**This draft does not constitute an official AAPD health oral policy or clinical guideline until approval by the General Assembly. Circulation is limited to AAPD members.**

# Guideline on Record-keeping

## Originating Council

Council on Clinical Affairs

## Review Council

Council on Clinical Affairs

## Adopted

2004

## Revised

2007, 2012, 2017

## 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,

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~~

~~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

Accountability Act (HIPAA) consent[5,6].

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**[7-10]

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/toddler[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[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

"http://www.aapd.org/media/Policies_Guidelines/RS_MedHistoryForm.pdf ".

**~~Medical~~ Supplemental history for adolescents**[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 ~~ab~~use, 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 "http://www.aapd.org/media/Policies_Guidelines/RS_MedHistoryForm.pdf ".

**Medical update**[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**[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.

- 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**[7,8,15]

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[16].
- Caries risk assessment[17].
- Assessed behavior of child[18].

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~~ 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[19] provide~~s~~ greater details on diagnostic procedures and documentation for t~~his clinical circumstance~~ emergent traumatic injury care.

**Treatment recommendations and informed consent[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[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[21], medications, and/or nitrous oxide/oxygen[22], ~~and~~ type/duration of protective stabilization[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[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[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[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[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

- 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 (e.g., anorexia, bulimia, pica)
- 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~~ infections

Musculoskeletal

- Arthritis

- Scoliosis
- Bone/joint problems
- Temporomandibular disorders ~~TMJ problems~~—popping, clicking, locking, difficulties opening or chewing

~~Integumetary~~ Integumentary

- Herpetic/ulcerative lesions
- Eczema
- Rash/hives
- Dermatologic conditions

Neurologic

- Fainting
- Dizziness
- Autism Spectrum Disorder
- Developmental disorders
- Learning problems/delays (e.g. enrollment in specialized school or individualized education plan)
- ~~Mental~~ Intellectual disability
- Brain injury
- Cerebral palsy
- Convulsions/seizures
- Epilepsy
- Headaches/migraines
- Hydrocephaly
- Shunts—ventriculoperitoneal, ventriculoatrial, ventriculovenous

Psychiatric

- ~~Abuse~~ Maltreatment (e.g. physical abuse, sexual abuse, dental neglect, bullying)
- Alcohol and chemical dependency
- Emotional disturbance
- Hyperactivity/attention deficit hyperactivity disorder
- Pediatric acute-onset neuropsychiatric syndrome (PANS)
- Obsessive compulsive 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)
- Sexually transmitted infections
- Zika virus
- Lyme disease

Family history

- Genetic disorders

- Problems with general anesthesia
- Serious medical conditions or illnesses

Social concerns

- Chronic exposure to passive smoke
- Religious or philosophical objections to treatment
- Legal custody/guardianship status

**Appendix II—Dental History***

Previous dentist, address, telephone number

~~Family dentist~~

Date of last ~~visit~~ dental examination

Date of last dental radiographs, number and type taken, if known

Date of last fluoride treatment

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/where/how
- 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, weaned/when
- Bottle feeding/no-spill training (sippy) cup use
  - Frequency
  - Content—Formula, milk water, juice
  - Weaned/when
- Sugar-sweetened or sugar-containing beverages – e.g. Sodas, fruit juice, sports drinks, ~~beverages —~~ amount, frequency
- Snacks—type, frequency

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 (~~TMJ/~~**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[28, 29]

- 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
- 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

- 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[30]
- Traumatic injuries
- Third molars

Radiographic examination[31]

- 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[17]

## References

1. Speidel TM, Jerrold LJ. Record keeping to avoid or defend lawsuits: A defense attorney's perspective. Am J Orthod Dentofac Orthop 2004;125(6):754-6.
2. Heid DW, Chasteen J, Forrey AW. The electronic oral health record. J Contemp Dent Pract 2002;3(1):43-5.

3. Atkinson JC, Zeller GG, Shah C. Electronic patient records for dental school clinics: More than paperless systems. J Dent Educ 2002;66(5):634-42.
4. Balgrosky JA. Essentials of health information systems and technology. Burlington, MA: Jones and Bartlett Learning; 2015.
5. Sfikas PM. HIPAA security regulations: Protecting patients' electronic health information. J Am Dent Assoc 2003;134(5):640-3.
6. U.S. Department of Health and Human Services. HIPPA Privacy Regulations. Available at "http://www.hhs.gov/hipaa/for-professionals/index.html" Accessed November 8, 2016. (Archived by WebCite® at: "http://www.webcitation.org/6lsBs7A0v")
7. Little JW, Falace DA, Miller CS, Rhodus, NL. Patient evaluation and risk assessment. In: Dental Management of the Medically Compromised Patient. 8th ed. St. Louis, Mo: Elsevier; 2013: 1-18.
8. Dean JA. Examination of the mouth and other relevant structures. In: Dean JA, ed. McDonald and Avery's Dentistry for the Child and Adolescent. 10th ed. St. Louis, Mo: Elsevier; 2016: 1-16.
9. Weir J. Practice Management. In: Dean JA, ed. McDonald and Avery's Dentistry for the Child and Adolescent. 10th ed. St. Louis, Mo: Elsevier; 2016: 653-82.
10. American Academy of Pediatric Dentistry. Guideline on adolescent oral health care. Pediatr Dent ~~2011;33(special issue):129-36~~ 2016;38(special issue):155-62.
11. American Academy of Pediatric Dentistry. Guideline on Perinatal and infant oral health care. Pediatr Dent ~~2012;34(special issue):132-6~~ 2016;38(special issue):150-54.
12. American Academy of Pediatric Dentistry. Resource Section. Pediatric Medical History 2016;38(special issue):428-430.
13. Scharf RJ, Scharf GJ, Stroustrup A. Developmental Milestones. Pediatr Rev. 2016;37(1):25-37
14. American Academy of Pediatric Dentistry. Guideline on periodicity of examination, preventive dental services, anticipatory guidance, and oral treatment for children. Pediatr Dent ~~2011;33(special issue):102-9~~. 2016;38(special issue):133-41.
15. American Academy of Pediatric Dentistry. Guideline on acquired temporomandibular disorders in infants, children, and adolescents. Pediatr Dent ~~2011;33(special issue):248-53~~ 2016;38(special issue):308-14.
16. American Academy of Pediatric Dentistry. Guideline on prescribing dental radiographs for infants, children, adolescents, and persons with special health care needs. Pediatr Dent ~~2012;34(special issue):299-301.~~ 2016;38(special issue):355-57.

