Recordkeeping

Latest Revision
2026

How to Cite: American Academy of Pediatric Dentistry. Recordkeeping. *The Reference Manual of Pediatric Dentistry*. American Academy of Pediatric Dentistry; 2026:616-623.

Abstract

This best practice presents recommendations regarding recordkeeping for dental patients. The patient record is an essential component of the delivery of competent and quality oral health care. Electronic dental records may assist with quality and efficiency of health care. Data security and privacy of identifiable health information are important considerations in recordkeeping. The patient record allows the provider, the patient, and authorized third parties to access the history and details of patient assessment and communications between dentists and patients, as well as specific treatment recommendations, alternatives, and risks and care provided. This document provides dental professionals with guidance on several pertinent aspects of dental recordkeeping including general charting considerations, components of a patient record, patient medical and dental histories, comprehensive and limited clinical examinations, treatment planning and informed consent, progress notes, correspondence and consultations, records transfer, corrections to records, retention of records, and patient access to their health records. The scope of information to include and formatting for consistency and ease of interpretation are addressed.

This document was developed through a collaborative effort of the American Academy of Pediatric Dentistry Councils on Clinical Affairs and Scientific Affairs to offer updated information and guidance on recordkeeping.

KEYWORDS: DENTAL RECORDS; DOCUMENTATION; ELECTRONIC HEALTH RECORDS; MEDICAL RECORDS

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 document will assist the practitioner in assimilating and maintaining a comprehensive, uniform, and organized record addressing patient care. It is not intended to address documentation pertaining to administrative procedures (eg, billing, infection control).

Methods

This best practice was developed by the Council on Clinical Affairs, adopted in 2004,[1] and last revised in 2021.[2] This revision included a new literature search of the PubMed/MEDLINE database using the following parameters: (*evidence based dentistry* [**Majr**] OR *pediatric dentistry* [Majr] OR *dental care for children* [Majr] OR *paediatric dentistry* [**Tiab**] OR *dental health services* [Majr] OR *dentistry* [Majr] OR *public health dentistry* [Majr] OR *community dentistry* [Majr]) *AND* (*electronic health record** [Tiab] OR *integrated electronic health record** [Tiab] OR *integrated health record** [Tiab] OR *integrated record** [Tiab] OR *electronic patient record** [Tiab] OR ***EHR*** [Tiab] OR *dental record** [Tiab] OR *medical history taking* [Majr] OR *medical record** [Tiab] OR *record keeping* [Tiab] OR *Health Insurance Portability and Accountability Act* [Majr] OR ***HIPAA*** [Tiab] OR *teledentistry* [Tiab] OR *data breach** OR *medical necessity** [Tiab] OR *problem-focused record** OR *record transfer* [Tiab] OR *health information exchange* [**MeSH**] OR *cybersecurit** [Tiab] OR *confidentiality* OR *patient privacy* [Tiab]); fields: all; limits: within the last 10 years, English. This search identified 790 articles. A second PubMed/MEDLINE search using the terms: *artificial intelligence* AND *medical record* AND *dentistry* with limits: 5 years, reviews identified 50 abstracts. A Google search for *health care record destruction* also was performed. Papers for review were chosen from these searches and from 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.

* *Used in the PubMed search to identify all terms that begin with this truncated base.*

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.[3] The patient record is an important legal document in third-party relationships.[3] Poor or inadequate documentation of patient care consistently has been reported as a major contributing factor in unfavorable legal judgments against dentists.[4,5] Therefore, the AAPD

ABBREVIATIONS
AAPD: American Academy of Pediatric Dentistry. **AI:** Artificial intelligence. **EHR:** Electronic health record(s). **HIPAA:** Health Insurance Portability and Accountability Act. **Majr:** Medical subject headings major topic. **MeSH:** Medical subject heading. **PHI:** Protected health information. **Tiab:** Title and abstract.

