Maine Board of Dental Practice  
Policy Guidance #2016-05 - Recordkeeping Guidelines  
Adopted 12/09/2016 (Previously adopted March, 2007)  

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Note: Board policies are offered to licensees as guidance only and are not enforceable.  

One of the primary functions of the Maine Board of Dental Practice is to thoroughly evaluate and make decisions on complaints submitted to the Board. In order to objectively and forthrightly deliberate the issues involved, the Board relies in part, but to a great extent, on the records submitted by licensees of the Board. These records are of significant value to the health care provider, patient, and authorized third party payer(s) in the identification and delivery of appropriate and quality health care. Moreover, the overall dental record is an important component of caregiver defense when legal issues arise in the medical/dental arena. This document is intended as a set of guidelines only; it is not brought forth, or to be construed, as a standard of care.  

General Information  

When it comes to documentation, particularly in the area of record keeping, it is perhaps unfortunate but true that “if it’s not documented, it didn’t occur”; that’s the mind-set of the legal world. Thus it becomes imperative that the dental caregiver identify and record all pertinent information in the patient’s chart. The dental record should be contemporary, chronological, accurate, and legible. Admissions to the chart need not be limited to the dentist of record but may include entries by hygienists, assistants, and front office personnel. All entries should be dated and include the initials or names of those making the report and, when appropriate, countersigned by the dentist responsible for care.  

There are no standards or particular guidelines that serve all dental procedures or dental personnel. Patients who are evaluated and treated for a specific problem (such as an emergency, a second opinion or an isolated consultation) may not constitute “a patient of record” in comprehensive dental terms (i.e. dental home). As such, these patients may correctly be seen for limited dental care and need not have the type of exam, diagnosis and treatment plan expected by the dental care provider who commits to general, comprehensive care. Nevertheless, problem oriented care is expected to include all information necessary for complete and thorough treatment of the specific problem. In addition, the patient or patient’s guardian should be informed of the limited nature of the dental evaluation and treatment and be advised to seek comprehensive care when indicated.  

The Dental Record  

As previously noted, various members of the dental team may have access to and record in the dental chart. This begins as early as the first phone call or first visit to the dental office when the patient (through the receptionist) identifies basic personal information (i.e. name, DOB, telephone number, address, referral, chief complaint and perhaps significant medical history). This initiates the permanent dental record. In addition to this basic information, the patient’s record should include the following information:
**Medical History**

The medical history should be pertinent to any possible dental treatment. Many dental practices include within the medical history a standardized list of questions and/or medical conditions for the patient to complete or identify prior to initial consultation with the healthcare provider. Completion of this form does not relinquish the licensee’s responsibility to further question the patient in order to clarify or identify the extent of the patient’s medical condition. The medical history should specifically include a list of all allergies and current medications. The past medical history needs to be complete with past and current diagnoses as well as previous surgical procedures/hospitalizations. The patient’s family physician should be recorded in the case of medical consultation or emergency. At times, it may be prudent to have a formal letter or note from the attending physician concerning the patient’s diagnoses and/or potential issues to address with treatment (such as the need for prophylactic antibiotics). Patients with follow-up visits should have the chart reviewed and updated for possible changes and/or additions to the medical history.

**Dental History**

In addition to the medical history, a thorough dental history needs to be part of the chart. For those acting as the “dental home” for the patient, this should be complete and up-to-date. For those consulting for or treating an isolated problem (such as endodontics or oral surgery), the dental history should comprehensively address the dental history related to the specific problem at hand. Of importance to all practitioners, but often neglected, is the history surrounding oral hygiene and habits, orofacial trauma, and temporomandibular dysfunction (TMD).

**Patient Examination**

A natural follow-up to the medical/dental histories is the patient’s clinical examination. If there is a recorded or stated chief complaint, the initial exam may be limited to this concern. However, the dental caregiver would be remiss if a general (albeit limited), orofacial exam were deferred. This is an excellent opportunity to identify other dental issues of significance. For those practitioners providing a dental home for a patient, this exam should be complete with charting of dental caries, current restorations, and periodontal status. Soft and hard tissue evaluation, including TMD assessment, as well as radiographic examination, are all important issues leading to a complete dental examination.

Of particular importance to proper dental treatment and overall health of the patient is the identification and recording of the patient’s current blood pressure and pulse. Every patient (when possible) should have the blood pressure and pulse taken and recorded, both initially and before the administration of drugs (i.e. local anesthetics, oral sedatives, etc.) that can possibly affect the patient’s vital signs. The dental professional has the unusual opportunity to identify those patients who have potentially life limiting problems (such as hypertension and cardiac arrhythmias) that have previously gone undiagnosed.
Correspondence and Laboratory Documents

Any correspondence, such as consults, and/or laboratory report(s), or authorization(s) concerning the patient to be, or in the midst of treatment represent a vital part of the dental chart. These correspondences or laboratory documents can be filed elsewhere but should be noted on the chart in a chronological and contemporaneous manner.

Treatment Plan and Informed Consent

Following the history and physical examination, the diagnosis or diagnoses should be clearly established and a prioritized treatment plan developed; both should be recorded. At this point, the dentist is obligated to inform the patient of the diagnosis and explain to the patient the need and/or benefits of treatment. Treatment options should be stated and recorded as well. When defining the treatment or treatment options, the risks and expected results (without guarantees) should be clearly stated and recorded. Depending on the situation to be addressed, every patient should have an implied or written informed consent completed. (The Board has previously produced guidelines for Informed Consent which can be obtained “on-line” or through the Board’s office.) Both the treatment plan and the informed consent are essential parts of the overall dental record.

Progress Notes

Progress notes are a key element to a complete and up-to-date dental record. Each patient visit should be dated and recorded chronologically and contemporaneously. Although the progress note represents the record of ongoing treatment (by the dental home), the form of the progress note can also be used by the dental practitioner who is evaluating and treating the patient for limited care (i.e. consults, isolated endodontic or oral surgical treatment, etc.).

Patient Dismissal

If a patient is dismissed from the dental practice, an appropriate letter of dismissal should be sent to the patient and retained within the dental chart. If the patient should request the dental records to be sent to another dentist, upon receipt of a signed, written request by the patient, a copy of the records and a duplication of the x-rays should be sent in a timely manner for a reasonable charge. Original records and x-rays are the property of the dentist (who made the records and/or took the x-rays) and they should be retained by the dentist of record.

Conclusion

Record keeping is an important and vital part of overall dental treatment; it aids in the protection of both the patient and the dental professional. This set of guidelines represents only a brief overview on the topic; it is neither meant to be all inclusive nor meant to establish a standard of care. More in-depth information concerning record keeping can be found through various publications and educational lecture presentations.