

# Guideline on Record-keeping

## Originating Council

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## Review Council

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## Adopted

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## Purpose

The American Academy of Pediatric Dentistry (AAPD) recognizes the patient record is an essential component of the delivery of competent and quality oral health care. It serves as an information source for the care provider and patient, as well as any authorized third party. This guideline will assist the practitioner in assimilating and maintaining a comprehensive, uniform, and organized record addressing patient care. However, it is not intended to create a standard of care.

## Methods

This guideline was developed through reviews of current literature, recommendations of the American Dental Association, and current record-keeping by pediatric dental residency programs, dental schools, and pediatric dental practitioners, as well as consultation with experts in risk management. A MEDLINE search was conducted using the keywords “record-keeping”, “dental chart”, “dental record”, “risk management”, “electronic patient record”, and “electronic oral health record”.

## Background

The patient record provides all privileged parties with the history and details of patient assessment and communications between dentist and patient, as well as specific treatment recommendations, alternatives, risks, and care provided. The patient record is an important legal document in third party relationships. Poor or inadequate documentation of patient care consistently is reported as a major contributing factor in unfavorable legal judgments against dentists.<sup>1,2</sup> Therefore, the AAPD recognizes that a guideline on record-keeping may provide dentists the information needed to compile an accurate and complete patient chart that can be interpreted by a knowledgeable third party.

An electronic patient record is becoming more commonplace.<sup>3,4</sup> Advantages include quality assurance by allowing comparative analysis of groups of patients or providers, medical and dental history profiles for demographic data, support for decision making based on signs and symptoms, administrative management for patient education and recall, and electronic data interchange with other professional and third parties. The

software must contain all the essential elements of a traditional paper record.

The elements of record-keeping addressed in this guideline are general charting considerations; initial patient record; components of a patient record; patient medical and dental histories; comprehensive and limited clinical examinations; treatment planning and informed consent; progress notes; correspondence, consultations, and ancillary documents; and confidential notes. Additionally, appendices to this guideline illustrate items for consideration in the development of patient medical and dental histories and examination forms. These lists, developed by experts in pediatric dentistry and offered to facilitate excellence in practice, should be modified as needed by individual practitioners. These samples do not establish or evidence a standard of care. In issuing this information, the AAPD is not engaged in rendering legal or other professional advice. If such services are required, competent legal or other professional counsel should be sought.

## Recommendations

### General charting considerations

The dental record must be authentic, accurate, legible, and objective. Each patient should have an individual dental record. Chart entries should contain the initials or name of the individual making the note. Abbreviations should be standardized for the practice. Risk management experts recommend a problem-oriented record.<sup>5</sup> After data collection, a list is compiled that includes medical considerations, psychological/behavior constraints, and the oral health needs to be addressed. Problems are listed in order of importance in a standardized fashion making it less likely that an area might be overlooked. The plan identifies a general course of treatment for each problem. This plan can result in the need for additional information, consultation with other practitioners, patient education, and preventive strategies.

### Initial patient record

The parent's/patient's initial contact with the dental practice, usually via telephone, allows both parties an opportunity to

address the patient's primary oral health needs and to confirm the appropriateness of scheduling an appointment with that particular practitioner. During this conversation, the receptionist may record basic patient information such as:

- Patient's name, nickname, and date of birth
- Name, address, and telephone number of parent
- Name of referring party
- Significant medical history
- Chief complaint

Such information constitutes the initial dental record. At the first visit to the dental office, additional information would be obtained and a permanent dental record developed.

