Record-keeping

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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 best practice was originally developed by the Council on Clinical Affairs and adopted in 2004. This document is a revision of the previous version, last revised in 2012. This revision included a new literature search of the PubMed®/MEDLINE database using the terms: dental record, electronic patient record, problem-oriented dental record, medical history taking, medical record, record keeping, and Health Insurance Portability and Accountability Act (**HIPAA**); fields: all; limits: within the last 10 years, humans, and English. 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 recommendation 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 electronic data base that is retrievable by office personnel in the event that patient records are lost or damaged.

The elements of record-keeping addressed in this 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 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. 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.

ABBREVIATIONS
AAPD: American Academy Pediatric Dentistry. **HIPAA:** Health Insurance Portability and Accountability Act. **TMD:** Temporomandibular disorder. **TMJ:** Temporomandibular joint.

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/HIPAA consent.[5,6]

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

- Radiographic assessment.
- Caries risk assessment.
- Parental consent/patient assent.
- 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 (e.g., 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[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 (e.g., gross/fine 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,[14] 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*.

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[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, and body art (e.g., intra- and extra-oral piercings, tattoos), as well as the use of oral contraceptives and pregnancy for the female adolescent. A sample confidential history form is available on AAPD's website at *www.aapd.org/policies/*.

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[8,9,11,15]

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[7,8,16]

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/body mass index calculation (e.g., 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.[17]
- Caries risk assessment.[18]
- Assessed behavior of child.[19]

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. 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 Assessment of Acute Traumatic Injuries form[20] provides greater details on diagnostic procedures and documentation for emergent traumatic injury care.

Treatment recommendations and informed consent[21]

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.[21] 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 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[22], medications, and/or nitrous oxide/oxygen[23], type/duration of protective stabilization[24], 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 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.[25] 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.[26]

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 Recommendation on Management of the Developing Dentition and Occlusion in Pediatric Dentistry[27] 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.[28] 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 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
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, and 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
  - Heart murmur
  - Infective endocarditis
  - 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 infections
- Musculoskeletal
  - Arthritis
  - Scoliosis
  - Bone/joint problems
  - Temporomandibular disorders (**TMD**)—joint popping, clicking, locking, difficulties opening or chewing
- 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 disability
  - Brain injury
  - Cerebral palsy
  - Convulsions/seizures
  - Epilepsy
  - Headaches/migraines
  - Hydrocephaly
  - Shunts—ventriculoperitoneal, ventriculoatrial, ventriculovenous
- Psychiatric
  - 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
  - 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
  - Lyme disease
  - Zika virus
- Family history
  - Genetic disorders
  - Problems with general anesthesia
  - Serious medical conditions or illnesses
- Social concerns
  - Chronic passive smoke exposure
  - Religious or philosophical objections to treatment
  - Legal custody/guardianship status

Appendix II—Dental History*

- Previous dentist, address, telephone number
- Date of last 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)—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
- TMJ / TMD[16]
  - 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[29,30]
  - 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[31,32]
  - Traumatic injuries
  - Third molars
- Radiographic examination[33]
  - 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

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