



Dental Professional Liability

Record Keeping and Documentation

Upon completion of this section, you should be able to:

- **Understand appropriate paper and/or electronic record keeping practices** to enhance patient care and reduce professional liability risks.
- **Adopt techniques and procedures for both dentists and staff members** to improve the accuracy and comprehensiveness of patient records.
- **When necessary, make corrections or additions to patient records** that preserve their integrity as legal documents.
- **Understand the importance of addressing and complying** with federal and state privacy and security laws/regulations in dental practice.
- **Perform risk assessments for paper and/or electronic patient record systems**, identify issues and implement appropriate corrective actions.

Please Note

A number of sample risk management forms and letters are available electronically in association with this manual, including written informed consent templates, patient termination letters, records release authorization forms and others. Dentist's Advantage-insured dentists may access these sample documents on the [Dentist's Advantage website](#).

Each PDF sample permits customization: copy and paste the sample text from the PDF template document to a text editing file (MS Word, Apple Pages, etc.); edit text and add your dental practice information where appropriate; save the file to create a blank form for ongoing use. If necessary, customize the text of the form template for specific patient needs. You may wish to include components from various sources if the templates provided do not meet the needs of your practice.

While a number of form templates are available, documents are not available for every dental procedure. We encourage you to create consent forms for those dental procedures you perform frequently. You may wish to use the sample consent forms as an outline and review the manual section on informed consent. Consider consulting your attorney to ensure that your forms comply with state informed consent statutes.

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Accurate and thorough records are one of the most powerful risk management tools, as the information captured can support that the professional services provided met or exceeded the standard of care. In addition, comprehensive, timely documentation reduces the opportunity for treatment errors, communication problems and patient dissatisfaction.

Whether in paper or electronic format, the dental healthcare information record (“dental record”) serves two major purposes. It preserves your memory about important patient information and facilitates the sharing of vital information, both within and outside your practice. All information critical to the diagnosis, treatment, and continued care of the patient should be documented in the dental record. Paper-based and electronic records are referenced throughout this section of the manual. However, more specific information on electronic health records (EHR) is included under the “Electronic Records” heading.

In the event that you become a defendant in a malpractice action, a comprehensive dental record is integral to your defense. It is difficult for a plaintiff to challenge an accurate and unaltered dental record written at the time of treatment. On the other hand, poor records make it very difficult to effectively defend a dentist against a claim or lawsuit, although excellent care may have been provided.

One of the most significant problems in defending professional liability claims occurs when diagnosis, treatment, referral, consultation or patient issues are not supported by appropriate documentation. At a malpractice trial, the jury will be told, and the defendant dentist must acknowledge, that all pertinent patient information – personal and clinical – should be documented in the dental record. If the record is then found to be deficient, the dentist’s credibility as a witness is severely weakened. In the subsequent battle of oral testimony, a jury comprised of the patient’s peers will believe the patient’s version of the events, if that version is credible.

Note however that under the **final Omnibus Rule**, covered entities must **provide an individual** with a **copy of their records** in electronic format, if requested.

Record Organization

There are many acceptable dental recordkeeping systems. Most frequently, dental records are organized alphabetically by name or account number. Color-coded tabs or file folders are commonly used with paper records to further simplify record storage and retrieval.

Notably, the use of electronic patient records continues to expand in dentistry. However, paper and hybrid (a mix of paper and electronic) records are not uncommon in dental practices. While electronic records have many advantages, they are not a panacea. New risks and risk management considerations typically accompany any significant change. Due diligence is, therefore, required in the preparation for and transition to electronic record systems in order to limit or eliminate potential liability issues.

The admissibility of electronic patient records in legal proceedings has been established in numerous healthcare malpractice cases. Therefore, check with your state board of dentistry to ensure that no handwritten mandates apply to any portion of dental records. In the event of a lawsuit, electronic records can be printed to comply with record requests, referral needs or discovery requests. Note however that under the final Omnibus Rule, covered entities must provide an individual with a copy of their records in electronic format, if requested.

Experience with claims that involve electronic patient records show that it can be challenging to compile all pertinent records for the claim investigation. For example, the patient’s records may be found in a number of different electronic “buckets”. As a result, the process may be much more involved than clicking one “print” button or copying one or two computer files. Discovery may involve standard portions of the electronic health record, as well as:

- metadata (hidden files that may be used to authenticate entries and other information)
- clinical decision support data (system alerts, reminders and similar tools)
- email records
- information stored on smartphones, tablet devices and/or other mobile devices and storage media.

If the record becomes part of the defense of a malpractice claim or dental board complaint, the dentist would be required to attest that the printout or electronic files represent a true and accurate account of the patient's treatment. It is critical therefore to be conversant with your electronic record system design, and the types of data that may be requested/required during the claim or legal discovery process. Our experience indicates that the format of the patient record – paper versus electronic – is insignificant relative to the information contained in or missing from the record.

Certain aspects of “paperless” records can be advantageous in comparison to paper charts. Electronic records are:

- recoverable, because electronic files that have been backed up and stored off-site can be reloaded onto a system following a fire, flood, hurricane, or other loss that would otherwise destroy paper records.
- accessible from many locations via an intranet or the Internet, permitting a dentist to retrieve a chart from a home computer to document a telephone conversation, or send complete records instantly to similarly equipped consulting dentists.
- consistently legible, reducing the risk of miscommunication or disputed entries.

Whatever system you use, it should be employed consistently. Recordkeeping systems should address the needs of the dentist, staff, and patient. Your staff should be well trained in understanding and using your system. Guidelines for recordkeeping should be established and used by everyone. Ensure that your guidelines contain a comprehensive infection control protocol pertinent to handling paper and/or electronic records as appropriate.

Paper records should be maintained in folders or envelopes of similar style and size. Color and other coding systems must be consistent and easily understood to avoid confusion. With electronic systems, the dentist and office staff must be equally comfortable with creating, finding and copying records as they are with opening a file drawer to obtain a patient's paper chart.

Record Elements

It is important to note that some states have codified the elements that must be included in all dental records, which will be addressed later in this section. It is essential that dentists understand and comply with state dental record requirements. In the absence of or in addition to any state requirements, consider the following elements that should be included in patient records:

- Patient personal identification and demographic information
- HIPAA-related documents
- Medical and dental histories
- Examination records
- Diagnoses and diagnostic records (including radiographs, models and photographs)
- Treatment plans
- Informed consent and informed refusal documentation
- Progress notes (see below for further detail)
- Referral and consultation correspondence and reports
- Written patient authorization for each occasion when records are released
- Patient correspondence

Patient financial information should be included in the progress notes only when the financial issue directly relates to the delivery of patient care or a patient's treatment decision. Other financial notations such as daily fees, past due balances, and collection actions should be omitted. An example of a recommended financial reference would be a patient declination of a recommended treatment or pursuit of a less expensive alternative due to financial reasons.

The primary rationale for excluding financial information from progress notes is that the principal function of the progress note is to serve as a repository for pertinent clinical information. Financial account information and notations do not provide clinical insight, except as noted above. In addition, charts that contain financial information, especially when there is more financial than clinical information, may give the impression to jurors and dental licensing board investigators that the dentist is more focused on fees than patient welfare.

Who Can Make Record Entries?

Documentation by dental staff is just as important as documentation by the dentist. Any member of the dental staff can enter what they see, what they hear, and what they are told to write by the dentist. The entries of the dentist and the staff are considered equivalent, and what a staff member writes is regarded as representing the report of the dentist.

All staff members should sign or initial their entries. All staff entries must be reviewed by the dentist, who should verify their accuracy, make any necessary changes or additions, and co-sign the entry. This protocol is especially important for those dentists who delegate the task of writing clinical progress notes to their chairside assistant. The data recorded by staff under the dentist's direction remains the dentist's responsibility. If an entry is illegible, incomplete or incorrect, the patient may suffer consequences and the dentist will be held responsible. If litigation arises, a court and jury will not be persuaded by a defense that the staff entries in the records were in error.

Some practitioners create dental record notes via dictation. Whether created from a recording that is later transcribed, or by use of voice recognition software, they find that the time saved using dictation, coupled with the accuracy and comprehensiveness achieved by dictation, offsets the costs involved. Transcribed progress notes should be reviewed for accuracy and initialed or signed and dated by the dental provider. Similarly, artificial intelligence systems are being integrated into healthcare record systems to listen and transcribe clinical interactions and discussions. As for traditional transcription methods, the output of artificial intelligence systems should be reviewed for accuracy and completeness: the dental record remains the responsibility of the treating dentist, regardless of the documentation method.

Good Record Keeping Practices

Record Keeping Guidelines

- The patient's name should appear on every page of the dental record.
- Label each diagnostic report or object (radiograph, model, photo, etc.) with the patient's name and date. Digital radiographs and other files that are compliant with the Digital Imaging and Communications in Medicine (DICOM) dental standards incorporate patient information as "metadata" in each file (see the Bibliography for more on DICOM). This metadata can be viewed in DICOM compliant software systems.
- Make a note of every patient visit and telephone conversation. Email and text messages that contain patient care information must also be considered as part of the dental record. How this information is captured may vary, depending upon the record system. Use of personal telephones and other mobile devices should be avoided. Security/privacy with these electronic communications also must be addressed.
- Record the date in full (day/month/year).
- Record information during patient visits or promptly within 24 to 48 hours, preferably not later than the day of treatment. Understand the documentation time requirements for electronic systems.
- For paper records, write legibly! Also consider the default font style and size for clear and easy-to-read electronic records. Print and evaluate samples from all parts of the electronic record.
- Use dark ink – black ink photocopies best. (Red or blue ink is acceptable on exam forms as long as it copies well.)
- Be factual, objective, and clear.
- Be comprehensive – address who, what, when, where, and why.
- Use appropriate language and a professional tone.
- Use abbreviations and symbols consistently and in accordance with practice-approved lists.
- Do not skip lines in the record.
- Require each entry to be signed (or at least initialed) by the person making it. Metadata will capture the author's identity, but typing the name or initials is recommended, to clarify printed records.
- Use quotation marks to accurately record patient complaints and comments.
- Ensure that records document all findings and corrective actions through their resolution.