### Components of a patient record

The dental record must include each of the following specific components:

1. Medical history
2. Dental history
3. Clinical assessment
4. Diagnosis
5. Treatment recommendations
6. Progress notes

When applicable, the following should be incorporated into the patient's record as well:

1. Radiographic assessment
2. Caries risk assessment
3. Informed consent documentation
4. Sedation/general anesthesia records
5. Trauma records
6. Orthodontic records
7. Consultations/referrals
8. Laboratory orders
9. Test results
10. Additional ancillary records

### Medical history<sup>1,2,6-8</sup>

An accurate, comprehensive, and up-to-date medical history is necessary for correct diagnosis and effective treatment planning. Familiarity with the patient's medical history is essential to decreasing the risk of aggravating a medical condition while rendering dental care. The practitioner, or staff under the supervision of the practitioner, must obtain a medical history from the parent (if the patient is under the age of 18) before commencing patient care. When the parent cannot provide adequate details regarding a patient's medical history, or if the dentist providing care is unfamiliar with the patient's medical diagnosis, consultation with the medical health care provider may be indicated.

Documentation of the patient's medical history includes the following elements of information, with elaboration of positive findings:

- Medical conditions and/or illnesses
- Name and, if available, telephone number of primary and specialty medical care providers

- Hospitalizations/surgeries
- Anesthetic experiences
- Current medications
- Allergies/reactions to medications
- Other allergies/sensitivities
- Immunization status
- Review of systems
- Family history
- Social history

Appendix I provides suggestions for specific information that may be included in the written medical questionnaire or during discussions with the patient/parent. The history form should provide the parent additional space for information regarding positive historical findings, as well any medical conditions not listed. There should be areas on the form indicating the date of completion, the signature of the person providing the history (along with his/her relationship to the patient), and the signature of the staff member reviewing the history with the parent/guardian. Records of patients with significant medical conditions should be marked "Medical Alert" in a conspicuous yet confidential manner.

### Medical history for adolescents<sup>9</sup>

The adolescent can present particular psychosocial characteristics that impact the health status of the oral cavity, care seeking, and compliance. Integrating positive youth development<sup>8</sup> into the practice, the practitioner should obtain additional information confidentially from teenagers. Topics to be discussed may include nutritional and dietary considerations, eating disorders, alcohol and substance abuse, tobacco usage, over-the-counter medications and supplements, body art (eg, intra- and extraoral piercings, tattoos), and pregnancy.

### Medical updates

At each patient visit, the history should be consulted and updated. Recent medical attention for illness or injury, newly diagnosed medical conditions, and changes in medications should be documented. A written update should be obtained at each recall visit.

### Dental history<sup>2,6,10,11</sup>

A thorough dental history is essential to guide the practitioner's clinical assessment, make an accurate diagnosis, and develop a comprehensive preventive and therapeutic program for each patient. The dental history should address the following:

- Chief complaint
- Previous dental experience
- Date of last dental visit/radiographs
- Oral hygiene practices
- Fluoride use/exposure history
- Dietary habits (including bottle/no-spill training cup use in young children)
- Oral habits
- Previous orofacial trauma

- Temporomandibular joint (TMJ) history
- Family history of caries
- Social development

Appendix II provides suggestions for specific information that may be included in the written dental questionnaire or during discussions with the patient/parent.

### **Comprehensive clinical examination<sup>2,7,12</sup>**

The clinical examination is tailored to the patient's chief complaint (eg, initial visit to establish a dental home, acute traumatic injury, second opinion). A visual examination should precede other diagnostic procedures. Components of a comprehensive oral examination include:

- General health/growth assessment
- Pain assessment
- Extraoral soft tissue examination
- TMJ assessment
- Intraoral soft tissue examination
- Oral hygiene and periodontal health assessment
- Assessment of the developing occlusion
- Intraoral hard tissue examination
- Radiographic assessment, if indicated<sup>13</sup>
- Caries risk assessment<sup>14</sup>
- Assessed behavior of child

Appendix III provides suggestions for specific information that may be included in the oral examination.

The dentist may employ additional diagnostic tools to complete the oral health assessment. Such diagnostic aids may include electric or thermal pulp testing, photographs, laboratory tests, and study casts. If the child is old enough to talk, the speech may be evaluated and provide additional diagnostic information.

