item 6j. – relating to hepatic disease.
 - F. Line item 6n. – relating to Tuberculosis.
 - G. Line item 6q. – relating to sexually transmitted diseases.
 - H. Line item 6t. – relating to AIDS or immunosuppression.
 - I. Line item 6a&b. – relating to bleeding abnormalities.
 - J. Line item 12b. – relating to taking anticoagulants.
 - K. Line item 12c. – relating to taking blood pressure meds.
 - L. Line item 12d. – relating to taking steroids.
 - M. Line item 12i. – related to taking drugs for heart trouble.
 - N. Line item 12j. – related to taking Nitroglycerin.
 - O. Line item 13atoh. – relating to allergies to medications.



DENTAL CLINIC

Attachment 2 to:

Policy and Procedure Oral Health Records Management

Record Keeping Considerations

1. **Date and time of appointment (include the year)**
2. **Clinical findings**
3. **Chief complaint of the patient**
4. **Radiographs and findings, number taken**
5. **Tests and results**
6. **Diagnosis**
7. **Treatment plan as rendered (expanded fully)**
8. **Use standard abbreviations**
9. **How the treatment was rendered**
10. **Anesthesia – site and dose**
11. **Post-operative instructions**
12. **Medications prescribed and how to be taken**
13. **Treatment refused**
14. **Patient comments**
15. **Treatment accepted**
16. **Failed appointments**
17. **Lack of following directions**
18. **Non-compliance by the patient**
19. **Limitations of treatment**
20. **Risks of treatment**
21. **Risks of not having treatment**
22. **Future treatment that may be required**
23. **Name of the doctor to whom the patient was referred**
24. **A copy of the referral sheet**
25. **Signature for refused recommendations**
26. **Informed consent document**
27. **Discussion topics**
28. **Drawing or pictures used in describing treatment or clarifying treatment**
29. **Estimated expenses for the patient**
30. **Medication reactions**
31. **Copy of the information letter**
32. **Corroborating notes by your auxiliary with signature or initials**

33. **Avoid using vernacular**
34. **Use accepted dental and medical terminology**
35. **Record oral orders**
36. **Denture approval**
37. **Adverse patient attitude**
38. **All existing restorations**
39. **Foreign bodies found**
40. **Inadvertent mishaps during treatment and the advising of the patient (broken file, root tip, etc.). Be complete.**
41. **There are not guarantees**
42. **Materials used**
43. **Home care instructions and pamphlets**
44. **Laboratory prescriptions**
45. **All telephone calls regarding the patient's treatment. Record if no answer, also.**
46. **Telephone calls received at home from a patient**
47. **Patient's expected method of payment**
48. **Complete medical history**
49. **Complete dental history**
50. **Allergy to metals**
51. **Allergy to acrylics**
52. **Allergy to latex**
53. **Allergy to vinyl**

