Guideline on Record-keeping

Originating Council
Council on Clinical Affairs

Review Council
Council on Clinical Affairs

Adopted
2004
Revised

Purpose
The American Academy of Pediatric Dentistry (AAPD) recognizes that 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 is an update of the previous document adopted in 2004 and last revised in 2007, 2012. This revision included a new systematic literature search of the MEDLINE/PubMed® electronic database using the following parameters: Terms: dental record, electronic patient record, problem-oriented dental record, medical history taking, medical record, record keeping, and HIPAA; Fields: all; Limits: within the last 10 years, humans, and English. Four hundred ninety-five articles matched these criteria. Papers for review were chosen from this list and from the references within selected articles and dental textbooks. When data did not appear sufficient or were inconclusive, recommendations were based upon expert and/or consensus opinion by experienced researchers and clinicians.

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,
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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\(^1\). 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, and perhaps will become mandatory\(^1\-^3\). Health information systems and electronic health records are being implemented as a means to improve the quality and efficiency of health care\(^4\). 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. Daily back up of the office software system should be performed and stored in an e-located data base retrievable by the office in the event that patient records are lost or damaged.

The elements of record-keeping addressed in this guideline document 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...
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problem-oriented record (Valenza 1994). 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.
- Availability of medical/dental records (including radiographs) pertaining to patient’s condition.

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:

- Medical history.
- Dental history.
- Clinical assessment.
- Diagnosis.
- Treatment recommendations.
- Progress notes.
- Acknowledgment of receipt of Notice of Privacy Practices/Health Insurance Portability and
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Accountability Act (HIPAA) consent.

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

- Radiographic assessment.
- Caries risk assessment.
- Informed consent documentation. Parental consent/ patient assents
- Sedation/general anesthesia records.
- Trauma records.
- Orthodontic records.
- Consultations/referrals.
- Laboratory orders.
- Test results.
- Additional ancillary records.

**Medical history**

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. Additionally, a thorough history can aid the diagnosis of dental as well as medical conditions. 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.
- Current therapies (i.e., physical, occupational, speech)
• 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/legal 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/legal guardian. Records of patients with significant medical conditions should be marked Medical Alert in a conspicuous yet confidential manner.

Supplemental history for infants/toddlers\textsuperscript{11,12}

The very young patient can present with unique developmental and social concerns that impact the health status of the oral cavity. Information regarding these considerations may be collected via a supplemental history questionnaire for infants/toddlers. Topics to be discussed may include a history of prematurity/perinatal complications, developmental considerations, feeding and dietary practices, timing of first tooth appearance, and tooth brushing initiation and timing as well as toothpaste use. Assessment of developmental milestones (i.e., fine/gross motor skills, language, social interactions) is crucial for early recognition of potential delays and appropriate referral to therapeutic services\textsuperscript{13}. As a majority of infants and toddlers of employed mothers receive childcare on a regular basis from persons other than their parents, (census.gov) and because the primary caretaker influences the child’s risk for caries, the questionnaire also should ascertain childcare arrangements. Data gathered from this questionnaire will benefit the clinical examination, caries risk assessment, preventive home-care plan, and anticipatory guidance counseling. A sample form is available on the AAPD Website at
Medical Supplemental history for adolescents\textsuperscript{10,12}

The adolescent can present particular psychosocial characteristics that impact the health status of the oral cavity, care seeking, and compliance. Integrating positive youth development into the practice, the practitioner should obtain additional information confidentially from teenagers. (AAPD Ped Med History ref section) 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 (e.g., intra- and extraoral piercings, tattoos), as well as and the use of oral contraceptives and pregnancy for the female adolescent. A sample confidential history form is available on the AAPD Website at \url{http://www.aapd.org/media/Policies_Guidelines/RS_MedHistoryForm.pdf}.

Medical update\textsuperscript{12}

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\textsuperscript{8,9,11,14}

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.
- Sports activities.
- Previous orofacial trauma.
- Temporomandibular joint (TMJ) history.
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**

The clinical examination is tailored to the patient’s chief complaint (e.g., 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/BMI calculation (i.e., height/weight/vital signs)
- 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.
- Caries risk assessment.
- 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 in children who are able to talk.

**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 must 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 for the Management of Traumatic Dental Injuries Guideline on Management of Acute Dental Trauma The Assessment of Acute Traumatic Injuries Form\(^\text{19}\) provides greater details on diagnostic procedures and documentation for this clinical circumstance emergent traumatic injury care.

**Treatment recommendations and informed consent**\(^\text{20}\)

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 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. For adult patients, with special health care needs, it is important to determine who legally can provide consent for treatment\(^\text{20}\). The practitioner should document interpreters or translation services used to aid communication (e.g., in person, by telephone). Documentation should include that the parent appeared to understand and accepted the proposed procedures. Any special restrictions of requested by 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 entry must minimally contain the following information:

- Date of visit.
- Reason for visit/chief complaint.
- Radiographic exposures and interpretation, if any.
- Treatment rendered including, but not limited to, the type and dosage of anesthetic agents\(^\text{21}\), medications, and/or nitrous oxide/oxygen\(^\text{22}\) and type/duration of protective stabilization\(^\text{18,23}\).
treatment complications, and adverse outcomes.

- Post-operative instructions and prescriptions as needed.

In addition, the entry generally should document:

- Changes in the medical history, if any.
- Adult accompanying child.
- Verification of compliance with preoperative instructions.
- Reference to supplemental documents.
- Patient behavior guidance.
- **Planned treatment for next 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\textsuperscript{24}. 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 Before, During, and After Sedation for Diagnostic and Therapeutic Procedures: Update 2016\textsuperscript{25}.

