Guideline on Record-keeping

Originating Council
Council on Clinical Affairs

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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 an appropriate record addressing many aspects of 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, and consultation with experts in risk management. A MEDLINE search was conducted using the keywords "record-keeping", "dental chart", and "dental record".

Background

The patient record provides all privileged parties with the history and details of patient assessment and communications between dentist, patient, and caregiver, as well as specific treatment recommendations, alternatives, risks, and care provided. It 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.[1,2] Therefore, the AAPD recognizes that a guideline on record-keeping may provide dentists the information needed to compile an accurate and complete pediatric patient chart that can be interpreted by a knowledgeable third party.

The elements of record-keeping addressed in this guideline are general charting recommendations; initial patient record; components of a patient record; patient medical and dental histories; comprehensive and limited clinical examinations; treatment recommendations 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. Excluded from this guideline are the specific requirements of Health Insurance Portability and Accountability Act, informed consent documentation, transfer of patient records, financial records, and the discharge of a patient. Federal and state laws regulate these areas of care; the practitioner is encouraged to consult local and state laws and individual legal counsel regarding these topics.

Recommendations

General charting considerations

The dental record must be authentic, accurate, legible, and objective. Each patient should have an individual dental record (ie, not several family members in the same chart). Chart entries should contain the initials or name of the individual making the note. Abbreviations should be standardized for the practice.

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

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 child'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:

- Child's name, nickname, and date of birth
- Name, address, and telephone number of parent/legal guardian
- 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. Informed consent documentation
3. Sedation/general anesthesia records
4. Trauma records
5. Orthodontic records
6. Consultations/referrals
7. Laboratory orders
8. Test results
9. Additional ancillary records

Medical history[1-5]

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/legal guardian (if the patient is under the age of 18) before commencing patient care. When the parent/legal guardian 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/guardian 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[7]

The adolescent can present particular psychosocial characteristics that impact the health status of the oral cavity, care seeking, and compliance. Integrating positive youth development[8] 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 (ie, 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[2,3,5,8]

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[2,4,9]

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
- 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 examination, if indicated
- Assessed behavior of child

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

Based upon the visual 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, caries-risk assessment tool[10], 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

The AAPD's Clinical Guideline on Management of the Developing Dentition[11] and Clinical Guideline on Management of Acute Traumatic Injuries[12] provide greater details on diagnostic procedures and documentation for these clinical circumstances.

Treatment recommendations and informed consent[10-20]

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 management techniques, and fee for proposed procedures. The dentist is obligated to educate the parent/legal guardian 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/legal guardian will accept or can afford. After the treatment plan is presented, the parent/legal guardian 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/legal guardian 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
- Changes in the medical history, if any
- Treatment rendered, including anesthetic agents used
- Patient behavior
- Post-operative instructions
- Anticipated follow-up visit

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 Clinical Guideline on the Elective Use of Minimal, Moderate, and Deep Sedation and General Anesthesia for Pediatric Dental Patients.[14]

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.

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 for children, especially those 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
- Male/female
- 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
  - 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
  - Mouthbreathing
- Cardiovascular
  - Congenital heart defect/disease
  - Heart murmur
  - High blood pressure
  - Rheumatic fever
  - Rheumatic heart disease
- Respiratory
  - Asthma – medications, triggers, last attack, hospitalizations
  - Tuberculosis
  - Cystic fibrosis
  - Frequent colds/coughs
  - Respiratory syncytial virus
  - Reactive airway disease/breathing problems
  - Smoking
- Gastrointestinal
  - Eating disorder
  - Ulcer
  - Excessive gagging
  - Gastroesophageal/acid reflux disease
  - Hepatitis
  - Jaundice
  - Liver disease
  - Intestinal problems
  - Prolonged diarrhea
  - Unintentional weight loss
  - Lactose intolerance
  - Dietary restrictions
- Genitourinary
  - Bladder infections
  - Kidney infections
  - Pregnancy
  - On birth control pills
  - Sexually transmitted diseases
- Musculoskeletal
  - Arthritis
  - Scoliosis
  - Bone/joint problems
  - TMJ problems—popping, clicking, locking, difficulties opening
- Integumetary
  - Fever blisters
  - Eczema
  - Rash/hives
  - Dermatologic conditions
- Neurologic
  - Fainting
  - Dizziness
  - Autism
  - Developmental disorders
  - Learning problems/delays
  - Mental disability
  - Brain injury
  - Cerebral palsy
  - Convulsions/seizures
  - Epilepsy
  - Headaches/migraines
  - Hydrocephaly
  - Shunts—ventriculoperitoneal, ventriculoatrial
- Psychiatric
  - Abuse
  - Alcohol and chemical dependency

- Emotional disturbance
- Hyperactivity/Attention Deficit Hyperactivity Disorder
- Psychiatric problems/treatment

Endocrine
- Diabetes
- Growth delays
- Hormonal problems
- Precocious puberty
- Thyroid problems

Hematologic/lymphatic/immunologic
- Anemia
- Blood disorder
- Transfusion
- Excessive bleeding
- Bruising easily
- Hemophilia
- Sickle cell disease/trait
- Cancer, tumor, other malignancy
- Immune disorder
- Chemotherapy
- Radiation therapy
- Hematopoietic cell (bone marrow) transplant

Infectious disease
- Measles
- Mumps
- Rubella
- Scarlet fever
- Varicella (Chicken pox)
- Mononucleosis
- Cytomegalovirus (CMV)
- Pertussis (Whooping cough)
- Human immunodeficiency virus/Acquired Immune Deficiency Syndrome – (HIV/AIDS)

Family history
- Genetic disorders
- Problems with general anesthesia
- Serious medical conditions or illnesses

Social concerns
- Passive smoke exposure
- Religious or philosophical objections to treatment

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 such as finger, thumb, pacifier, tongue or lip sucking, bruxism, clenching (past and present)
Snoring
Diet and dietary habits
- Breast feeding/bottle feeding
  - Frequency
  - Formula, milk water, juice
  - Weaned? When?
- Cup or no-spill training (sippy) cup use
- Sodas, fruit juice, sports drinks, beverages
  - Amount
  - Frequency
- Snacks
  - Foods
  - 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
- Vital signs
  - Blood pressure
  - Pulse

Extraoral examination
- Facial features
- Nasal breathing
- Lip posture
- Symmetry
- Pathologies
- Skin health

Temporomandibular joint/disorder (TMJ/TMD)[9]
- Signs of clenching/bruxism
- Headaches from TMD
- Pain
- Popping/clicking
- Function

Intra-oral soft tissue examination
- Tongue
- Roof of mouth
- Frenulae
- Floor of mouth
- Tonsils
- Lips
- Pathologies noted

Oral hygiene and periodontal assessment[2,19,20]
- 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
- Mobility
- Bleeding/suppuration
- Furcation involvement

Assessment of the developing occlusion
- Facial profile
- Canine relationships
- Molar relationships
- Overjet
- Overbite
- Midline
- Crossbite
- Alignment
- Crowding
- Influence of oral habits
- Appliances present

Intra-oral 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
- Enamel hypoplasia
- Congenital defects
- Existing restorations
- Defective restorations
- Caries
- Pulpal pathology[16]
- Traumatic injuries
- Third molars

Caries-risk assessment[10]

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