- Use the SOAP format to document emergency visits and treatment not in the original treatment plan. The SOAP format is delineated later in this section.
- Retain copies of all dental laboratory prescriptions.
- Handle and maintain records in a confidential manner.
- Handle paper records and use electronic equipment in accordance with infection control protocols.
- Train new employees in the recordkeeping methods of the office and document all training.
- Implement a procedure to regularly perform quality assurance record audits to ensure accuracy, consistency, and comprehensiveness.

Determining How Much to Write/Type

A frequently asked question about recordkeeping is “How much do I *really* need to write?” There are two equally important components to that answer. You should write sufficient information in the chart to:

- permit you, your staff, or any other dentist to determine exactly what treatment was performed at each appointment, why that treatment was necessary, and what treatment is next – based solely on your documentation, and
- meet all recordkeeping requirements of your state dental board.

As an aid to meeting the first test, document sufficient information to pass what is commonly referred to as the “amnesia test”:

If you were to *forget* everything you ever knew about each and every one of your patients, but you *remembered* everything you know about how to practice dentistry, would you be able to read your patient charts, and quickly be able to:

1. know what treatment the patient has had and why, and
2. perform whatever treatment is next for that individual and know why it’s necessary?

The second component of recordkeeping adequacy varies by state and can present additional risks. A dentist whose records do not comply with dental practice act requirements may be sanctioned by the state dental board (e.g., monetary fine, license probation, remediation), in addition to facing potential professional liability allegations by the patient.

Some state dental boards provide direction regarding minimum requirements for dental records in their states. For example, the Illinois Dental Practice Act (225 ILCS 25/50) states:

“Every dentist shall make a record of all dental work performed for each patient. The record shall be made in a manner and in sufficient detail that it may be used for identification purposes.”

Such a standard lacks concrete parameters either for patient care or risk management purposes. Therefore, we recommend that Illinois dentists, as well as those in other states with similar minimal requirements, use the amnesia test as a guideline.

Conversely, other state dental practice acts are more specific in their wording. Although the Florida Board of Dentistry (Sec. 466.018(3)) does not cite a list of what dentists are expected to record, it places the recordkeeping bar rather high by requiring that:

“Every dentist shall maintain written dental records and medical history records which justify the course of treatment of the patient. The records shall include, but not be limited to, patient history, examination results, test results, and, if taken, X rays.”

Thus, in Florida, simply writing what you did would not be sufficient. Your record must *justify* your actions through your documentation. Moreover, the defense of malpractice allegations and dental board complaints typically requires this documentation standard.

Many state boards have adopted dental record requirements and criteria in order to provide further direction for licensees on *how* to justify their treatment. For example, the Minnesota Board of Dentistry Administrative Rules (3100.9600) leads the dentist through a set of very specific items, that must be incorporated in every chart:

Subpart 2. Dental records. Dentists shall maintain dental records on each patient. The records shall contain the components specified in subparts 3 to 10.

Subpart 3. Personal data. Dental records must include at least the following information:

- A. the patient's name;
- B. the patient's address;
- C. the patient's date of birth;
- D. if the patient is a minor, the name of the patient's parent or guardian;
- E. the name and telephone number of a person to contact in case of an emergency; and
- F. the name of the patient's insurance carrier and insurance identification number, if applicable.

Subpart 4. Patient's reasons for visit. When a patient presents with a chief complaint, dental records must include the patient's stated oral health care reasons for visiting the dentist.

Subpart 5. Dental and medical history. Dental records must include information from the patient or the patient's parent or guardian on the patient's dental and medical history. The information shall include a sufficient amount of data to support the recommended treatment plan.

Subpart 6. Clinical examinations. When emergency treatment is performed, items A to C pertain only to the area treated. When a clinical examination is performed, dental records must include:

- A. recording of existing oral health care status;
- B. any radiographs used; and
- C. the facsimiles or results of any other diagnostic aids used.

Subpart 7. Diagnosis. Dental records must include a diagnosis.

Subpart 8. Treatment plan. Dental records must include an agreed upon written and dated treatment plan except for routine dental care such as preventive services. The treatment plan must be updated to reflect the current status of the patient's oral health and treatment.

Subpart 9. Informed consent. Dental records must include a notation that:

- A. the dentist, advanced dental therapist, or dental therapist discussed with the patient the treatment options and the prognosis, benefits, and risks of each; and
- B. the patient has consented to the treatment chosen.

Subpart 10. Progress notes. Dental records must include a chronology of the patient's progress throughout the course of all treatment and postoperative visits. The chronology must include:

- A. all treatment provided;
- B. all medications used and material placed;
- C. the treatment provider by license number, name, or initials; and
- D. when applicable, the identity of the collaborating dentist authorizing treatment by license number.

Clearly, dental boards view **good recordkeeping** as an effective **patient safety tool**. Similarly, the risk management process seeks to achieve the same goal.

This list is substantial, and every item is important. The listing serves to guide dentists toward recordkeeping practices that benefit both the patient and the dental practice.

As one of the primary purposes of state boards of dentistry is the protection of the public, codification of recordkeeping requirements supports this mission. Clearly, dental boards view good recordkeeping as an effective patient safety tool. Similarly, the risk management process seeks to achieve the same goal.

Documenting in the Patient Record

There is no single standard method or form for writing progress notes. Regardless of your handwritten or electronic system and formatting, include the following information, in addition to criteria cited in the previous section, when documenting patient care. Note that the inclusion of many of these items may be expressly required by your state dental practice act.

- Date (day/month/year) of examination or treatment
 - Cancelled and failed appointments also must be recorded
- Results of your review of the patient's medical history and physical status. This includes blood pressure, current medications and over-the-counter remedies. Recording patient weight is also recommended, and this may be required by your state regulations.
- Clinical findings and observations, both normal and abnormal
 - If you use a dental examination form, complete all blanks and boxes on the form to verify you have examined those areas or structures. Symbols such as + or a check mark may be used, or the abbreviation "WNL" for "within normal limits." However, such symbols or abbreviations may be utilized only if they are formally defined and approved for use by the practice and universally utilized by all staff. With electronic forms, consider eliminating default responses to prevent errors. A default response of "WNL" for example, may result in a "failure to diagnose" allegation in the future.
 - Record all objective findings essential to your diagnosis and treatment plan.
- Clinical findings to be documented include, but are not limited to, size, depth and location of caries; areas of inflammation; periodontal pocketing; furcation involvements; mobility; mucogingival defects; radiographic findings; pulp, percussion and thermal testing results; root proximity problems; violations of the biologic width; and soft tissue lesions with differential diagnosis.
- Regarding radiographs, do not simply state that radiographs were taken or obtained. Always document that radiographs were reviewed, and state the positive, or negative, findings.
- Document other negative findings, when appropriate, or when consistently documented by members of the practice for similar situations. For example:
 - Document when a previously noted soft tissue lesion has healed and is no longer present.
 - Document the absence of fever, despite the presence of infection.
- Diagnoses
- Treatment performed, including:
 - Anesthesia used – type, concentration, volume or amount (milligrams, grams, etc.) administered, vasoconstrictor presence or absence, concentration of vasoconstrictor
 - Dental materials and devices used – liners, cements, restoratives, restoration shade, etc.
 - Patient protection, such as dental dam
- Prescriptions and medications (include confirmation that premedication was taken as prescribed, and any over-the-counter medication) and documentation of consultation with the patient's physician and/or pharmacist, if appropriate
- Patient satisfaction and dissatisfaction, including any complaints and concerns
- Lack of patient compliance
- Treatment complications or unusual occurrences, and the corrective action taken
- Pertinent discussions/communications (in person and by telephone, text or email)
- Informed consent and informed refusal discussions
- Referrals to specialists and consultants
- Postoperative and follow-up instructions
- Plans for the next visit
 - If appropriate, this should include the clinical rationale for any deviation from the documented treatment plan, the discussion of the modification with the patient and the patient's consent to the modification

Accuracy Matters

It is essential to write the proper words, and a sufficient number of words, to accurately express yourself. The absence of accuracy in recordkeeping creates a potential for unintended inferences and conclusions to be asserted by plaintiffs and their attorneys.

Below is the chart entry of a patient's initial visit with a new dentist.

CC: Mild gingivitis due to braces – bleeding probably sometimes. 1-1/2 years with braces – no idea when they will be taken off. Patient has been previously told she had perio disease but was never told to see a specialist. Patient was not told she had bone loss. Moderate amount of plaque and tartar. Patient will be recommended to see periodontist after braces are removed.

Let's evaluate the note to see if we can learn more about the patient's situation. We'll begin with the first line, "CC (chief complaint): Mild gingivitis due to braces – bleeding probably sometimes." Although it is good practice to record the patient's chief complaint, what is the likelihood that the patient expressed her complaint using these words? The categorization of the periodontal status as "gingivitis" appears to be the dentist's conclusion. The phrase "bleeding probably sometimes" is ambiguous and does not have any quantitative meaning.

Which individual has "no idea when" the braces will be removed, the patient or the dentist? The note doesn't say. Perhaps the patient knows but hasn't disclosed that to the dentist. Who told the patient she "had perio disease" – her neighbor, her spouse, her previous dentist? When was she informed? The note indicates she was "never told to see a specialist" but provides no explanation. Perhaps she was not referred because her previous dentist did not believe there was a clinical reason for referral. Or, perhaps that phrase is a criticism of the previous dentist who neglected to provide a necessary referral. The true meaning is impossible to decipher due to the lack of detail in the entry.