### **Examinations of a limited nature**

If a patient is seen for limited care, a consultation, an emergency, or a second opinion, a medical and dental history should be obtained, along with a hard and soft tissue examination as deemed necessary by the practitioner. The parent should be informed of the limited nature of the treatment and counseled to seek routine comprehensive care.

The AAPD's Guideline on Management of Acute Dental Trauma<sup>15</sup> provides greater details on diagnostic procedures and documentation for this clinical circumstance.

### **Treatment recommendations and informed consent**

Once the clinician has obtained the medical and dental histories and evaluated the facts obtained during the diagnostic procedures, the diagnoses should be derived and a sequential prioritized treatment plan developed. The treatment plan would include specific information regarding the nature of the procedures/materials to be used, number of appointments/time frame needed to accomplish this care, behavior guidance techniques, and fee for proposed procedures. The dentist is obligated to educate the parent on the need for and benefits of the recommended

care, as well as risks, alternatives, and expectations if no intervention is provided. When deemed appropriate, the patient should be included in these discussions. The dentist should not attempt to decide what the parent will accept or can afford. After the treatment plan is presented, the parent should have the opportunity to ask questions regarding the proposed care and have concerns satisfied prior to giving informed consent. Documentation should include that the parent appeared to understand and accepted the proposed procedures. Any special restrictions of the parent should be documented.

### **Progress notes**

An entry must be made in the patient's record that accurately and objectively summarizes each visit. The following information should be included:

- Date of visit
- Reason for visit/chief complaint
- Adult accompanying child
- Verification of compliance with pre-operative instructions
- Changes in the medical history, if any
- Radiographic exposures and interpretation
- Reference to supplemental documents
- Treatment rendered, including anesthetic agents<sup>16</sup> and/or nitrous oxide/oxygen<sup>17</sup>
- Patient behavior
- Post-operative instructions and prescriptions
- Anticipated follow-up visit

A standardized format may provide the practitioner a way to record the essential aspects of care on a consistent basis. One example of documentation is the SOAP note.<sup>18</sup> SOAP is an acronym for "subjective" (S) or the patient's response and feeling to treatment, "objective" (O) or the observations of the clinician, "assessment" (A) or diagnosis of the problem, and "procedures accomplished and plans" (P) for subsequent problem resolving activities. The signature or initials of the office staff member documenting the visit should be entered.

When sedation or general anesthesia is employed, additional documentation on a time-based record is required, as discussed in the AAPD's Guideline for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.<sup>19</sup>

Progress notes also should include telephone conversations regarding the patient's care, appointment history (ie, cancellations, failures, tardiness), non-compliance with treatment recommendations, and educational materials utilized (both video and written), along with identification of the staff member making the entry in the dental record.

### **Orthodontic treatment**

The AAPD's Guideline on Management of the Developing Dentition and Occlusion in Pediatric Dentistry<sup>20</sup> and the American Board of Pediatric Dentistry site visit requirements<sup>8</sup> provide general recommendations on the documentation of

orthodontic care. Signs and/or symptoms of TMJ disorders should be recorded when they occur before, during, or after orthodontic treatment.<sup>21</sup> During orthodontic treatment, progress notes should include deficiencies in oral hygiene, loose bands and brackets, patient complaints, caries, root resorption, and cancellations and failures.

**Correspondence, consultations, and ancillary documents**

The primary care dentist often consults with other health care providers in the course of delivery of comprehensive oral health care, especially for patients with special health care needs or complex oral conditions. Communications with medical care providers or dental specialists should be incorporated into the dental record. Written referrals to other care providers should include the specific nature of the referral, as well as pertinent patient history and clinical findings. A progress note should be made on correspondence sent or received regarding a referral, indicating documentation filed elsewhere in the patient’s chart. Copies of test results, prescriptions, laboratory work orders, and other ancillary documents should be maintained as part of the dental record.

**Confidential notes**

The practitioner may elect to keep on a separate form subjective notes addressing impressions and opinions of the doctor and/or staff concerning parent/patient interactions that may or did result in negative consequences.