17. American Academy of Pediatric Dentistry. Guideline on caries-risk assessment and management for infants, children, and adolescents. Pediatr Dent ~~2011;33(special issue):110-7~~ 2016;38(special issue):142-49.
18. American Academy of Pediatric Dentistry. Guideline on behavior guidance for the pediatric dental patient. Pediatr Dent ~~2011;33(special issue):161-73~~ 2016;38(special issue):185-98.
19. American Academy of Pediatric Dentistry. Assessment of Acute Traumatic Injuries. Pediatr Dent ~~2011;33(special issue):331-2~~ 2016;38(special issue):431-32.
20. American Academy of Pediatric Dentistry. Guideline on Informed Consent. 2016;38(special issue):351-53.
21. American Academy of Pediatric Dentistry. Guideline on use of local anesthesia for pediatric dental patients. Pediatr Dent ~~2011;33(special issue):174-80~~ 2016;38(special issue):204-210.
22. American Academy of Pediatric Dentistry. Guideline on use of nitrous oxide for pediatric dental patients. Pediatr Dent ~~2011;33(special issue):181-4~~ 2016;38(special issue):211-15.
23. American Academy of Pediatric Dentistry. Guideline on Protective Stabilization of Pediatric Dental Patients. 2016;38(special issue):199-203.
24. Chasteen JE, Cameron CA, Phillips SL. An audit system for assessing dental record keeping. J Dent Educ 1996;60 (12):978-86.
25. American Academy of Pediatric Dentistry. Guidelines on monitoring and management of pediatric patients before, during, and after sedation for diagnostic and therapeutic procedures: Update 2016 Pediatr Dent ~~2011;33(special issue):185-201~~. 2016;38(special issue):216-35.
26. American Academy of Pediatric Dentistry. Guideline on management of the developing dentition and occlusion in pediatric dentistry. Pediatr Dent ~~2011;33(special issue): 229-41~~. 2016;38(special issue):289-310.
27. Machen DE. Legal aspects of orthodontic practice: Risk management concepts. Am J Orthod Dentofac Orthop 1989;96(2):173-5.
28. Greenwell H. American Academy of Periodontology Committee on Research, Science, and Therapy. Periodontal therapy. J Periodontol 2001;72(11):1624-8.
29. Califano JV. American Academy of Periodontology Research, Science, and Therapy Committee. Periodontal diseases of children and adolescents. J Periodontol 2003;74 (11):1696-704.
30. American Academy of Pediatric Dentistry. Guideline on pulp therapy for primary and young permanent teeth. Pediatr Dent ~~2011;33(special issue):212-9~~. 2016;38(special issue):280-88.
31. Burke R, Stigers JI. Radiology. In: Nowak AJ, Casamassimo PS, eds. The Handbook of

Pediatric Dentistry, 4th ed. American Academy of Pediatric Dentistry Chicago, Ill.; 2011:74-81.

~~American Academy of Pediatric Dentistry. Guideline on management of acute dental trauma. Pediatr Dent 2011; 33(special issue):220-8.~~

~~McDonald RE, Avery DR, and Dean JA. Examination of the mouth and other relevant structures. In: Dean JA, Avery DR, McDonald RE , eds. Dentistry for the Child and Adolescent. 9th ed. St. Louis, Mo: Mosby; 2011: 1-18.~~

~~Nelson GV. Guidelines to the prevention of problems in record keeping. Part I. Pediatr Dent 1989;11(2):174-7.~~

~~Nelson GV. Records, charting, and problem areas in documentation: Part II. Pediatr Dent 1989;11(3):240-2.~~

~~Valenza JA. Medical risk report: Improving patient management and record keeping through a problem-oriented approach. J Greater Houston Dent Soc 1994;65(9):46-8.~~

~~Who is minding the kids? Child Care Arrangements :Spring 2011. U.S. Department of Commerce. https://www.census.gov/prod/2013pubs/p70-135.pdf. Accessed Dec 5, 2016. (Archived by WebCite® at: http://www.webcitation.org/6mYPBs1A4~~