Now we move on to the next line, "Patient was not told she had bone loss." Was she not told because there was no bone loss? Or, if there is bone loss, is this another criticism of the previous dentist, who should have informed her but failed to do so? And how would the author know the patient was never told? He didn't accompany this patient to all of her previous dental appointments. Maybe she was told, perhaps many times, but she forgot or withheld the information. Once again, the ambiguity creates more questions than answers. If bone loss is present, it would have been more accurate to write, "Patient reports she was never informed of existing bone loss."

"Moderate amount of plaque and tartar" is a reasonable statement to make. However, if the plaque and tartar are moderate in quantity, it is logical to wonder about their influence on the periodontium, such as the extent of inflammation and loss of attachment. Yet, these aspects are omitted from the note. In the last sentence, we learn of the need for a periodontal referral after the completion of orthodontic treatment. Exactly why is the patient in need of a periodontal referral? The note fails to include a periodontal diagnosis. There is no definitive statement as to bone loss. There is no mention of pocket depths, bleeding, or inflammation. It appears the patient is being referred due to a "moderate amount of plaque and tartar." What wasn't documented was that this patient had generalized pocketing > 5 mm in the posterior, moderate posterior alveolar bone loss, and significant gingival inflammation, all compounded by active orthodontic tooth movement. Her diagnosis was chronic generalized periodontitis, but those words were never reflected in the chart. As a result, it was inappropriate to have recorded "mild gingivitis" as the periodontal diagnosis.

One other troubling aspect of the last sentence is the treatment sequence. The dentist wrote that he planned to refer the patient only after her orthodontic care was completed. What was the reason for waiting? In this case, the dentist who wrote this note was heavily criticized by the plaintiff's periodontal expert for failing to refer her immediately. Because periodontal disease may be exacerbated by active tooth movement and to mitigate the risk of disease progression, the dentist should have considered these factors and referred accordingly.

While there are many ways to write a good exam or progress note, we'll now consider how the note at the beginning of this section could have been improved. Since it contained ambiguities, we will begin by sharing with you the facts that the dentist observed or was told. During his exam, he found moderate plaque and calculus, mild inflammation of the gingival margin, generalized posterior 5-6 mm pocketing, generalized bleeding on probing throughout the mouth, and a loss of 1.5 mm of alveolar bone height in the posterior. Other oral soft tissues were normal in appearance with no signs of oral cancer. Her blood pressure was taken. The patient informed him of the following: 1) she was uncertain when the braces were to be removed; 2) her gums usually bleed when she brushes with any thoroughness; 3) she was on an in-house soft tissue management program at her last dentist; and 4) she does not recall being told by any previous dentist that she had bone loss or that she needed to see a periodontist. Here is one example of a note that includes the necessary information.

Reviewed med hx. No meds, med hx noncontributory. BP 124/76. CC: "My gums bleed whenever I brush real hard." Exam: No decay noted. Oral CA screening neg. Pt in full ortho for past 1-1/2 years, states she doesn't know when tx will be done. Mild inflammation at gingival margin, moderate plaque & calculus, generalized FM bleeding on probing. Pocket depths 5-6 mm in posterior, ≤3mm in anterior – see perio chart. @1.5 mm crestal bone loss in posterior. I asked pt about perio hx. States she started perio tx before ortho began. States previous dentist told her he could treat her without referral because "case wasn't too bad." States she had FM root planing & recalls every 4-6 months. I informed pt about current perio status, new X-rays show existing bone loss. Pt reports she was never informed of existing bone loss. Dx: generalized chronic periodontitis in posterior areas, moderate gingivitis in anterior. Discussed need to stop ortho movement until perio needs are addressed. Referred pt to periodontist.

Of course, you may use abbreviations to make the note easier and quicker to write. And you might choose to sequence or describe the information somewhat differently. An electronic record system may require entry of the data into specified data fields. However written, a note of this type provides the reader with a much better idea of the patient's status, regardless of whether that reader is a periodontist, a plaintiff's attorney, a juror, or simply you, two years from today.

Clearly, accuracy in recordkeeping is important. Good record-keeping involves selecting words that accurately convey what you heard, saw, and considered. To maximize the effectiveness of your documentation, we suggest the following:

- Use words and descriptions that are clearly understood.
- Be specific rather than vague.
 - "Pt. has draining fistula on buccal from periapical abscess #13", rather than "Appears pt. might have signs of an infection"
 - "PA shows distal decay #21 within 1 mm of pulp chamber, likely will need RCT," rather than "D caries #21"
 - "Lesion on R cheek is now 14 mm in diameter, was 7 mm at last visit", rather than "R cheek spot bigger than before"
 - "Periodontal diagnosis now generalized chronic periodontitis," rather than "Perio worse than before"
- When documenting discussions with patients, accurately record what you told the patient. For example, "Informed pt. of risk of numbness," rather than "Risk of paresthesia"
- Unless you witnessed an event, always record the source of the information or opinion presented to you.
 - "Pt. reports he slipped in shower and broke his tooth," rather than "Pt. slipped in shower and broke tooth"
 - "Pt. stated he thought prior Dr. did RCT poorly," rather than "Prior dentist did poor RCT"
- Thoroughly explain the basis of the clinical decision-making process and evidence that supports the diagnosis and plan of care.
 - For example, rather than writing "#30 might need endo," document the clinical evidence that supports the statement.
 - What does the dentist see? A large restoration, decay, a periapical lesion?
 - What other factors are involved in the clinical decision-making process? Traumatic occlusion, parafunctional habits, canal calcification?
 - In what time frame might this occur? Tomorrow, next week, next month, next year?
 - Under what circumstances? If decay progresses, if the tooth becomes painful, if the patient continues grinding?

The “SOAP” Format

Lack of documentation is a common problem arising from unscheduled emergency appointments, as well as scheduled visits, when the patient presents with complaints that require a change in the original treatment plan. Consider a patient who returns for crown preparation on tooth #18 three weeks after you’ve completed emergency placement of a bonded composite for a fractured cusp. The patient indicates that since the emergency visit, chewing is painful and the tooth is sensitive to hot and cold. The radiograph you take shows periapical pathology, and after additional testing, you appropriately recommend root canal therapy.

What error might occur in the record entry for this visit? Your last progress note states “Next visit: crown #18” but in lieu of following the treatment plan, you recommended and performed a completely different treatment. To avoid a failure in documentation, the patient’s record should indicate why you deviated from the planned treatment, including patient complaints, diagnostic information acquired, your clinical observations, differential diagnosis, and patient informed consent for a new treatment plan. While that may seem like a great deal to write, it accurately documents what occurred. If the patient has a poor outcome from the subsequent treatment, you’ll have documentation that you met or exceeded the standard of care.

Whenever a progress note is made for emergency care or for treatment that reflects a change in the written treatment plan, document the event using the SOAP format. This format uses the acronym SOAP to remind the author to follow the prescribed formula:

- Record the patient’s **Subjective** comments, including desires, expectations, and physical complaints. Write the patient’s chief complaint in his or her own words with quotation marks around it. Use open ended questions that allow patients to fully describe their problems, such as:
 - “When did you first notice the pain/swelling/loose filling?”
 - “Has the problem changed since you first noticed it? If so, how?”
 - “How have you addressed the problem since you first became aware of it? Did that help?”
- Make note of your **Objective** evaluation. Include the results of your medical history review, physical exam, clinical findings, diagnostic test results, radiographic findings, and all observations.
- Note your **Assessment**. Your assessment of the patient’s problem is your differential diagnosis, which may be simple or complex depending on the information collected from the patient’s subjective comments and your objective evaluation.
- Outline the **Plan**, the treatment you plan and deliver. All aspects of the actual treatment must be documented, including:
 - Patient preparation (informed consent discussion, NPO status, preoperative medications such as antibiotics and anxiolytics, local anesthesia, dental dam, etc.)
 - Actual patient treatment (include flap design, type and number of sutures, adhesives, bases, liners, restorative materials and shades, irrigants, impression materials, cements, etc.)
 - Postoperative instructions and medications prescribed (prescription *and* over-the-counter)
 - Plans for the next visit

Make sure each note includes an appropriate level of detail in all four sections, and no section is omitted. Here's a sample SOAP note for the emergency treatment example given at the beginning of this section:

- S:** "Ever since you put in that big filling I can't drink anything hot or cold or eat on that side of my mouth. Lately it hurts more when I lie down." Chief complaint: pain from hot, cold, and chewing in LL. Pt reports pain began 5 days after last appt. Pain more severe since onset; spontaneous at times; described as "throbbing and deep."
- O:** Reviewed med hx: pt taking Lipitor for high cholesterol, no other meds. Pt presents w/ large bonded MODBL composite #18 replacing MB cusp. Tender to palpation. Pain on biting, exquisitely painful to even light percussion. Heightened pain responses to both cold and heat. PA shows PDL thickening @ M root w/ slight breakdown of lamina dura. Perio #18 WNL, no pockets >3mm.
- A:** Irreversible pulpitis #18.
- P:** Recommended RCT #18. Gave pt endo pamphlet #2 and responded to the patient's questions. Alternatives of RCT by endodontist and extraction also offered. Explained further pain and probable abscess if no tx; risks of tx: pain, infection, separated instrument, lack of healing; that #18 may still require extraction after RCT; need for buildup & crown after RCT; explained fees, answered pt. questions. Pt understands tx and agrees to RCT #18. 2 cartridges Lido 2% w/ epi 1:100,000. #7A clamp, dental dam, access, extirpated pulp. Established lengths: MB-19.0mm to MB cusp; ML-19.5mm to MB cusp; single Distal canal-18.5mm to DB cusp. All canals filed to #15. Minimal shaping. NaOCl flush. Dried. ZOE temp placed in access. Reduced occlusion. No purulence noted. Rx: Ibuprofen 600mg, 1 tab q6h for pain x 15 tabs. 1 refill. Gave pt endo post-op instruction sheet and reviewed orally. Next Visit: shape & fill.

