DENTAL CHARTING & DOCUMENTATION

OPS.081

Approved By:	Board of Directors	Adopted Date:	7/6/96
Distribution:	All Dental Staff	Revision Date(s):	6/5/00, 8/21/03, 10/20/15, 3/15/16

Purpose

The following shall constitute the standards for dental documentation:

Policy

Visit Notes

1. S.O.A.P (Subjective, Objective, Assessment, and Plan) notation will be used.
2. Visit notes must comply with equivalent to the templates within the EDR.
3. Each entry will be dated
4. Each entry will be signed by the provider. Complete signature and title are required. Initials in combination with a signature stamp are acceptable.
5. The entry will contain the tooth number(s) and surface(s) for each tooth treated on that day.
6. The text will contain all materials used or placed on or in the tooth and soft tissue.
7. Any treatment done on the tooth or soft tissue, other than restorative, will be noted, i.e., root canal therapy, extraction, root planning, etc.
8. All anesthesia and the amount will be documented.
9. Any prescription or medication given will be documented.
10. Any referral given will be documented.
11. Oral hygiene instruction and specific procedures that the patient needs to perform to establish and/or maintain health will be documented.
12. Handouts pertinent to current procedures or existing conditions should be given. Any handouts given will be documented.
13. A plan or procedure and estimated date for the next appointment will be written at the conclusion of the entry.

Radiographs

1. On bitewing radiographs, each interproximal space must be open and readable on at least one film.
2. On periapical radiographs the apices of the teeth must be present and readable.
3. All films will have reasonable contrast and purity to allow easy, debris free, viewing.
4. All films will be free of cone cuts.
5. Digital X-Ray is used at all dental sites and stored in the patients electronic record.
6. Panographic X-Ray for ages 7 and up every 3-5 years as deemed necessary by the provider.

Examination

1. It is our goal to provide each patient with a comprehensive dental exam annually. Each dental exam will include the following:
2. A cancer check will be performed and documented.
3. Periodontal assessment will be documented.
4. The occlusion of the patient will be documented.
5. For any patient with active caries despite good oral hygiene, fluoride status will be established and documented, and supplementation recommended if appropriate. CAMBRA (caries risk assessment) will be established.
6. Oral Hygiene Instruction (OHI) will be initiated and documented at the first clinic visit. This will be followed and reinforced on subsequent visits.
7. Review of health history.
8. A written treatment plan specific enough to develop an estimated cost of treatment.

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9. Assessment and documentation of tobacco use. Tobacco users will be informed of available cessation options.

Health History

1. Health histories will be taken, reviewed and initialed at first visit.
2. History will be updated, reviewed and initialed at each examination, or annually.
3. Changes in health history will be assessed and documented at all visits.

Tooth Charting

1. The charting will be accurate and up to date.
2. The tooth chart will correspond with the procedure notes.
3. All existing restorations, missing teeth, etc., will be charted.
4. All restorations and extractions to be done will be charted.
5. As each procedure is completed it will be noted.

Other

1. All patient no-shows for RCT, Seat Crowns, Active Denture Cases and high risk children will be reviewed and initialed by the dentist, and an assessment of need for follow-up contact made.
2. All documents received from other entities and pertaining to current patient care (such as referral reports, biopsy reports, pharmacy refill requests, after hours call reports, etc.) will be reviewed and initialed by the dentist, and be housed in the chart. Other documents (such as phone messages, patient letters or complaints) will be reviewed by the dentist and housed in the chart at his or her discretion.

Attachments:
Dental Exam Form

Approved,

Cheyenne Spetzler
Chief Operations Officer

Acknowledged,

Carter Wright, DDS