

GUIDELINES

Approved the College - **month 2019**
This document replaces the version
published in May 2008.

Dental Recordkeeping

The Guidelines of the Royal College of Dental Surgeons of Ontario contain practice parameters and standards that should be considered by all Ontario dentists in the care of their patients. These Guidelines may be used by the College or other bodies to determine if appropriate standards of practice and professional responsibilities have been maintained.

CONTENTS

INTRODUCTION	2	RADIOGRAPHIC EXAMINATION	7
USE OF THIS DOCUMENT	2	• Initial Examination for New Patients	7
RECORDKEEPING BASICS	2	• Recall or Returning Patients	8
GENERAL RECORDKEEPING PRINCIPLES	3	• Radiographic Quality	8
GENERAL PATIENT INFORMATION	3	DIAGNOSIS AND TREATMENT PLANNING	8
MEDICAL HISTORY	3	• Emergency/Specific Examination for New Patients	9
• Choosing a Medical History Questionnaire	4	INFORMED CONSENT	9
• Follow-Up Questions and Review of Systems	4	• Other Significant Consent Information	10
• Recall History	4	PROGRESS NOTES	10
DENTAL HISTORY	5	• Tips for Chart Entries	10
CONFIDENTIALITY	5	REFERRAL DOCUMENTATION	11
• Compliance with Privacy Legislation	6	PATIENT FOLLOW-UP AND RECALL EXAMINATIONS	11
COMPREHENSIVE CLINICAL EXAMINATION	6	FINANCIAL RECORDS	12
• Vital Signs	6	DRUG RECORDS	12
• Extra-Oral Evaluation	6	• Securely Issuing Written Prescriptions	13
• Intra-Oral Evaluation	6	RETENTION OF DENTAL RECORDS	13
		• Additional Considerations	14
		RELEASE AND TRANSFER OF DENTAL RECORDS	14
		ADDITIONAL RECORDKEEPING REQUIREMENTS	15



Royal College of
Dental Surgeons of Ontario

6 Crescent Road
Toronto, ON Canada M4W 1T1
T: 416.961.6555 F: 416.961.5814
Toll Free: 800.565.4591 www.rcdso.org

Introduction

Dentists have professional, legal and ethical responsibilities to maintain a complete record of each patient's dental care. Clear, accurate and up-to-date patient records are essential to the delivery of high quality care.

Patient records must be well-organized, legible, understandable and readily accessible. They remind the dentist of past and present conditions of the patient and treatments already provided, and they facilitate communication with other practitioners involved in the patient's care. For effective continuity of care, another dentist should be able to review the record easily and carry on with the patient's treatment.

Use of This Document

These Guidelines are to be used by dentists in providing routine dental care; they may not be adequate for all practice situations. While the examples used in this document apply primarily to general dentists, the principles relate to all dentists. In all circumstances, a dentist must use reasonable professional judgment to decide what modifications are necessary. The essential objective is safe treatment of the patient. The terms "appropriate" and "pertinent" have been used throughout these Guidelines to indicate where professional judgment is expected to be used.

Recordkeeping Basics

In dentistry, a record is any item of information, regardless of form or medium, created or received by a dentist, dental office or health profession corporation, and maintained to provide care to patients and conduct business.

The scope of patient records will vary, depending on the conditions with which a patient presents and the complexity of the treatment required. However, certain baseline data should be common for all patients, including:

- accurate general patient information;
- a medical history that is updated regularly;
- a dental history;
- an accurate description of the conditions that are present on initial examination, including an entry such as "within normal limits" where appropriate;
- a record of the significant findings of all supporting diagnostic aids, tests or referrals, such as radiographs, diagnostic study models and reports from specialists;
- a diagnosis and treatment plan;
- a notation that informed consent was obtained from the patient for treatment;
- a notation that patient consent was obtained for the release of any patient information to a third party;
- a description of all treatment that is provided, materials and drugs used, and where appropriate, the outcome of the treatment;
- an accurate financial record;
- a record of all communication with the patient relevant to their care, including in-person conversations, call notes and e-mails.

In addition to their content, how records are created and maintained will vary and change. Historically, dentists used paper charts and ledgers to keep records for their patients. The use of electronic records by dentists, including digital radiography, has grown substantially in Ontario.

All patient records, traditional and electronic, must comply with these Guidelines. Electronic records raise additional issues regarding accuracy, authenticity and access.

For more detailed information about the essential principles in managing and protecting electronic records, as well as the minimum requirements of related electronic records management systems, refer to the College's Guidelines on [Electronic Records Management](#).