What Not to Include in Patient Records

Some things are better left undocumented. The following should be heeded in creating records:

- Never use correction fluid such as White Out® or Liquid Paper® to correct errors in paper records.
- Do not write disparaging or subjective comments or abbreviations about the patient, such as "patient is rude to office staff," "patient is a complainer," etc.
- Do not write disparaging comments about the prior dentist. ("Patient was improperly treated by Dr. ...")
- Never record the patient's daily fees in the progress notes. Fee amounts are not considered as part of a clinical treatment record.
- Do not use words that are ambiguous or vague. "Periodontal diagnosis: poor" does not adequately describe the clinical findings or the true diagnosis.
- Do not record information that requires follow-up action on your part if you are not going to take that action. For example, writing "Patient to be seen in 3 days for re-evaluation" places the onus for evaluating the patient's subsequent status on the dentist.
- Do not use language that suggests carelessness or negligence. ("I hadn't noticed the ulceration at any of the previous appointments.")
- Do not erase decay noted on examination records in order to note completed restorations. This is considered record adulteration. If you wish to graphically display a patient's progress from oral disease to oral health, do so on a form other than the examination record.
- Do not record telephone discussions with attorneys, risk managers, claims specialists, or insurance agents in the patient dental healthcare record.

Documenting Telephone Calls

A great deal of important information is exchanged during telephone calls. The timeliness and extent of documentation of telephone calls between patients and dentists and their staffs are often the issue that is critical to the defense of a malpractice allegation. The lack of a timely response to a patient's (or patient advocate's) telephone call is often a cause of significant dissatisfaction.

- Document in the patient's record all calls regarding cancelled appointments, medications, emergencies, referrals, consultations, and any aspect of patient care.
- When you are unable to reach the patient by telephone, document the telephone number called and make a notation such as "No answer, left message on machine" or "Spoke with spouse, left message to call back."
- Document after-hours telephone calls at your earliest opportunity. Be certain to clearly indicate any direction provided to the patient and necessary further action, such as patient or dentist follow-up.

To facilitate after-hours access to care, many dentists use answering services, carry pagers or cellular telephones, or use office voice mail or answering machines. When speaking with patients after hours, without access to patient files, it is sometimes difficult to verbally compile and then document all pertinent information regarding his or her call. If problems develop afterward, a terse, cryptic note written on a scrap of paper will not impress a jury. It may even suggest that the dentist failed to take a proper history or convey necessary information to the patient.

Information received during after-hours calls can be documented on a form, or in a log or diary. Such forms should be placed into the patient's record, and logs or diaries should be permanently maintained by the practice as documentation for use in any subsequent litigation. Important information recorded should be transferred or attached to the patient record in a timely manner. If you don't wish to carry items for documentation, immediately call your office and dictate a message on the office answering machine for later transcription. If electronic records are used, notes can be scanned into the patient's records. If you dictate a voice recording or type a note into a smart phone, tablet device or home computer, take appropriate precautions to protect the privacy and security of the captured information. Another option for electronic records is to establish a secure access portal to permit real-time documentation in the patient record. Establish and implement written policies and procedures to address use of personal or practice-owned mobile electronic devices. More information is available on the use of mobile technology on the U.S. government website, HealthIT.gov.

A telephone contact form can guide you in asking the proper questions and capturing essential patient information in an organized and accessible manner. It can be used in any situation where data must be obtained and documented quickly and the patient chart is not immediately accessible. The completed paper or electronic version of the form can be brought back to the office, with the information added to the patient chart or electronic record, saving the original record as well. The result will be an organized, effective system, making follow-up care easier to track and minimizing potential documentation gaps. A number of sample risk management and dental office forms are available that may be modified to suit your own needs. *Please refer to [page IX](#) for information about access to risk management forms.*

Information received during **after-hours calls** can be **documented** on a form, or in a log or diary. Such forms should be **placed into the patient's record**, and logs or diaries should be **permanently maintained** by the practice as documentation **for use in** any subsequent **litigation**.

Correcting Dental Records

Occasionally, erroneous information is entered in the record, or important information is omitted. Current hand-written record evaluation methods – such as ink analysis, light reflection tests, transmission analysis, and computerized handwriting analysis – can detect even the most sophisticated attempts to adulterate a paper record. Electronic record entries are generally automatically dated and timed when entered as part of the computer operating system or software program. An adulterated record makes defense of any patient claim extremely difficult. It also raises the issue of fraud, and the possibility of punitive damages or criminal charges, which are not insurable in many jurisdictions. For paper records:

- **Never use correction fluid or other means to obliterate an erroneous entry!**
- If an error is made while making an entry, draw a single line through the error and initial it. Lined-out entries must remain readable so that incorrect inferences cannot be made about their content.
- If an error is discovered after an entry is complete, draw a single line through the error and initial *and date* it contemporaneously. Add the correct information in the next available space in the record, keeping the date of the correction clear. You may also wish to clarify the reason for the correction.
- When making an addition to a prior treatment entry, do so in the next available space in the record, rather than in the margin or the body of a previous entry, and contemporaneously date and time the entry. Information scribbled haphazardly into an old note or added in the margins or between the lines carries the inference of impropriety, even if it was written at the time of service.
- If you receive a notice of peer review, disciplinary or professional liability action, do not make changes or additions to the record in question, even if the additions or changes reflect what actually occurred, although not previously recorded.
 - Any necessary additions, deletions and changes to the record after notice of a peer review, disciplinary or professional liability action can be made in a separate narrative report or by oral testimony. This supplemental narrative report is ordinarily addressed to the defense attorney to maintain confidentiality under the doctrine of attorney-client privilege.
 - Copies of such a report should be kept in a separate file to prevent the material from being inadvertently copied and released to the plaintiff.

Electronic Records

Computers can be helpful in overcoming the problems of internal record keeping conflicts. Good computer systems automatically update ledgers or recall information when a treatment entry is made. Some will automatically add a note in the treatment record when a prescription is written, when a recall card is sent or when a telephone call is recorded. If purchasing a computer-based EHR system, check for these and similar automation features. If already using a system, be aware of and take full advantage of its features. As previously noted, be aware of any “default” features for examination forms or other parts of the clinical record and consider their risks. Disabling such features may be advisable.

One drawback to many electronic systems is the challenge of capturing patient signatures on important documents, such as medical histories and informed consent forms. To overcome this problem, you can either have the patient sign a paper form, then scan the form into your computer system; or utilize a form of “electronic signature” (e-signature) that meets applicable legal and regulatory requirements. Under the [HIPAA Omnibus Final Rule](#), e-signatures may satisfy requirements for a signature “to the extent the signature is valid under applicable law.” Some states have enacted their own e-signature statutes.

If you currently have an EHR in place, or you are in the process of purchasing or developing a system for electronic health records, remain vigilant with respect to legal and regulatory requirements, including e-signatures. Technology continues to evolve rapidly and laws/regulations are not static. Therefore, all dentists and other healthcare providers should confirm e-signature compliance and regularly review the process with experienced legal and information technology personnel. Vendors provide useful information, but consulting with independent advisors is also recommended.

Complete information on e-signature requirements is beyond the scope of this manual. One example is provided since this may initially seem to be a simple solution to dental office e-signatures. Installing an electronic signature pad, comparable to those used for credit purchase procedures at retail establishments will not necessarily comply with legal requirements. In addition to other requirements, the signature image must be securely and automatically added to the form/record by the software/computer system. This form of electronic signature may easily be compromised, unless the system/software prevents altering, moving, or copying and pasting of the digitized signature.

If you decide to scan a signed paper form to capture a patient signature, retain the original signed form. Under what is known as the Best Evidence Rule, original signed documents are preferred to copies or other reproductions. Archive all original documents alphabetically in a master file, rather than creating separate patient charts with each containing only a few pages. This approach precludes the ability to maintain a totally paperless office. However, in today's litigious society, original documentation of the patient's medical history and informed consent represents a critical risk management strategy.

Another potential disadvantage of electronic records is that plaintiff attorneys may attack the integrity of electronic records, asserting that they may have been altered without detection. The use of a system that creates audit trails indicating when a record was last modified, coupled with various backup methodologies that prevent alteration of the records, can address the issues of access and security.

Some safeguards that should be incorporated in electronic record keeping systems include the following:

- When selecting or developing an electronic record keeping system, the system should require a unique username and passwords for each authorized user. Passwords should be sufficiently complex, and changed regularly, such as every 6 months. Office policies should state that usernames and passwords should never be shared.
- Ensure that operating system, software updates and security patches are installed in a timely manner. Also regularly update important third party applications (e.g., Java and Flash).
- Require every individual making progress note entries to type his or her name at the end of each note.
- Review and electronically "co-sign" progress notes entered by staff members.
- Protect against unauthorized system entries. Staff access should be limited to specific portions of the patient record or require review by an authorized staff member.
- Protect against unauthorized electronic intrusion. Your system contains a great deal of confidential patient information that requires protection in accordance with state and federal statutes and regulations. Breaches of this information can result in serious financial liability and reputational harm. Use appropriate software and/or hardware barriers to reduce the risks of "hacking" and "infection" by a computer virus, and train your staff on safe computer usage. These threats are real and becoming more common in dentistry. Be sure to document all training. Use a virus detection program to check all data for viruses before uploading. Consider using a full disk encryption solution on any device (laptop/desktop/mobile) that stores patient data.
- Do not attempt to adulterate records under any circumstances. Nearly all changes to electronic records may be detected. Although the computer screen appears to contain seamless information, data entered at different times is usually recorded in different locations on the storage media. Moreover, the computer operating system and in most cases, the EHR application or program create "metadata" on a continuous basis. Metadata is "data about data." The computer system/program creates/records information, including but not limited to: (i) when a document was created or edited and by whom; (ii) when a document is accessed, even if not edited; and (iii) date and time when saved. Dentists and all healthcare professionals must, therefore, timely document activities and findings, while the details are easily recalled. Document immediately if possible, but not longer than 24 to 48 hours after the treatment, communication or other activity.

