Guideline on Record-keeping

Originating Council
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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.[1,2] 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.[3,4] 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.[5] 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[1,2,6-8]

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[9]

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 (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 diag-nosed medical conditions, and changes in medications should be documented. A written update should be obtained at each recall visit.

Dental history[2,6,10,11]

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[2,7,12]

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 com-prehensive 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[13]
- Caries risk assessment[14]
- 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[15] 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 preoperative instructions
- Changes in the medical history, if any
- Radiographic exposures and interpretation
- Reference to supplemental documents
- Treatment rendered, including anesthetic agents[16] and/or nitrous oxide/oxygen[17]
- 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.[18] 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.[19]

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[20] and the American Board of Pediatric Dentistry site visit requirements[8] 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.[21] 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 (including 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
- 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
- Systemic birth control
- Sexually transmitted diseases

Musculoskeletal
- Arthritis
- Scoliosis
- Bone/joint problems
- TMJ problems—popping, clicking, locking, difficulties opening or chewing

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, ventriculovenous

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, telephone 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)[12]
    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[22,23]
    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[24]
- Traumatic injuries
- Third molars

Radiographic examination[25]
- 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[14]

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