recognizes that recommendations on recordkeeping may provide dentists the information needed to compile an accurate and complete patient chart that can be interpreted by a knowledgeable third party. Health information systems and electronic health records (EHR), including electronic dental records (EDR), are being implemented as a means to improve the quality and efficiency of health care.[6] 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. In addition, EHR enable quality improvement to be implemented in individual or group practices more readily. Quality improvement is the process of evaluating clinical practice, measuring effectiveness, and implementing changes to improve patient outcomes.[7] Quality improvement strategies support and evaluate care delivery and allow changes to be made in clinical practice. While most electronic dental billing systems do not easily allow for entry of diagnostic codes, clinicians can enter dummy codes to represent diagnoses and outcomes to evaluate clinical outcomes more easily.[7] Integrated EHR, which merge medical and oral health information, can give clinicians a more complete picture of their patients' health status. The combined records also can facilitate communication between dentists and other health care professionals.[8] Although clinical documentation has a vital role in health care, this task creates a significant administrative burden and has been linked to rising rates of clinician burnout.[9] While the current use of artificial intelligence (**AI**) in dentistry is mainly concentrated around the evaluation of digital diagnostic methods, especially radiology, AI applications are being utilized to manage EHR and reduce clinicians' workloads.[10,11] Despite its increasing use in dentistry, AI faces an issue of acceptance, with its obstacles including ethical, legal, and technological ones.[12] Effective governance is a prerequisite to precisely address regulatory, ethical, and trust issues, while increasing the acceptance and integration of AI.[10] Additional research is needed to ensure patient safety and accountability and to advance AI's full potential in dentistry.

The Health Insurance Portability and Accountability Act[13] (HIPAA), passed by Congress in 1996, has evolved significantly. Its primary purposes are to provide standards for privacy and security of individually-identifiable health information, but it also provides for data breech notifications and additional requirements for covered entities.[13] A dental practice becomes a HIPAA-covered entity when certain transactions, such as claims, are sent electronically by the office or a clearinghouse on behalf of the dentist.[14] The US Department of Health and Human Services recommends that dentists and their staff participate in regular education and training on HIPAA requirements to maintain familiarity with changing regulations regarding patient privacy.[13]

Data security is important in recordkeeping and, with the widespread use of EHR, security requires evaluation of every data interface, including data that is stored in the cloud, to ensure data and patient information protection.[15] A requirement of the Security Rule of HIPAA is to perform regular security risk analyses of electronic systems that store and transmit protected health information (**PHI**).[16] Daily backup of the office software system stored in an electronic data base retrievable by off-site personnel allows for the continuity of care and business operations in the event that patient records are lost or damaged. To be compliant with HIPAA, software systems, including backup hard drives, should be encrypted in case of a data breach. Correspondence with another care provider via email, facsimile, and other forms of communication may be encrypted to protect PHI, and providers are subject to regulations and mandates on this topic.[17] Impermissible use or disclosure of PHI also is considered a data breach subject to state and federal laws regarding security breach notification.[18] Record access is intended only for those who require it to perform their duties. If a computer accessing patient information is placed where people other than the patient can view the screen, a privacy filter can decrease risk of compromise. Screen closure after a period of inactivity will help protect privacy if the computer is left unattended.[19]

Recommendations

The elements of recordkeeping 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; teledentistry; records transfer; record correction and retention; and accessibility to records. Forms completed by the patient, parent, and health care guardian should be available in languages commonly found in the area where a treatment facility is located.[20]

General charting considerations

The dental record must be authentic, accurate, well thought out, legible, and objective.[4] Each patient should have an individual dental record. A well-documented record reflects a patient's history and care, allowing for continuity of care.[21] Chart entries should contain the initials or name of the individual making the note. Progress notes should document telephone conversations and electronic communications correspondence regarding the patient's care. Documentation is the responsibility of many dental team members, including the dentist, hygienist, dental assistant, front desk staff, and others.[22] Abbreviations should be standardized for the practice. After data collection, a list is compiled that includes medical considerations, psychological/behavioral considerations, 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. Documentation

should include everything that was accomplished during an appointment including, but not limited to, discussion of medical history changes, assessments performed, educational materials utilized (both video and written), and discussions with the caregiver and/or patient. Appointment history (eg, cancellations, failures, tardiness, rescheduled visits) may be retained in the record. Chart entries should be made at the time of the appointment or soon thereafter.[3,22]