- Back up your computer data daily and store the backup data away from the office nightly to prevent the total loss of data in the event of a fire, flood, burglary, or other catastrophic event. Another type of back-up called “mirroring” may represent a viable option for healthcare records. Restoring a system back-up can be time-consuming, especially with large files (images/radiographs, for example). Mirroring creates an exact copy of the records on a separate computer drive or system that is immediately available for use, if the primary system crashes or is compromised. Consult with your Information Technology (IT) professional or record system vendor regarding options.
- Check your backup system frequently. Remember that electronic media can eventually fail. Follow advice of IT professionals for media replacement schedules.
- Maintain a signed “backup log” showing completion dates.

Computers are neither foolproof nor immune to accidents and sabotage. To protect your data:

- Keep your electronic storage media away from magnets and excessive heat. Magnets can alter or erase electronic storage media.
- Store back up data off-site, in a secure, waterproof and fire-resistant environment. If “Cloud” back-up systems are considered, work with IT professionals and your attorney to ensure that appropriate security and privacy controls are in place that comply with applicable federal and state regulations.

Clinical users will seek creative ways to **work around an EHR system** if its **functions lack flexibility** or fail to reflect and support actual clinical practice. **EHR implementation plans** must **balance user needs and preferences** with patient **safety considerations**.

Downtime, Scanning and Workarounds

No EHR or computer system is fail-safe. If IT problems or power outages occur, providers and support personnel may not have access to the EHR for hours, days or longer. Develop and implement policies and procedures to help address system downtime or outages due to weather events or other emergency scenarios. Cloud-based systems and/or back-up may be one approach. Consult with IT professionals and EHR vendors to help assess solutions that will prevent or minimize documentation gaps in the EHR.

Whether during the transition to an EHR or with established systems, scanning of paper documents will be necessary. Scanning frequency will depend upon many factors, including the EHR’s capabilities and interoperability. Ensure and validate that scanned documents may be catalogued, filed and retrieved, similar to native electronic documents and records.

Clinical users will seek creative ways to work around an EHR system if its functions lack flexibility or fail to reflect and support actual clinical practice. Left unmonitored, such improvisations can seriously undermine patient safety. To avoid this hazard, EHR implementation plans must balance user needs and preferences with patient safety considerations.

Hybrid Records and Transition to EHR

Many providers utilize “hybrid” records, which encompass both paper and digital records, during the transitional period, while reviewing and meshing the EHR system with existing work practices.

During this hybrid phase, it is important to assess staff members’ computer skills and readiness in order to navigate between paper and electronic formats. Lack of transitional planning and training can result in confusion, resistance and errors, potentially leading to breakdown even before the system is fully implemented.

To simplify the transition, consider the following risk management interventions:

- Determine the components of the patient healthcare information record that will remain in paper form during the transition, and devise policies to protect and preserve data maintained in a hybrid state.
- Identify areas of potential duplication across paper and electronic systems, and reduce or eliminate potentially confusing redundancies, especially in the high-risk areas of medication prescription and administration, allergy notation, and follow-up on laboratory and diagnostic reports.
- Establish written parameters for the use of paper notes in the hybrid record in order to reduce the risk of missing or inconsistent electronic documentation.

- Ensure that staff members possess necessary IT competencies before proceeding with EHR implementation. Consider evaluating skills of staff members and documenting results.
- Acknowledge the increased workload implications of a newly implemented EHR system, and provide appropriate support in the form of a call center, additional hands-on training and/or reduced patient loads for clinicians during the transition period. If necessary, assign additional IT staff to clinical settings to assist.
- Pilot new EHR modules in order to identify glitches, make corrections, and increase staff members' proficiency and sense of ownership.
- Encourage EHR users to provide comments, suggestions and other input on an ongoing basis. Document follow-up on all verbal and written suggestions and complaints.
- Consider scheduling regular staff forums to educate staff about EHR and sound communication practices, as well as to encourage questions and discussion.
- Monitor system interfaces for changes in user behavior. If a common workaround is detected, instruct clinicians to utilize recommended procedures until the risks and benefits of the alternative method are thoroughly understood and the workaround is either approved or prohibited. In addition, analyze problematic clinical processes to better understand why end-users believe that they are compelled to circumvent standard procedures.
- Retain vendor guidebooks, resources, protocols and programs for reference in the event of a professional liability claim involving system design or utilization. Access additional resources and information on EHR transition on the [HealthIT.gov website](https://www.healthit.gov).

Copy and Paste Practices

Clinicians commonly use copy-paste and copy-forward functions to document information within EHR systems. The practice – often referred to as “cloning” – involves selecting some or all of a prior note and replicating it in another entry in the EHR, or repeatedly copying forward a prior notation to create a series of entries. When appropriately utilized in accordance with standardized guidelines, this practice can save time for busy providers without compromising care. However, reflexive use of such shortcuts may result in serious patient mishaps, as well as violation of HIPAA privacy rules, federal and payer audit requirements, and fraud and abuse regulations.

Cloning also may adversely affect the ability to defend professional liability claims by raising questions about the record's credibility. As a consequence, costly forensic analysis may be required in order to refute allegations of negligent dissemination of erroneous information. The misuse of copy-paste and copy-forward functions creates vulnerabilities when patients receive care from multiple healthcare providers who primarily rely upon the EHR to communicate patient diagnostics and treatment plans. In the absence of direct communication between treating providers, erroneous or outdated information may be mistaken as truthful. Such information may influence clinical decision-making and potentially expose providers to claims based upon delayed diagnosis, failure to diagnose and misdiagnosis.

Consider the following risk management recommendations, among others:

- Incorporate regulatory and industry standards regarding the proper use of copy-paste and related functionalities into IT governing policies, EHR documentation guidelines and training programs. (See ECRI Institute's "[Copy/Paste: Prevalence, Problems, and Best Practices](#).”)
- Avoid repetitive copying and pasting when documenting high risk items, such as laboratory results, radiology reports and drug formulations.
- Review and update any shared information found elsewhere in the EHR before pasting it into current entries, especially problem lists, diagnoses, allergies, current medications and relevant medical history care across the continuum.

- Expressly prohibit the following risk-prone functions:
 - Copying-pasting text from another clinician’s note without accurate attribution, which may constitute medical plagiarism and lead to allegations of billing fraud.
 - Deleting original source text or data and inserting it elsewhere in the record, thus altering the initial entry and compromising documentation integrity.
 - Carrying forward information – such as prior medical history or diagnostic results – that is readily available elsewhere in the EHR, creating clutter and that may adversely affect the readability and usefulness of the record.
- Monitor the copy-paste conduct of providers and institute corrective action when the following “red flags” are observed:
 - Copying of outdated and/or redundant information.
 - Inconsistent progress notation.
 - Unnecessarily long progress notes (AKA “note bloat”).
 - Notes that cannot easily be authenticated, dated or attributed to an original author.
- Measure the level of compliance with copy-paste protocols for clinicians who create notes in the EHR, and include findings in the annual performance review process.
- Consider disabling the EHR system’s copy-paste function if inappropriate copying and pasting of entries becomes a chronic problem.

Template Documentation

EHR vendors offer various tools – including template documentation and population via default – designed to make writing notes easier, while minimizing the hazards of duplication.

Templates feature predefined text options targeted to specific conditions and procedures, while populating via default involves one-click data entry to indicate normal status.

When using these forms of documentation, commonly referred to as documentation by exception (DBE), entry of negative or out-of-the-ordinary findings must be entered separately. EHR templates create a high risk for “cloned” documentation. Moreover, failure to enter negative or extraordinary findings may lead to allegations of deficient care and may be difficult to defend in the event of litigation.

Consider the following actions to strengthen EHR practices:

- Assess whether vendor-developed templates adequately support recommended work practices. If they do not, adjust them to accurately reflect current protocols, standards and regulations.
- Include a variety of input controls to facilitate the capture of all relevant findings, both normal and abnormal. Possibilities include right-left-bilateral confirmation, positive/negative notation, and multiple-choice text and number features.
- Incorporate voice recognition and text-entry tools in order to document subjective observations to support template use and permit patient-specific variability.
- Create a section within templates for relevant past medical history, positive findings on exams and answers to “red flag” questions. For example, on a strep throat template, include prominent prompts for fever, headache, rash, and a history of heart valve or kidney problems.
- Perform quality audits to track incidence of “scribing,” i.e., the overwriting of one practitioner’s authenticating notes by another. Audits also should identify clutter-prone templates and DBE practices (e.g., when routine patient encounters produce more than one or two pages of documentation).
- Prohibit staff from tampering with the EHR audit trail capability. Explain that the function is necessary and that tampering with the audit trail (metadata) may result in serious legal consequences for both the individual and the organization in the event of a claim or lawsuit.

Patient Privacy, Record Confidentiality and Electronic Security

Protecting the privacy of patient health records and other protected information has always been important in dentistry. Electronic records and communications have presented new challenges and requirements with which every dentist should be conversant. Compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, and the regulations promulgated under these laws, is an important aspect of dental practice that should not be minimized or overlooked.

Federal and state legal requirements are stringent with respect to protected health information. All office personnel must be aware of the confidential nature of the information included in a dental record, regardless of whether that record is on paper or in a computer system. The staff must understand the importance of protecting and not disclosing patient information to any unauthorized individual inside or outside the office. Dentists and practice staff must comply with all federal and state laws pertaining to patient privacy and record confidentiality.

In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) to simplify administration, assure portability of health insurance coverage, and facilitate communication of medical records and other information between healthcare providers and health plans. The provisions of the Act that most affected dentistry were the wide range of patient privacy issues and the requirements pertaining to dentists who engage in any manner of electronic claim submission. Dentists who submit entirely paper insurance claim transactions are not subject to the Act, although they continue to be subject to individual state privacy laws and requirements.