General Recordkeeping Principles

Patient records must provide an accurate picture of the conditions present on initial examination, as well as the clinical diagnosis, treatment options, the proposed and accepted treatment plan, a record of the treatment performed, details about any referrals, and the prognosis and/or outcome of the treatment where applicable. In keeping and maintaining acceptable patient records, the following principles are essential:

- All entries should be dated and recorded by hand in permanent ink or typewritten, or be in an acceptable electronic format and be complete, clear and legible.
- All entries should be signed, initialled or otherwise attributable to the treating clinician.
- Radiographs and other diagnostic aids, such as diagnostic study models and intra-oral photographs, should be dated and properly associated to the correct patient by name, and the interpretation of the findings documented when considered appropriate by the practitioner.
- An explanation of the overall treatment plan, treatment alternatives, any risks or limitations of treatment and the estimated costs of the treatment should be provided to each patient, parent, legal guardian or substitute decision-maker, as appropriate, and noted in the patient record. In complex or difficult cases, consider additional signed documentation of informed consent.

General Patient Information

Patient records must contain the following general information, which must be updated regularly:

- patient name, address and contact information, including telephone numbers (home, work, mobile) and email addresses (optional)
- date of birth
- name, address and contact information of the patient's physician (or other primary family health care provider) and any medical specialists
- name, address and contact information of any referring health care professional, if applicable
- emergency contact name (and relationship to the patient) and telephone numbers

- name of the person or agency responsible for payment
- insurance information, if applicable

Medical History

To allow for the provision of safe dental care, dentists must ensure that all **necessary and relevant** medical information is obtained prior to initiating treatment. This information should be collected systematically, recording the patient's present state of health and any serious illnesses, conditions or adverse reactions in the past that might affect the dental management of the patient. In particular, the following key areas must be addressed for all patients:

- presence of any heart disease or condition
- ever had or tested positive for any immuno-compromising disease
- any known allergies
- a list of all current medications, including dose
- details of past hospitalizations and/or serious illnesses
- current pregnancy or breastfeeding

In taking a patient's medical history, the following checklist may be helpful:

- heart disease, heart attack, blood pressure condition, stroke or transient ischemic attack (TIA)
- replacement/repair of a heart valve or history of infective endocarditis
- any prosthetic joints
- any immuno-compromising diseases or therapies; e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy
- hepatitis A/B/C, jaundice, liver disease or gastrointestinal disorder
- blood disorder, bleeding or bruising tendency
- any known allergies: medications, latex/rubber products, seasonal/environmental, foods
- peculiar or adverse reaction to any medicines or injections; e.g. local anesthetics
- significant respiratory diseases; e.g. asthma, emphysema, tuberculosis
- endocrine disorder; e.g. diabetes, thyroid
- epilepsy or seizures
- kidney disease
- nutritional status/eating disorder; e.g. anorexia nervosa, bulimia

- drug/alcohol/cannabis use or dependency
- use of tobacco and related products; e.g. e-cigarettes
- psychiatric disorder/treatment
- any other conditions or problems of which the clinician should be aware
- family history of any diseases or medical problems; e.g. diabetes, cancer, heart disease
- current pregnancy or breastfeeding

Any drug allergies and any significant illnesses or conditions that are pertinent to the patient’s care should be conspicuously noted within the patient record.

Sensitive personal health information must NOT be recorded on the exterior of a patient’s chart. Instead, a colour-coded sticker system may be used to alert relevant dental staff.

CHOOSING A MEDICAL HISTORY QUESTIONNAIRE

A medical history form, questionnaire or system should adequately reflect the dentist’s practice. It should be comprised of a reasonable set of questions to assist the dentist in obtaining the necessary information from the patient to determine if dental procedures can be performed safely.

The design of a medical history questionnaire must provide sufficient space to initially record all relevant information. In addition, it must allow for a positive or negative response by the patient to each of the questions. Consider including a not sure/ maybe response, which allows the patient to convey uncertainty. Click here for a [sample medical history questionnaire](#).

Once completed, the medical history questionnaire should be reviewed, dated and signed by the treating dentist and updated regularly. In addition, the dentist should have the completed form signed by the patient, parent, legal guardian or substitute decision-maker.

FOLLOW-UP QUESTIONS AND REVIEW OF SYSTEMS

A medical history questionnaire is only a starting point to obtain information from the patient; it must be reviewed and interpreted by the treating dentist to determine if enough information has been obtained to provide safe dental care.

Additional information may be obtained through discussion with the patient to clarify any positive or unclear responses before initiating care. Responses that indicate a potentially serious medical condition may warrant follow-up with an appropriate review of the system affected (ROS), which must be clearly documented. A history of heart attack, for instance, may necessitate a review of the cardiovascular system. Additional information may also be obtained by conducting an appropriate physical examination of the head, neck and intra-oral cavity, the taking and recording of vital signs, such as heart rate and blood pressure, and/or consultation with the patient’s present and prior health care providers.