**Appendices\***

\*The information included in the following samples, developed by the AAPD, is provided as a tool for pediatric dentists and other dentists treating children. It was developed by experts in pediatric dentistry, and is offered to facilitate excellence in practice. However, these samples do not establish or evidence a standard of care. In issuing this information, the AAPD is not engaged in rendering legal or other professional advice. If such services are required, competent legal or other professional counsel should be sought.

**Appendix I—Medical history\***

- Name and nickname
- Date of birth
- Gender
- Race/ethnicity
- Height/weight by report
- Name, address, and telephone number of all physicians
- Date of last physical examination
- Immunization status
- Summary of health problems
- Any health conditions that necessitate antibiotics prior to dental treatment

- Allergies/sensitivities/reactions
  - Anesthetics, local and general
  - Sedative agents
  - Drugs or medications
  - Environmental
  - Latex
  - Food
  - Dyes
  - Metal
  - Acrylic
- Medications, including over-the-counter analgesics, vitamins, and herbal supplements
  - Dose
  - Frequency
  - Reactions
- Hospitalizations—reason, date, and outcome
- Surgeries—reason, date, and outcome
- Significant injuries—description, date, and outcome
- General
  - Complications during pregnancy and/or birth
  - Prematurity
  - Congenital anomalies
  - Cleft lip/palate
  - Inherited disorders
  - Nutritional deficiencies
  - Problems of growth or stature
- Head, ears, eyes, nose, throat
  - Lesions in/around mouth
  - Chronic adenoid/tonsil infections
  - Chronic ear infections
  - Ear problems
  - Hearing impairments
  - Eye problems
  - Visual impairments
  - Sinusitis
  - Speech impairments
  - Apnea/snoring
  - Mouth breathing
- Cardiovascular
  - Congenital heart defect/disease
  - Heart murmur
  - High blood pressure
  - Rheumatic fever
  - Rheumatic heart disease
- Respiratory
  - Asthma—medications, triggers, last attack, hospitalizations

Tuberculosis	Headaches/migraines
Cystic fibrosis	Hydrocephaly
Frequent colds/coughs	Shunts—ventriculoperitoneal, ventriculoatrial
Respiratory syncytial virus	Psychiatric
Reactive airway disease/breathing problems	Abuse
Smoking	Alcohol and chemical dependency
Gastrointestinal	Emotional disturbance
Eating disorder	Hyperactivity/attention deficit hyperactivity disorder
Ulcer	Psychiatric problems/treatment
Excessive gagging	Endocrine
Gastroesophageal/acid reflux disease	Diabetes
Hepatitis	Growth delays
Jaundice	Hormonal problems
Liver disease	Precocious puberty
Intestinal problems	Thyroid problems
Prolonged diarrhea	Hematologic/lymphatic/immunologic
Unintentional weight loss	Anemia
Lactose intolerance	Blood disorder
Dietary restrictions	Transfusion
Genitourinary	Excessive bleeding
Bladder infections	Bruising easily
Kidney infections	Hemophilia
Pregnancy	Sickle cell disease/trait
Systemic birth control	Cancer, tumor, other malignancy
Sexually transmitted diseases	Immune disorder
Musculoskeletal	Chemotherapy
Arthritis	Radiation therapy
Scoliosis	Hematopoietic cell (bone marrow) transplant
Bone/joint problems	Infectious disease
TMJ problems—popping, clicking, locking, difficulties opening or chewing	Measles
Integumentary	Mumps
Fever blisters	Rubella
Eczema	Scarlet fever
Rash/hives	Varicella (chicken pox)
Dermatologic conditions	Mononucleosis
Neurologic	Cytomegalovirus (CMV)
Fainting	Pertussis (whooping cough)
Dizziness	Human immunodeficiency virus/acquired immune deficiency syndrome—(HIV/AIDS)
Autism	Family history
Developmental disorders	Genetic disorders
Learning problems/delays	Problems with general anesthesia
Mental disability	Serious medical conditions or illnesses
Brain injury	Social concerns
Cerebral palsy	Passive smoke exposure
Convulsions/seizures	Religious or philosophical objections to treatment
Epilepsy	