In January 2013, the Omnibus Final Rule pertaining to the HIPAA Privacy and Security Rule was published by the U.S. Department of Health and Human Services (HHS), with a compliance deadline for many of the new requirements of September 23, 2013. The Omnibus Final Rule clarified and strengthened various existing requirements under HIPAA Privacy, HIPAA Security, and Health Information Technology for Economic and Clinical Act (HITECH) breach notification laws. Several new requirements were added, as well as a more active enforcement initiative for privacy/security breaches and legal/regulatory compliance.

A few important points regarding the Omnibus Final Rule, which:

- Extended the Privacy Rule and the Security Rule to a covered entity's business associates and contractors
- Established new limitations on the use of protected health information for marketing purposes
- Expanded patient rights to request/receive copies of health records in electronic format
- Strengthened the ability of patients to prevent disclosure of information to health insurance plans

HIPAA acts as a federal "floor" for patient information security. In states with more stringent privacy requirements than HIPAA, state law will prevail and thus preempt HIPAA requirements. In states where HIPAA would grant more stringent privacy protection than state law, HIPAA will preempt state law. Therefore, you must be aware of the privacy requirements in your state to determine whether state or federal laws or regulations apply.

HIPAA requires healthcare providers to present a written explanation or notice of both your privacy practices and the privacy rights of patients. The notice must be supplied to patients during their first dental visit to your office and to individuals who request the information. Also, a copy must be made available in your patient waiting area. Providers also must make a good faith effort to receive a patient's acknowledgment of the receipt of the privacy notice on the first date that services are delivered to the patient. Retain a copy of each written acknowledgement pertaining to receipt of the privacy notice. Model notice of privacy practice templates are available for download that incorporate requirements of the Omnibus Final Rule. The free model documents are available on the [HHS website](#): search "model notices of privacy."

HIPAA requires the protection of all personal medical records and other individually identifiable health information that is used or disclosed by a covered entity in any form – electronic, paper or oral. It also confers significant rights upon patients to control how their protected health information (PHI) is used. The law ensures patient access to medical records, requires patient consent before information is released in most routine situations and permits recourse to patients whose privacy protections are violated.

HIPAA requires that healthcare providers, including dentists, implement reasonable safeguards to avoid prohibited disclosures. The recommended measures include:

- Designation of a “privacy officer” to develop and implement the privacy policies of your practice
- Staff training to understand and follow privacy policies and procedures
- Establishment of safeguards (e.g., document shredding, locked file cabinets and appropriate electronic safeguards) to protect PHI from prohibited or inadvertent disclosures

The following additional protocols provide privacy safeguards:

- Handle patient records in a manner that precludes other patients from viewing them.
- Never place medical alert stickers containing highly sensitive and confidential patient information on the *outside* of paper charts. Such information must be kept inside the chart.
- Stickers placed on the outsides of charts should be uniform in color and size and should also be blank with no writing. The sticker should serve only as an alert to dental personnel that important information is contained inside the chart.

In addition to safeguards for paper records, care must be exercised with the confidential information in your office computer system.

- Access to confidential information should be password protected, limited to specific portions of the patient record or subject to review by an authorized staff member. Implement strategies to protect against breaches by unauthorized parties.
- Place computer monitors to preclude casual glances by others at a poorly located screen.
- Choose complex passwords and change them regularly.
- Passwords should be written and stored in a safe deposit box or other secure location.
- Covered entities, as defined under HIPAA to include healthcare providers, must conduct a risk assessment of their organization and systems to ensure compliance with HIPAA’s administrative, physical, and technical safeguards. A risk assessment and gap analysis reveals issues that may compromise the security of protected health information. HHS now provides a complimentary downloadable tool (software) to assist healthcare providers with this requirement: see the Legal/Regulatory Related Resources section of the bibliography or navigate the [HealthIT website](#) and search for “risk assessment tool.”

Reasonable safeguards must be taken to protect patient information when communicating electronically, whether sending record copies to other providers or patients, or for purposes of patient communication about dental care via email or text messages. Through exchanges via email and other electronic communications, protected health information (PHI) may be inadvertently transmitted to an unauthorized third party, representing a breach of unsecured PHI and thus a violation of HIPAA. Therefore, the use of HIPAA-compliant encrypted email systems and other methods to protect electronic patient/provider communications are recommended to help ensure compliance.

If PHI is revealed on practice-owned equipment or employee-owned devices used for healthcare-related purposes, this practice may constitute a breach of the HIPAA Privacy and Security Rules and related state laws. Also, the use of cellular telephones to take and share photographs or audio and video recordings relating to a patient has significant privacy implications. HIPAA privacy and security requirements (and technology systems) are complex and government enforcement activities continue to increase. From a risk management perspective, legal and regulatory compliance is critical in today’s healthcare environment to protect patients from improper disclosure of PHI. Implementation of a HIPAA compliance program, including ongoing staff training, in order to reinforce current requirements, represents an important element of your practice protocols.

Encrypted email systems/vendors are readily available. Dentists should consult with information technology professionals, attorneys and other experts to understand the advantages and capabilities of systems under consideration. Another option to examine for secure healthcare communications specifically is “Direct Secure Messaging,” launched as part of a public-private partnership to facilitate secure point-to-point communications between healthcare providers. Additional details on this topic also may be accessed on the [HealthIT website](#). Search for “direct secure messaging” on that website or check for links in the bibliography under the Record Keeping and Documentation section.

The HIPAA legislation and related regulations are voluminous and complex and beyond the scope of this manual. Though many aspects have little or no bearing on most dental practices, various requirements that apply to dentistry are important in today’s practice environment. Every practice must comply with requirements or risk significant monetary penalties that may result from ongoing enforcement activities. In addition, professional penalties may apply. In November 2014, the Connecticut Supreme Court ruled that patients can sue for negligence if a healthcare office/practitioner violates privacy/patient confidentiality regulations. Other states reportedly have taken similar positions.

For a more comprehensive discussion of HIPAA privacy and security requirements and compliance, we strongly encourage you to contact the American Dental Association (ADA) and/or other organizations (such as law firms and practice consultants) that offer complete compliance and staff training programs. You may wish to retain and consult legal counsel about privacy requirements and to pursue the technical, legal and regulatory issues that may arise in your practice. Remember that your state may have enacted statutes or promulgated regulations that are more stringent than federal requirements. For more information, you also may wish to access the U.S. Department of Health & Human Services, [Office of Civil Rights website](#).

Releasing Confidential Patient Records

The HIPAA Privacy Rule states that specific patient consent for the use and disclosure of a patient's protected health information (PHI) for purposes of *treatment, payment, or healthcare operations* (TPO) is not required.

- **Treatment** pertains to providing or arranging to provide for patient care.
- **Payment** refers to billing (which may involve benefits companies and credit card/financial institutions).
- **Healthcare operations** include quality improvement and assessment, accreditation, credentialing and case management activities.

Apart from these conditions, all personnel must understand that, absent a court order, patient information must not be released to anyone without the patient's written consent. This prohibition includes releasing records to spouses, parents of adult children, children of aged parents, siblings, work associates, and in some situations, insurance companies, and governmental agencies (which may include state dental board investigators). Even attorneys representing patients are required to have written patient authorization to obtain a copy of the record.

The release of information for referrals to, and consultations with, other healthcare providers would probably be construed as *treatment* as defined above. It is important to note that your state laws pertaining to the release of confidential patient information may be more stringent than the federal HIPAA requirements, and may *require* authorization in these circumstances. Therefore, it is optimal to obtain specific patient authorization for disclosure whenever you are uncertain or uncomfortable about sending copies of records.

In addition, the HIPAA Omnibus Rule permits PHI disclosure without patient authorization under four circumstances:

- Pursuant to legal process or as otherwise required by law
- To locate or identify a material witness, missing person, suspect or fugitive
- Under specified conditions regarding a crime victim
- If a covered entity believes PHI constitutes evidence of a crime committed on its premises

Thus, PHI may be disclosed without patient consent under court order, subpoena, in dental malpractice cases, under mandatory reporting laws, or in connection with governmental audits. For example, by filing a dental malpractice lawsuit, the patient will be considered to have waived the privilege against disclosure. If there is a concern regarding the release of records, you may decide to first contact an attorney, while considering the time constraints of the request or legal process.

Another important point on disclosure came directly from Leon Rodriguez, Director of the Office for Civil Rights, U.S. Department of Health & Human Services in a January 15, 2013 letter to health-care providers. In the letter, Mr. Rodriguez stated:

“I wanted to take this opportunity to ensure that you are aware that the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule does not prevent your ability to disclose necessary information about a patient to law enforcement, family members of the patient, or other persons, when you believe the patient presents a serious danger to himself or other people.”

Here are additional comments and suggestions regarding the release of confidential patient information:

- **The dentist owns the dental record and all diagnostic information.**
- **The patient has the legal right of access to all information in the record.**
- Never release original records or radiographs, only copies. Many state dental practice acts mandate that you retain the original records.
- If you choose to release copied patient records based upon a telephone request from the patient, document the request in the patient’s record before photocopying or making electronic copies and obtain a contemporaneously dated, signed consent for the prior release at the next patient encounter.
- Dentists are required to provide the requested records in a reasonable time and manner. Refusing to transfer records because of unpaid dental bills is a violation of the law in most states. While the federal requirement is that healthcare providers act on a request for access to records within 30 days following receipt of the request, it is important to note that some states require a response in a shorter time period. Check with your attorney or state board of dentistry to confirm state requirements.
- You may charge the patient, or anyone the patient authorizes to receive a copy of the record, a *reasonable* amount to pay for duplication costs. If you charge a fee, establish a consistent fee policy for copying records for patients and others. If you don’t know what constitutes a reasonable charge, contact a copying or duplicating service listed in the telephone directory and ask for the current rate for copying medical records. Note that some states have adopted specific requirements and limitations on such charges. Again, consult your attorney or state board to confirm state-specific information.
- Document in the patient’s chart the request and the date the copy was sent (or picked up). Failure to make such notations could prove embarrassing if, in a professional negligence defense, a copy of the patient record surfaces containing information that differs from what is on file in your office. Maintain all original patient authorizations in the record (release of records, signature on file, etc.). If records are sent by mail, utilize certified, registered mail with a required return receipt and maintain the receipt in the patient’s records. If records are picked up by the patient, ask that he or she sign and date a records receipt.
- Staff members who respond to record requests should release only the records specifically requested and should check with the dentist before mailing or sending electronic records to verify that the correct components are being sent.
- In the unlikely event you forward original records from your office, retain for yourself copies of all documents and radiographs.