Noncompliance, miscommunication, and patient behavior which might interfere with the recommended treatment, including missed or rescheduled appointments, should be documented. Miscommunication is behind nearly every allegation of substandard care.[5] If a practitioner needs to add or clarify a note, a separate entry in the chart should be made.[19,22] Templates for EHR are widely available; these have shown to increase compliance when compared to hand-written notes.[23] Clinicians should be aware of accuracy when completing templates, as incomplete sentences, unpopulated fields in templates, and conflicting statements have been noted.[24]

Initial patient record

The initial contact with the dental practice, usually via telephone or web-based form, allows an opportunity to address the patient's primary oral health needs and to confirm the appropriateness of scheduling an appointment with that particular practitioner. This conversation or form may elicit basic patient information such as

- patient's name, nickname, and date of birth.
- sex assigned at birth and gender identity.
- name, address, and telephone number of parent/health care guardian.
- name of referring party.
- significant medical history.
- chief complaint.
- availability of medical/dental records (including radiographs) pertaining to patient's condition.
- preferred language.

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.[3]

- medical history
- dental history
- clinical assessment
- radiographic or other images obtained, if any, and their interpretation
- diagnosis or differential diagnosis
- treatment recommendations
- parental/health care guardian consent
- progress notes
- acknowledgment of receipt of notice of privacy practices/HIPAA consent[13]

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

- caries-risk assessment
- periodontal-risk assessment
- patient assent
- sedation/general anesthesia records
- traumatic injury records
- orthodontic records
- consultations/referrals
- laboratory orders
- test results
- additional ancillary records
- posttreatment instructions and prescriptions

Medical history[25(p5-6),26(p143),27]

An accurate, comprehensive, and up-to-date medical history is necessary for correct diagnosis, effective treatment planning, and patient safety. Familiarity with the patient's medical history is essential to decreasing the risk of aggravating a medical condition while rendering oral health 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/health care guardian[28] if the patient is a nonemancipated minor or an intellectually disabled adult before commencing patient care. If the patient/parent/health care guardian cannot provide adequate details regarding the 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 illnesses
- name and, if available, telephone number of primary and specialty medical care providers
- current therapies (eg, 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

The history form should provide additional space for information regarding positive historical findings, as well as 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 relationship

to the patient), and the signature of the staff member reviewing the history with the parent/health care guardian. Records of patients with significant medical conditions should be marked 'medical alert' in a conspicuous yet confidential manner. The AAPD has developed a sample medical history form[29] for pediatric patients.

Supplemental history for infants/toddlers[29,30]

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 (eg, gross/fine motor skills, language, social interactions) is crucial for early recognition of potential delays and appropriate referral to therapeutic services.[31] As a majority of infants and toddlers of employed parents receive childcare on a regular basis,[32] 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. Supplemental history questions for an infant/toddler are included in the AAPD's sample pediatric medical history form.[29]

Supplemental history for adolescents[13,16]

The adolescent can present particular psychosocial characteristics that impact the health status of the oral cavity, care seeking, and compliance. To promote their developing autonomy and build a sense of trust by adolescent patients, the practitioner should obtain additional information confidentially from teenagers. Topics to be discussed may include nutritional and dietary considerations, eating disorders, alcohol and substance misuse, tobacco and electronic cigarette usage, over-the-counter medications and supplements, and body art (eg, oral piercings and oral jewelry/accessories, tattoos), as well as the use of oral contraceptives and pregnancy for the female adolescent. Supplemental history questions for an adolescent are included in the AAPD's pediatric medical history form.[29]

Medical update[29]

At each patient visit, the history should be consulted and updated. Recent medical attention for illness or injury, newly diagnosed medical conditions, allergy, and changes in medications should be documented. A written update should be obtained at each recall visit and updated in the dental record.