**Appendix II—Dental History\***

- Previous dentist, address, phone number
- Family dentist
- Date of last visit
- Date of last dental radiographs, number and type taken, if known
- Prenatal/natal history
- Family history of caries, including parents and siblings
- History of smoking in the home
- Medications or disorders that would impair salivary flow
- Injuries to teeth and jaws, including TMJ trauma
  - When
  - Treatment required
- Dental pain and infections
- Habits (past and present) such as finger, thumb, pacifier, tongue or lip sucking, bruxism, clenching
- Snoring
- Diet and dietary habits
  - Breast feeding - frequency
  - Bottle feeding/no-spill training (sippy) cup use
    - Frequency
    - Formula, milk water, juice
    - Weaned/When
  - Sodas, fruit juice, sports drinks, beverages—amount, frequency
  - Snacks—type, frequency
  - Meals—balanced
- Oral hygiene
  - Frequency of brushing, flossing
  - Assisted/supervised
- Fluoride exposure
  - Primary source of drinking water—home, daycare, other
  - Water—tap, bottled, well, reverse osmosis
  - Systemic supplementation—tablets, drops
  - Topical—toothpaste, rinses, prescription
- Previous orthodontic treatment
- Behavior of child during past dental treatment
- Behavior anticipated for future treatment

**Appendix III—Clinical Examination\***

- General health/growth assessment
  - Growth appropriate for age
  - Height/weight/frame size/body mass index (BMI)
- Vital signs
  - Blood pressure
  - Pulse
- Extraoral examination
  - Facial features
  - Nasal breathing
  - Lip posture
  - Symmetry
  - Pathologies
  - Skin health
- Temporomandibular joint/disorder (TMJ/TMD)<sup>12</sup>
  - Signs of clenching/bruxism
  - Headaches from TMD
  - Pain
  - Joint sounds
  - Limitations or disturbance of movement or function
- Intra-oral soft tissue examination
  - Tongue
  - Roof of mouth
  - Frenulae
  - Floor of mouth
  - Tonsils/pharynx
  - Lips
  - Pathologies noted
- Oral hygiene and periodontal assessment<sup>22,23</sup>
  - Oral hygiene, including an index or score
  - Gingival health, including an index or score
  - Probing of pocket depth, when indicated
  - Marginal discrepancies
  - Calculus
  - Bone level discrepancies that are pathologic
  - Recession/inadequate attached gingiva
  - Mobility
  - Bleeding/suppuration
  - Furcation involvement
- Assessment of the developing occlusion
  - Facial profile
  - Canine relationships
  - Molar relationships
  - Overjet
  - Overbite

Midline  
 Crossbite  
 Alignment  
 Crowding  
 Centric relation/centric occlusion discrepancy  
 Influence of oral habits  
 Appliances present  
 Intraoral hard tissue examination  
   Teeth present  
   Supernumerary/missing teeth  
   Dental development status  
   Over-retained primary teeth  
   Ankylosed teeth  
   Ectopic eruption  
   Anomalies/pathologies noted  
   Tooth size, shape discrepancies  
   Tooth discoloration  
   Enamel hypoplasia  
   Congenital defects  
   Existing restorations  
   Defective restorations  
   Caries  
   Pulpal pathology<sup>24</sup>  
   Traumatic injuries  
   Third molars  
 Radiographic examination<sup>25</sup>  
   Developmental anomalies  
   Eruptive patterns/tooth positions/root resorption  
   Crestal alveolar bone level  
   Pulpal/furcation/periapical pathology  
   Caries – presence, proximity to pulp space,  
     demineralization/ remineralization  
   Existing pulpal therapy/restorations  
   Traumatic injury  
   Calculus deposits  
   Occult disease  
   Explanation of inability to obtain diagnostic  
     image when indicated  
 Caries-risk assessment<sup>14</sup>

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