Record Retention

Record storage and retention are essential aspects of dental practice, whether the patient is in the midst of care or has moved to another practice. Paper and electronic records alike must be maintained, primarily for treatment continuity, but also for risk management purposes.

Ideally, records should be kept forever, whenever possible. On a more realistic level, records should be maintained well beyond any point of legal and/or administrative exposure for the dentist.

State statutes of limitations prescribe the period of time within which a lawsuit can be brought. However, statutes of limitations for filing dental malpractice actions vary from state to state, and many states create exceptions for minors or legally impaired patients. For minors, in many states, the time period doesn't begin to run until the child attains the age of majority, which also varies from state to state. For a patient who is legally impaired at the time an incident occurs, the statutes of limitations clocks generally do not begin to run until the impairment is removed.

Even in cases not involving minors or impairment, other circumstances may result in the statutes of limitations being suspended, or "tolled," permitting plaintiffs to have their cases heard many years after the legal window of opportunity was believed to have closed.

Most states also have enacted record retention statutes which require retaining records for a minimum number of years. (Certain states do not expressly address the issue of dental record retention.) Such laws may be part of various state dental practice acts or other legislation, and often far exceed the time frames of the statutes of limitations. Consult your state dental board or local dental association for specific requirements. Note however that some state record retention requirements may be significantly shorter than the retention period recommended by your insurer or attorney to protect your interests.

In states without record retention laws, ask your attorney for a recommendation. Your attorney may base the recommendations on rulings from legal cases involving record keeping issues, as well as state statute of limitations requirements.

- Keep records forever, if possible.
- If permanent retention is not practical, maintain patient records for *at least* the minimum of time required by state dental practice acts or statutes. In *most* states, 12 to 15 years for adult records is sufficient.
- Dentists using digital radiography should retain, in unaltered form, all original images as well as all manipulated images used for diagnostic or treatment purposes. Such maintenance includes images that have been magnified, field-reversed or contrast-adjusted to better evaluate the patient's condition.
- Dentists utilizing electronic records will require a great deal of electronic storage capacity going forward as well as the ability to access the stored information. When selecting software, consider the long-term viability of the vendor, potential obsolescence of software programs and compatibility with past and future systems or standards. Appropriate and secure system back-ups and/or data mirroring must be in place. Unfortunately, this basic safeguard is often ignored.
- HIPAA requires that patient consents for disclosure and use of PHI be retained for six years from the date it was last in effect.

If permanent retention is not practical, **maintain patient records** for at least the **minimum of time required** by state dental practice acts or statutes. In most states, **12 to 15 years** for adult records is sufficient.

Improving Records Through Self-assessment

Dentists call the CNA risk management support line periodically with questions about audits that have been conducted by dental benefit companies or government agencies. Your own audit program can help to ensure that your documentation not only records events, but also includes appropriate and sufficient information to justify prescribed tests, diagnoses, treatment and third party billing practices. In addition to internal audits, commercial companies/consultants offer dental record audit services. If you do not currently implement an audit system, an audit services firm may provide an opportunity to initiate a program and compile resources/information on how to train staff and implement your own audit process.

While most dentists readily admit that their record keeping practices could be improved, they also acknowledge that they are often too pressed for time to write or type as much as they should. One aspect of managing risk is to recognize those circumstances when additional measures are warranted. In the realm of documentation, the dentist should develop more comprehensive entries for those patients and clinical procedures that present a heightened risk. The risk may be an adverse outcome or simply patient dissatisfaction, which may trigger dental professional liability claims.

Your practice and your patients can benefit from various self-assessment techniques. One option is a record review or quality assurance program. Such a program can be as simple as randomly selecting 10-20 records per month and performing a written review of their organization and the quality of their information. Conduct these audits regularly and have more than one staff member work on it. Upon completion of the review, necessary corrections should be made (in accordance with proper correction methods) to the specific records, and all staff should be alerted to check for similar deficiencies in other records. Audit results should indicate any areas of fundamental deficiency, which can be corrected by policies/procedures and documented training.

Informal record reviews can and should be conducted whenever the records are used. Dentist and staff should actively alert one another to record deficiencies or irregularities whenever discovered, and appropriately entered corrections should be made immediately upon discovery.

Another excellent tool to evaluate the quality of record keeping in your practice is to respond to a series of probing questions. Recognizing your vulnerability to a malpractice claim or to a weak defense in the event that a non-meritorious claim arises reduces the likelihood and severity of malpractice claims. The self-evaluative method of recognizing deficiencies can be effective in helping all dental team members enhance the quality of your practice documentation.

How to Use the Record Keeping Self-assessment Checklist

On the following pages, you will find a self-assessment checklist pertaining to various aspects of record keeping. For each query, determine if you and your staff practice the questioned technique *Always, Usually, Occasionally, or Never*.

The greater the number of *Always* or *Usually* responses, the better your documentation will continue to be. Those questions that you answer *Occasionally* or *Never* should be evaluated for enhanced incorporation into your daily routine.

Consider that this assessment tool does not encompass every possible documentation issue. In Addition, you may find that you use a technique that achieves the same result via a different method.

The purpose of using this self-assessment tool is for each practice to validate the good record keeping practices already employed and to more easily identify areas where documentation can be improved.

Record Keeping Self-assessment Checklist

Record keeping organization

- Do you maintain a record keeping system that permits you to locate a patient's record quickly?
- Do you maintain a record keeping system that facilitates finding misplaced patient records?
- If you utilize electronic records, do you make a system backup daily and store it off-site?
- Do you have an established office protocol for record handling and record access?
- Do you have a record keeping system that deters your staff from making unauthorized entries in patient records?
- Do you have a method for training new employees in the record keeping methods of the office?

Record confidentiality

- Do you and your employees handle patient records with attention to confidentiality?
- Do you require a written authorization from a patient to release confidential information?
- Do you have the original of all patient authorizations in the record (release of records, signature on file, etc.)?
- Do your records document HIPAA compliance?
- Do you refrain from placing confidential patient information (including health alert stickers) on the covers of patient files so that protected health information will not be inadvertently disclosed to other patients?

Access to information

- Do you permit patients to access the information in their dental record?
- Do you have a written policy for documenting that a record copy was sent out of the office?
- Do you have a written record release policy?
- Have you established a protocol for addressing the cost of copying records for patients and others?

Record retention and record purging

- Do you retain your records for at least the minimum amount of time of either your state statute of limitations or record retention requirement, whichever is longer?
- Do you maintain and store all after-hours and telephone logs and diaries?
- Do you have a system of storing inactive patient records?
- Have you established parameters for retention of diagnostics and if/when to discard them?
- If you no longer need a diagnostic, do you document in the patient's record the information on that diagnostic?
- Do you document whenever an original diagnostic is given to the patient or to a subsequent treater, or otherwise removed from the patient record?

Record review and quality assurance

- Do you have a system in your office for record review/quality assurance?
- Do you and your staff perform record audits on a regular basis?
- Do you discuss the results of your record audits with your staff?
- Do your dental records include information that mirrors the notations in the following documents:
 - Patient ledger?
 - Referral forms?
 - Consultation letters?
 - Recall cards?
 - Patient correspondence?
 - Telephone communications?
- Do you include checking the documents against your records during your record audits?

Individualized records

- Do you have a separate record for each patient?
- Have you maintained the patient's radiographs in the patient's individual record?
- Do you have the original of all patient records in your files?

Record keeping practices

- Do you write the patient's name on every page of the record?
- Do you make a note of every patient visit?
- Do you record the date in full (day/month/year)?
- Do you record information during patient visits or promptly afterward (not more than 24 to 48 hours)?
- Are your written entries legible?
- Do you use dark ink for written records?
- Are your entries factual, objective, and clear?
- Are your entries comprehensive, addressing who, what, when, where, and why?
- Do your entries use appropriate language and a professional tone?
- Do you refrain from recording disparaging or subjective comments or abbreviations about the patient?
- Do you refrain from recording disparaging or subjective comments about the prior dentist?
- Do you refrain from leaving open lines in the record?
- Do you contemporaneously sign and date any late entry?
- Is each entry signed (or at least initialed) by the person making it?
- Do you label each diagnostic (radiograph, model, photo, etc.) with the patient's name and the date it was taken?
- Do you use quotation marks "..." to accurately record patient complaints and comments?
- Do you record information in a patient record for all emergency treatment, even new patients seen for the first time for an emergency only?
- Do you retain copies of all dental laboratory prescription forms?
- Do you handle records in accordance with current infection control protocols?
- Do you refrain from routinely recording the patient's daily fees in the progress note?
- Based solely on your records, can you determine what treatment the patient has had and why it was necessary?

Patient personal information

- Do you have a comprehensive patient personal information section in the written patient record?
- Do you update this information regularly, such as at each recall?
- Do you maintain current emergency contact information, including cellular telephone numbers?
- Do you have written documentation of guardianship for minors, especially in cases of minors with divorced parents?

Health history

- Do you take a comprehensive medical history on every new patient?
- Do you document the patient's current medications and over-the-counter remedies and check for potential interactions (including contacting the patient's physician or pharmacist, if needed) before prescribing any additional medication?
- Do your records alert you to important medical conditions or other healthcare complications for each patient?
- Is this information prominently displayed inside the record?
- Does every provider review the patient's medical history prior to every treatment or consultation visit?
- Do you complete an abbreviated update of the patient's medical history at every visit and document the results?
- Do you complete a comprehensive update of the patient's medical history at every recall?
- Is the health history discussed with the patient at each visit to confirm the written information?