Dental history[25(p5-6),29,30,33]

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. A dental history questionnaire can be incorporated in the medical history intake forms.[29] 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 breastfeeding, 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

Questions pertaining to the patient's dental history are included in the AAPD's sample pediatric medical history form.[26]

Comprehensive clinical examination[25(p5-12),33-35(p8-13)]

A visual examination should precede other diagnostic procedures. Components of a comprehensive clinical examination include assessment of

- general health/growth (eg, height, weight, body mass index calculation, vital signs).
- pain.
- extraoral soft tissue.
- temporomandibular joint.
- intraoral soft tissue.
- oral hygiene and periodontal health.
- the developing occlusion and, when indicated appliance integrity.
- intraoral hard tissue.
- radiographs, if indicated.[36,37(p128)]
- caries-risk.[38]
- cooperative potential/ behavior of child.[39]

Informed consent should be obtained and documented, consistent with the statutes and code laws of individual states, prior to radiographic exposure. Documentation should include number of images obtained and diagnoses.[37(p128)] Images are retained as part of the dental record and can serve as an excellent economical and easily accessible database for child identification purposes.[40] The dentist may employ additional diagnostic tools to complete the oral health assessment. Such diagnostic aids may include electric or thermal pulp testing, percussion, transillumination, caries detection devices, salivary tests, photographs, cone-beam computed tomography (CBCT), laboratory tests, and study casts. Speech, in children who are able to talk, may be evaluated and provide additional diagnostic information. To enhance patient diagnosis and treatment documentation, the practitioner should consider including photographs of the child's oral condition in the dental record. Photographs may be indicated to

- facilitate diagnosis.

- verify presence or characteristics of a condition (eg, decalcification, molar-incisor hypomineralization) that may not be documented adequately by other means (eg, radiographs).
- monitor a finding for clinical changes.
- document acute traumatic injuries, particularly if abuse may be suspected.
- facilitate education and treatment planning.
- document teledentistry consultation.
- facilitate determination of medical necessity by third party payors.

Permission to obtain photographs to facilitate treatment should be addressed within a general consent for care.[41] If images containing PHI are intended for other use (eg, publication, presentation), specific written authorization is required.[41] Although photographs without identifiable PHI may be exempt from HIPAA regulations,[41] practitioners should consult HIPAA rule and state regulations prior to dissemination of images. Photographs, along with adequate diagnostic radiographs, can enhance the documentation of medical necessity of treatment.

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 along with a hard and soft tissue examination as deemed necessary by the practitioner must be obtained. Documentation should clearly state the limited scope of the evaluation. The parent/health care guardian should be informed of the limited nature of the treatment and counseled to seek routine comprehensive care after resolution of the acute issue. The AAPD's *Acute Traumatic Injuries: Assessment and Documentation*[42] form provides greater details on diagnostic procedures and documentation for emergent traumatic injury care.

Treatment recommendations and informed consent[43]

Once the clinician has obtained the medical, dental, and social histories and evaluated the information 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 teeth and surfaces to be treated, selected procedures/materials to be used, number of appointments/time frame needed to accomplish this care, behavior guidance techniques beyond basic communicative techniques that may be employed, and fee for proposed procedures. The dentist is obligated to educate the parent/health care guardian on the need for and benefits of the recommended care, as well as risks, alternatives, and expectations if no intervention is provided. An older child or adolescent who has sufficient cognitive ability and dental experience to engage in treatment discussions should be included in the process of informed consent.[43,44] Information should be provided to the patient in an age-appropriate manner, and practitioners should seek assent (agreement) from the patient whenever possible.[43] The dentist should not attempt to decide what the parent/health care guardian will accept or can afford. After the treatment options are presented, the parent/health care guardian should have the opportunity to ask questions regarding the proposed care and have concerns satisfied prior to giving informed consent. Informed consent may include various forms and be procedure specific.[43] For adult patients with special health care needs, determining who legally can provide consent for treatment is essential.[43] The practitioner should document interpreters or translation services used to aid communication (eg, in person, by telephone). Documentation should include that questions were encouraged and answered and the parent/health care guardian appeared to understand and accepted the proposed procedures. Any special restrictions or concerns voiced by the parent/health care guardian should be documented. The people who were present during the discussion may be documented. If the parent/health care guardian refuses treatment and a treatment refusal form is signed, it should be retained in the record.[22] A signed dental informed consent for sedation and general anesthesia should be maintained in the record. A signed informed consent form should not preclude or replace a detailed discussion regarding recommended treatment and treatment modalities.

