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) Alphabetical 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: ________________
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.
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
Attachment 3 to:

Policy and Procedure
Oral Health Records Management

Examples

1. The policy and procedure letter titled “Oral Health Records Management” contains guidelines of how we set up, format and complete our records.

2. Additional information:

   A. The patient will complete their medical information history prior to seating. You must review the completed history and clarify, amend and/or correct any positive entries. Check the patient history at every visit and update those that are out of date.

   B. Generally, format the dental progress notes as follows:

      1/7/99 c.c. “Pain #14, HHT, LOE, clinical and PAX #14 indicates severely carious #14 with periapical radiolucency, chronic apical periodontitis #14 – Ext., LA: Lidocaine 2% 1:100,000 Epi x 3.6 ml. By infiltration. Rx Tylenol #3 x 12, cap 4-6 PRN pain. Written & verbal post instr. Given. N.V. T Comp.

      Signature

   C. Format restorative as follows:

      1/7/99 HHR, Res appt, CAR #14-MO-dycal – copalite-AM, RD LA: Lidocaine 2% 1:00,000 EPI: X1.8ml by infiltration. OHI flossing instructions. N.V. op #18 & 19.

      Signature

   D. When doing an examination, include the following:

      1. Charting of restorations, missing teeth, caries, teeth requiring extraction, other Pathology, etc., as specified in the policy and procedure letter.
2. **Perio:** note the general periodontal condition of the patient (usually on adults only).
   Address one of three items:
   a. Presence or absence of irritants;
   b. Presence or absence of gingivitis; or
   c. Presence or absence of periodontitis.

3. **Occlusion:** indicate molar relationship; severe overbites and overjets and any Crossbite relationships.

4. **Cancer check:** examine the entire oral cavity and pharynx for any lesions.

5. **Prevention counseling:** include brief oral hygiene instruction, nutritional Counseling, advantages of sealants, and if applicable, stress the benefits of fluoride.

6. **Format examination appointment as follows:**

   1/7/99   HHT, comprehensive oral evaluation (COE), BWX, Neg. car, mild localized gingivitis present, class I molar relationship, OHI – nutritional and oral health counseling, N.V. pro and sealants. Signature.

E. **Perio charting is done on a separate form titled “Hygiene Exam”.**
Completion of this form is self-explanatory.