Dental history

- Do you document a patient's dental history?
- Do you have a written policy for obtaining the patient's authorization and contacting a prior treating provider concerning a dental history?
- Do you document the information received?

Diagnostic records

- Do you have a policy for determining the diagnostics necessary for each patient?
- Do you document your examination of all patients for:
 - Periodontal disease?
 - TMJ problems?
 - Oral cancer?
 - Caries?
 - Defective restorations?
 - Occlusal problems?
 - Other oral health problems?
- Does your periodontal examination document areas of inflammation, periodontal pocketing, furcation involvements, mobility, mucogingival defects, root proximity problems, violations of the biologic width, and your radiographic findings?
- Do you have a baseline periodontal charting, including pocket depths for each tooth, for all patients who have been diagnosed with periodontal disease?
- Do you complete all appropriate blanks and boxes on the dental examination form?
- Do you send only copies of radiographs, never originals?

Informed consent and informed refusal documentation

- Do you and your staff know the components of informed consent?
- Do you know when to have an informed consent discussion with your patient?
- Do you document that an informed consent discussion took place?
- Do you document in the patient record the receipt of informed consent when received from a patient?
- If you use written informed consent forms, do they:
 - Have a patient-friendly title?
 - Discuss the nature of the proposed treatment?
 - List alternative treatments?
 - Discuss possible complications of the recommended treatment?
 - Use the simplest language possible?
 - Allow you to customize the form for each patient?

- If you use written informed consent forms, do you:
 - Also have a face-to-face discussion with the patient?
 - Give the patient as much time as needed to ask questions?
 - Answer all patient questions and document this in the record?
 - Give the form to the patient on a date prior to the treatment date so the patient has time to think about the decision?
 - Give a copy of the form to the patient to retain?
 - Document the use of the form in the patient record, and maintain a copy in the patient record?
- Do you document a patient's refusal to follow your recommendations?
- If so, do you include that you informed the patient of the refusal risks and the probable consequences of failing to follow your recommendations?
- Do you give the patient written documentation of the information he or she was told about the refusal to follow treatment recommendations?

Treatment plans

- Do you have a written treatment plan for all patients, when appropriate?
- Do you give the patient a copy of the written treatment plan?
- Do you notify the patient when there has been a change in the treatment plan during treatment and obtain his or her informed consent for the revised plan?

Progress notes

- Do you make a note of every patient visit?
- Does your note include the following:
 - Date in full (day/month/year) of examination or treatment?
 - Review of medical history and findings?
 - Chief patient complaint?
 - Clinical findings and observations, both normal and abnormal?
 - Your diagnosis?
 - Receipt of informed consent?
 - Referral or planned consultation, if necessary?
 - Treatment performed, including anesthesia used, materials used, patient protection, such as eye protection or dental dam placement?
 - Prescriptions and medications (includes confirmation of premedication)?
 - Postoperative and follow-up instructions?
 - Plans for next visit?
- Do you use the SOAP format to document emergency visits and treatment not in the original treatment plan?
- If you do not follow a previously documented plan of action, do your records indicate why your treatment plan changed?
- Do you document cancelled and failed appointments in the patient record?
- Do you document patient satisfaction and dissatisfaction, including any complaints and concerns?
- Do you document patients' lack of compliance and discussions with patients regarding the risks of lack of compliance?
- Do you document treatment complications, unusual occurrences and the corrective action taken?
- Do you document all pertinent discussions (in person and by telephone)?
- Do you document all referrals to specialists and consultants?
- Do you give patients written postoperative instructions?
- Are your written instructions specifically tailored to the procedure?

Abbreviations and symbols

- Do you use abbreviations and symbols in the dental record?
- Do you use the American Dental Association and standard pharmacology abbreviations and symbols?
- If you use other abbreviations and symbols in your record keeping, do you:
 - Have a formal policy and list so that others can interpret your notations and ensure that all staff utilize the approved list?
 - Use the same abbreviation or symbol consistently for the same item?
 - Refrain from using the same abbreviation or symbol for more than one item?
 - Use abbreviations that make common sense?

Staff entries

- Do your staff members write/type in the dental record concerning treatment they witnessed or in which they participated, as well as pertinent discussions they had with patients?
- Do your staff members sign, date and time each entry they make in the dental record?
- Do you read and initial every clinical entry in the record made by one of your staff?

Correcting the dental record

- Do you correct records without obliterating the incorrect information?
- When you make an addition to a treatment entry, do you do so in the next available space in the record and date it contemporaneously rather than in the margin or the body of a previous entry?

Consultations

- If you obtain a consultation over the telephone, do you document in the patient record both the individual to whom you spoke and the information received?
- Do you retain a copy of all written consultations received from other healthcare providers?
- Do you explain the pertinent dental information clearly to non-dental professionals from whom you seek consultation?

Referrals

- Do you use a written referral form for every referral and retain a copy in the patient record?
- Does that referral form contain, at a minimum:
 - The name of the patient?
 - How long the patient has been with the referring practice?
 - What diagnostics are available to the specialist, and the date they were collected?
 - What diagnosis you have made for the patient?
 - What treatment has been completed to date?
 - What treatment you expect the specialist to consider or complete?
 - What treatment is planned when the patient completes specialty care?
 - What information is needed from the specialist?
 - How you want to handle maintenance, if applicable?
- Do you require a written referral form from all providers who refer to you?
- Do you call the provider to whom you referred a patient to follow up on whether the referral was pursued?
- Do you check with the patient to determine if the patient followed your referral recommendation?
- Do you inform the patient of the consequences of refusing a referral when the patient does not follow your referral recommendation?
- Do you document this information in the dental record?

Telephone calls, emails and text messages

- Do you have a system in place for alerting you to patient communications for emergency care or information after office hours?
- Do you and your staff record all attempts to reach a patient, including the number or address used and message left?
- Do you and your staff document information received by phone, email or text concerning a patient in the patient's record?
- Do you and your staff document information received by phone, email or text from a patient in the patient's record?
- Do you document in the patient record all communications concerning patient care you have received while away from the dental office?

Computerization

- If you record patient treatment notes, medical histories or other patient information on a computer, do you have:
 - An adequate backup system and or mirroring system? ("Mirroring" is an automated process that creates a second original and secure electronic record, separate from your primary system. This proves permits immediate access to patient records, if your primary system crashes or become compromised for any reason.)
 - A print-out or electronic storage medium with all patient information on it, labeled, dated, sealed and updated at regular intervals, such as quarterly?
 - A method to detect alteration or deletion of patient information?
 - A method for accessing the patient information before, during and after treatment?
 - Is the software/operating system current and in compliance with healthcare information security requirements?
 - Has a security risk assessment/gap analysis been conducted?
 - Are appropriate controls in place to limit access, such as sufficiently complex passwords and encryption technology?
 - Do you consider balancing user needs with patient safety considerations and system flexibility to avoid dangerous user workarounds?
 - Do you consider and incorporate regulatory and industry standards on the proper use of copy/paste and related functions in documentation guidelines and training?
 - Do you assess vendor-developed templates and adjust them if needed to support user needs and patient safety?
 - Do templates include necessary options to capture both normal and abnormal findings? Do they incorporate an option for narrative inputs?

Documentation of recall

- Do you have a patient recall system?
- Are recall notifications recorded in the patient record or in a recall system log?
- Do you record all missed recalls and patient appointment cancellations in the patient record?
- Do you monitor the number of missed recalls for each patient?
- Do you establish and implement a written policy to address patients who do not keep scheduled recall appointments?

Insurance documentation

- Do you maintain a written authorization from the patient to release information on an insurance form?
- Do you have an established office procedure for completion of insurance forms?
- Do you always review insurance forms for accuracy before they are sent to the insurance company?
- Does your original signature appear on all insurance forms filed on behalf of a patient?

Financial documentation

- Do you provide each patient with a written financial plan, when appropriate?
- Do you provide a "Truth-in-Lending" disclosure to all patients against whose accounts you may charge interest?
- Do you check your patient record for completeness before sending a patient to collection or initiating a court action to collect a debt?
- Do you review the relationship you had with the patient before sending a patient to collection or initiating a court action to collect a debt?

Notice of termination

- Do you evaluate the stability of the patient's health prior to terminating the relationship with a patient of record?
- Do you notify the patient in writing when you terminate a dentist-patient relationship?
- Do you offer (and document) to assist the patient in obtaining alternative dental services, assist in his or her transition and document the patient's response to the offer of assistance?
- Do you retain a copy of the notification in the patient record when you terminate a relationship with the patient?
- Do you document all actions taken to assist the patient in obtaining alternative dental services or his or her refusal of such assistance?
 - Do you document in writing in the patient record when you terminate a relationship with the patient?

Please refer to [page IX](#) for information about access to sample forms on "Patient Authorization to Release Confidential Information" and "Patient Contact After-hours."

This checklist serves as a reference for dental practices seeking to evaluate risk exposures associated with documentation and record keeping. The content is not intended to represent a comprehensive listing of all actions needed to address the subject matter, but rather is a means of initiating internal discussion and self-examination. Your clinical procedures and risks may be different from those addressed herein, and you may wish to modify the tool to suit your individual practice and patient needs. The information contained herein is not intended to establish any standard of care, serve as professional advice or address the circumstances of any specific entity. These statements do not constitute a risk management directive from CNA. No organization or individual should act upon this information without appropriate professional advice, including advice of legal counsel, given after a thorough examination of the individual situation, encompassing a review of relevant facts, laws and regulations. CNA assumes no responsibility for the consequences of the use or nonuse of this information.

For more information call Dentist's Advantage
at 888-778-3981, or navigate to the
Dentist's Advantage website Risk Management section.



In addition to this publication, CNA and Dentist's Advantage have produced additional risk control resources on topics relevant to dental professionals, including: newsletters; articles; forms; letters; and claim scenarios.

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