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Accurate and Complete Patient Records

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Those named in a dental malpractice action or called before a State Board of Dentistry regarding patient care know the feeling of trepidation it brings. They may recall the time it took from their practice and family, the potential loss of income, and the irreparable damage to their reputation. Even when dentists know they have met the accepted standards of care in the treatment of a patient, they still must defend themselves.

Many dentists learn the hard way that defending themselves and their reputation depends upon the quality and thoroughness of the patient records they keep. Your recollection of what transpired, no matter how credible, is never as powerful as an accurate, contemporaneous, and detailed dental record. A memorialization of events in writing creates a strong inference to the fact finder (juror, judge, or state board member) that something was said or done. If it is not in writing, it may be viewed as not being said or done.

I have reviewed hundreds of dental negligence claims and State Board violations. In my experience, the principal factor in verdicts against dentists—or unfavorable rulings by State Boards—is a dentist's failure to keep accurate, detailed, and contemporaneous patient records.

The accurate and complete dental record kept by today's prudent dentist serves many purposes. It establishes continuity of care for subsequent treating doctors. Most importantly, it provides a clear, logical, and concise record of the facts and occurrences that took place during treatment of the patient.

Avoid subjective evaluations in the dental record irrelevant to the patient's care and treatment, such as notations about the patient's physical appearance and personality. The properly maintained dental record is incontrovertibly the most valuable tool the dentist has in defense against an allegation of malpractice or a violation by a regulatory board. No detail is too small to be included in the dental record.

The accurate and contemporaneous treatment record should include, but not be limited to:

1. The reason the patient is seeking care with you
2. Appropriate radiographs and other imaging
3. Study models
4. Detailed contemporaneous treatment notes
5. Treatment plans[1]
6. Up to date dental and medical histories
7. Consent forms and the conversations associated with those forms
8. Medical consults
9. Referral forms
10. Photographs
11. Laboratory prescriptions
12. Medication prescriptions
13. Letters and correspondence with patient and other health care professionals
14. Patient complaints and their resolution
15. Missed or broken appointments and the effect it may have on the patient's oral health
16. Doctor and patient remarks
17. Financial arrangements
18. Laboratory or other test results
19. Privacy documentation
20. Insurance claim related documentation

Medical History

There are many good preprinted medical history forms available. It is your obligation to test the thoroughness of the form you utilize in your practice. The patient or responsible party must accurately and completely fill out the form; it must be signed and dated by both the patient and the doctor of record.

When getting a patient's medical history, the first question to ask your patient is "When was the last time you had a complete physical exam conducted by your medical doctor?" If the answer is three or more years, it is unlikely they can provide you with a current and accurate medical history. Request they get a physical exam before starting treatment, especially if any high-risk procedures are expected.

The history is not complete unless it is reviewed and discussed with the patient by the examining dentist and so noted on the patient treatment record. The dentist must question the patient about all significant answers. There should be no unanswered questions on the form. Prior to treatment, contact the patient's physician if necessary based upon the history the patient provides. The dentist is responsible for understanding the consequences to treatment of all medications

the patient is taking. At every recall, or every six months for extended treatment plans, there should be a supplemental health questionnaire.[2]

Examination

A thorough initial examination, including required x-rays, photographs, and study models (when necessary) is essential for all new patients. Note on the tooth charting area of the record all missing, filled, and restored teeth, along with notations of any carious lesions and teeth in disrepair. Mark existing bridges and removable prosthesis and note their condition. Include the results of a comprehensive soft tissue exam. Perform a complete oral cancer screening examination at the initial exam and at every recall exam. Perform a periodontal screening evaluation with a pocket depth sampling for every patient and/or a complete probing if indicated based upon the results of the screening exam, including an oral hygiene assessment.

Treatment Plan

Include a comprehensive treatment plan in every patient's chart (many state board regulations require this be done). Discuss with the patient and note in the chart all appropriate treatment alternatives based on the patient's oral examination. Note the final treatment plan and all alternative treatment plans on a form that includes a fee estimate for each one. Once the patient clearly understands the treatment plan and has had the opportunity to have all questions answered, both the patient and dentist should sign it.

Discuss with the patient their medical history, treatment plan, financial obligations, and all consents in language the patient can understand. Minor changes in a treatment plan can be noted in the patient treatment record, but major changes may require a new treatment planning form.

Informed Consent/Refusal

Consent forms are essential for all major surgical, periodontal, endodontic, fixed and removable prosthesis procedures—and any form of general anesthesia and sedation. The consent form must clearly describe the anticipated treatment, including all foreseeable risks, benefits, and alternatives to the proposed treatment and costs associated with each. Discuss all consent forms with the patient and then provide the patient the opportunity to ask questions of the treating doctor to validate the consent. Consents are signed and dated, with the original kept in the patient record and a copy given to the patient.

If a patient refuses any essential treatment, the patient is asked to sign an informed refusal form. As with the rule of informed consent, the patient must be given an opportunity to discuss the recommended treatment and the effects of refusal with the dentist. Make a contemporaneous notation in the chart that the patient was told of the risks—including the risk to their health—in not accepting the recommended treatment. Document that the patient has unequivocally and without condition refused the treatment and identify why the patient refused your advice for a particular course of treatment.[3]

Contemporaneous Treatment Record

This important part of the dental record must be legible and in ink if you are not using an electronic record keeping system. Document everything necessary for proper patient care and continuity of care for future practitioners. Treatment descriptions must be as thorough as possible and describe preexisting conditions, intraoperative, and postoperative conditions in detail. It must include all materials used (brand names and the like), devices, and medications with their amount and dosage. Document all negative and positive findings that were considered in reaching a diagnosis. Record all complications, mishaps, or other unusual circumstances that may have occurred.

It is critical to inform the patient of any adverse or unanticipated events or outcomes that may have transpired; note in the record that the patient was so informed. All entries are signed or initialed and dated by the person making them. If an auxiliary has kept the treatment notes, the treating doctor must review the same and also sign the entry. All referrals, phone contacts, and specialist discussions should be noted in the record.

Never erase, obliterate, or write over any entry. Corrections are made by a single line cross out (and initialed) or by a separate entry–indicating it is amending and/or supplementing a prior entry. No notations in the margin or between other notations. If you and your staff use abbreviations not conventionally accepted, they should be consistently used by all members of your staff.

Conclusion

Remember, no matter how safely and professionally you practice, it is impossible to predict if and when an action may be taken against you. If you take the prudent and correct steps of documentation, you will help defend yourself when necessary, while improving the quality of services you bring to your patients every day.

[1] Based on reviews of hundreds of dental records, the most common errors I see in are: lack of a documented treatment plan, no informed consent and/or refusal documentation, an incomplete or outdated health history, and unclear or partial documentation of treatment rendered.
[2] See ProAssurance Dental Practice Management Bulletin titled “Patient Medical History” for more information on taking and updating a patient’s medical history.
[3] See ProAssurance Dentist Practice Management Bulletin titled “Informed Refusal” for more comprehensive information.