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,
  - teeth restored and materials used
  - the type and dosage of anesthetic agents[45]
  - medications and/or nitrous oxide/oxygen[46]
  - type/duration of protective stabilization[47]
  - treatment complications
  - adverse outcomes
- postoperative instructions and prescriptions as needed

In addition, the entry generally should document

- changes in the medical history, if any.
- adult accompanying child.
- presence of a caregiver in the operatory, if applicable.
- significant conversations with the caregiver regarding limitations, prognosis, behavior challenges, or other considerations that might be out of the ordinary.
- 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.[48] SOAP is an acronym for subjective (S) or what the patient says or reports, objective (O) or the observations of the clinician or test results, assessment (A) or diagnosis/differential diagnosis of the problem, and plans (P) for what and how treatment will be provided. The signature or initials of the office staff member documenting the visit should be entered. The dentist has the ultimate responsibility for all entries made in the chart and may countersign all treatment progress note entries.

When sedation or general anesthesia is employed, additional documentation on a time-based record is required, as discussed in AAPD's *Guideline for Monitoring and Management of Pediatric Patients Before, During and After Sedation for Diagnostic and Therapeutic Procedures*.[49] The AAPD has developed a sample sedation record form for pediatric patients.[50]

Teledentistry[51]

Dentists are encouraged to understand their state's regulations regarding documentation and consent requirements for teledentistry. Documentation of a teledentistry patient visit should include a thorough description of the encounter in accordance with state regulations as part of the patient record. Security measures and privacy of protected patient information should be maintained in compliance with state and federal laws.[31]

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, which includes the date and mode of communication, should be made noting 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.[3]

Record transfer

If a parent/health care guardian requests a record transfer to another office, this request as well as what was sent should be documented in the chart. The AAPD has developed a sample transfer form for pediatric patients.[52]

Correction of records and records retention

For all dental records, whether electronic or paper, adherence to general guidelines helps avoid problems from a medicolegal standpoint. An individual should never allow others to use his password to access electronic files. Changes to a record should not be made after a patient complaint or a practitioner learns of pending legal action related to patient care. When changes must be made in a paper dental record, corrections should be clearly identified by drawing a single line through the error and placing one's initials/signature and date after the changes. If an electronic record is used, corrections should be noted by a separate clarifying/correcting entry in the chart.[21] The length of time for retention of records of child patients varies greatly by jurisdiction. The clinician should be aware of requirements and keep the records safely secured for the specified time. Thereafter, records may be destroyed in compliance with applicable state and federal laws. HIPAA requires hard copy records be destroyed in such a way that PHI cannot be accessed or reconstructed by unauthorized individuals.[53] Methods for destroying EHR include overwriting and degaussing and should be performed with consideration of modern data recovery techniques. Documenting the steps taken to destroy patient records is a sound risk management practice. Log entries should include how and when the destruction took place and who witnessed the event.[53]

Accessibility to records (Cures Act 2020)

In 2020, new federal rules implemented the bipartisan 21st Century Cures Act that, in part, "promotes patient access to their electronic health information, supports provider needs, advances innovation, and addresses industry-wide information blocking practices".[54] The rules forbid health care organizations, information technology vendors, and others from restricting patients' access to their electronic health care data (ie, information blocking). Although HIPAA gave patients the legal right to review their medical records, the new ruling goes further by giving them the right to access their electronic health records rapidly and conveniently via secure online portals. Providers must share not only test results, medication lists, and referral information but also notes written by clinicians.[55]

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