Progress notes also should include telephone conversations regarding the patient’s care, appointment history (i.e., 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\textsuperscript{26} provides 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\textsuperscript{27}. 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. Reports received from other health care providers should be incorporated into the patient’s chart. 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.

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—Sex
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 or other medications 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 medications, vitamins, homeopathic 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

Infective endocarditis
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354 Heart murmur
355 High blood pressure
356 Rheumatic fever
357 Rheumatic heart disease

358 Respiratory
359 Asthma—medications, triggers, last attack, hospitalizations
360 Tuberculosis
361 Cystic fibrosis
362 Frequent colds/coughs
363 Respiratory syncytial virus
364 Reactive airway disease/breathing problems
365 Smoking

366 Gastrointestinal
367 Eating disorder (e.g., anorexia, bulimia, pica)
368 Ulcer
369 Excessive gagging
370 Gastroesophageal/acid reflux disease
371 Hepatitis
372 Jaundice
373 Liver disease
374 Intestinal problems
375 Prolonged diarrhea
376 Unintentional weight loss
377 Lactose intolerance
378 Dietary restrictions

379 Genitourinary
380 Bladder infections
381 Kidney infections
382 Pregnancy
383 Systemic birth control
384 Sexually transmitted diseases infections
385 Musculoskeletal
386 Arthritis
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387 Scoliosis
388 Bone/joint problems
389 Temporomandibular disorders (TMJ problems)—popping, clicking, locking, difficulties opening or chewing
390 Integumentary
391 Herpetic/ulcerative lesions
392 Eczema
393 Rash/hives
394 Dermatologic conditions
396 Neurologic
397 Fainting
398 Dizziness
399 Autism Spectrum Disorder
400 Developmental disorders
401 Learning problems/delays (e.g. enrollment in specialized school or individualized education plan)
403 Mental Intellectual disability
404 Brain injury
405 Cerebral palsy
406 Convulsions/seizures
407 Epilepsy
408 Headaches/migraines
409 Hydrocephaly
410 Shunts—ventriculoperitoneal, ventriculoatrial, ventriculovenous
411 Psychiatric
412 Abuse Maltreatment (e.g. physical abuse, sexual abuse, dental neglect, bullying)
413 Alcohol and chemical dependency
414 Emotional disturbance
415 Hyperactivity/attention deficit hyperactivity disorder
416 Pediatric acute-onset neuropsychiatric syndrome (PANS)
417 Obsessive compulsive disorder
418 Psychiatric problems/treatment
419 Endocrine
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420 Diabetes
421 Growth delays
422 Hormonal problems
423 Precocious puberty
424 Thyroid problems
425 Hematologic/lymphatic/immunologic
426 Anemia
427 Blood disorder
428 Transfusion
429 Excessive bleeding
430 Bruising easily
431 Hemophilia
432 Sickle cell disease/trait
433 Cancer, tumor, other malignancy
434 Immune disorder
435 Chemotherapy
436 Radiation therapy
437 Hematopoietic cell (bone marrow) transplant
438 Infectious disease
439 Measles
440 Mumps
441 Rubella
442 Scarlet fever
443 Varicella (chicken pox)
444 Mononucleosis
445 Cytomegalovirus (CMV)
446 Pertussis (whooping cough)
447 Human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS)
448 Sexually transmitted infections
449 Zika virus
450 Lyme disease
451 Family history
452 Genetic disorders
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453 Problems with general anesthesia
454 Serious medical conditions or illnesses
455 Social concerns
456 Chronic exposure to passive smoke
457 Religious or philosophical objections to treatment
458 Legal custody/guardianship status

460 Appendix II—Dental History*
461 Previous dentist, address, telephone number
462 Family dentist
463 Date of last visit dental examination
464 Date of last dental radiographs, number and type taken, if known
465 Date of last fluoride treatment
466 Prenatal/natal history
467 Family history of caries, including parents and siblings
468 History of smoking in the home
469 Medications or disorders that would impair salivary flow
470 Injuries to teeth and jaws, including TMJ trauma
471 When/where/how
472 Treatment required
473 Dental pain and infections
474 Habits (past and present) such as finger, thumb, pacifier, tongue or lip sucking, bruxism, clenching
475 Snoring
476 Diet and dietary habits
477 Breast feeding—frequency, weaned/when
478 Bottle feeding/no-spill training (sippy) cup use
479 Frequency
480 Content—Formula, milk water, juice
481 Weaned/when
482 Sugar-sweetened or sugar-containing beverages—e.g. Sodas, fruit juice, sports drinks, beverages—amount, frequency
483 Snacks—type, frequency
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Meals—balanced, frequency, restricted or special diet
Oral hygiene
Frequency of brushing, flossing, oral rinse use
Assisted/supervised
Fluoride exposure
Primary source of drinking water—home, daycare, other
Water—tap, bottled, well, filtered/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—pulse, blood pressure
Extraoral examination
Facial features
Nasal breathing
Lip posture
Symmetry
Pathologies
Skin health
Temporomandibular joint disorder (TMD/TMD)15
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
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/suppurative
Furcation involvement
Assessment of the developing occlusion
Facial profile
Canine relationships
Molar relationships
Overjet
Overbite Midline
Crossbite
Alignment
Spacing/crowding
Centric relation/centric occlusion discrepancy
Influence of oral habits
Appliances present
Intraoral hard tissue examination
Teeth present
Supernumerary/missing teeth
Dental development status
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Over-retained primary teeth
Ankylosed teeth
Ectopic eruption
Anomalies/pathologies noted
Tooth size, shape discrepancies
Tooth discoloration
Enamel hypoplasia/fluorosis
Congenital defects
Existing restorations
Defective restorations
Caries
Pulpal pathology
Traumatic injuries
Third molars
Radiographic examination
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—pathological condition
Explanation of inability to obtain diagnostic image when indicated
Caries-risk assessment

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