RECALL HISTORY

The patient’s medical information should be reviewed and updated regularly to ensure that it remains accurate. The dentist may have the patient review the information previously obtained and advise of any changes, or the dentist may ask specific questions of the patient. In either case, the results of the inquiry must be clearly documented.

Appropriate questions include:

- Has there been any change in your health, such as any serious illnesses, hospitalizations or new allergies? If yes, please explain.
- Are you taking any new medications or has there been any change in your medications? If yes, please explain.
- Have you had a new heart problem diagnosed or had any change in an existing heart problem?
- When was your last medical checkup?
- Were any problems identified? If yes, please explain.
- Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?

A dentist may choose to have the patient complete an abbreviated recall history questionnaire. A sample form is provided with the accompanying materials to the [Medical History Recordkeeping Guide](#).

At some point, the accumulation of changes to the medical information or the simple passage of time may suggest to the dentist that the patient should complete a new medical history questionnaire. Reasonable clinical judgment must be used to determine when this is appropriate.

Dental History

In addition to the medical history, the patient record must note any significant dental history. Information obtained regarding a patient's dental history can supplement the clinical examination, and assist in planning and sequencing of dental care.

Specific habits and/or risk factors should be identified, such as oral hygiene practices or parafunction, which may have an impact on future treatment planning. If not already captured by the medical history, a family and social history should be included with questions regarding use of tobacco and related products (e.g. e-cigarettes), alcohol consumption, recreational drug use (e.g. cannabis), and hobbies and other interests.

Checklists and/or short-answer questions may be used to obtain information about the patient's dental history. The dental history questionnaire below is provided as an example.

(SAMPLE DENTAL HISTORY QUESTIONNAIRE)

- ▶ **What is the reason for your visit today? Are you currently experiencing any dental problems?**
- ▶ **Have you been seeing a dentist regularly? If not, why not?**
- ▶ **Are you nervous during dental visits?**
- ▶ **Have you had a bad experience or complications during dental treatment?**
- ▶ **When was your last dental visit? What was done at that appointment?**
- ▶ **When did you last have dental x-rays?**
- ▶ **Have you ever seen a dental specialist?**
- ▶ **How often do you brush your teeth? How often do you floss? Do your gums bleed when you brush or floss?**
- ▶ **Have you been told to take antibiotics before a dental appointment?**
- ▶ **Do you feel that you have bad breath?**
- ▶ **Are you happy with the appearance of your teeth?**
- ▶ **Do you have any problems with your jaw (clicking, limited movement, pain)?**
- ▶ **Have you ever had an injury to the teeth or jaws or been involved in a motor vehicle accident?**

The patient record should contain statements that identify the immediate need or chief complaint, as well as its history, as presented by the patient.

Another good way to obtain information is with "Motivational Interviewing". This uses a collaborative approach in which the dentist asks open-ended questions to reveal and understand the patient's needs and priorities. Examples include:

- ▶ **What is important to you about your oral health?**
- ▶ **How can our office help you achieve your oral health priorities and treatment expectations?**
- ▶ **What are the most important qualities of a dental practice for you? How can we best accommodate your needs?**
- ▶ **Do you identify as a person with a disability or as a Deaf person? If yes, how may we best assist you in our dental practice?**
- ▶ **Is there anything else we should know regarding your past dental history, including any specific concerns or problems (financial, scheduling etc.)?**

Confidentiality

Patients reveal, and patient records contain, sensitive personal health information, which must be kept in confidence. Personal health information and dental records must always be protected from unauthorized use or disclosure.

A dentist may need to consult with a patient's present or prior health care provider. The consent of the patient, parent, legal guardian or substitute decision-maker should be obtained before making contact. In addition, the dentist must retain and maintain a record of any communication with another health care provider regarding a patient, such as notes of telephone conversations, letters and other reports.

A dentist is responsible for ensuring that all staff are aware of requirements for maintaining confidentiality with respect to a patient's personal health information. Staff must obtain consent before disclosing or releasing a patient's personal health information or their dental records to any third party, including other family members.

Patient records should be stored securely, not left unattended or in public areas of the office, and destroyed appropriately and securely at the end of the required retention period (see section on **Retention of Dental Records**.)

COMPLIANCE WITH PRIVACY LEGISLATION

All health care providers must ensure that the personal health information of patients is protected at all times.

Ontario's Personal Health Information Protection Act (PHIPA) permits all health information custodians, including dentists, to collect, use and disclose personal health information for the purposes of providing health care, or facilitating the provision of health care, to patients. However, PHIPA also requires health information custodians to take steps that are reasonable in the circumstances to ensure that records of personal health information in their custody or control are retained, transferred and disposed of in a secure manner. In particular, health information custodians must ensure that records of personal health information in their custody or control is protected against theft, loss and unauthorized use or disclosure, and to ensure that the records containing the information are protected against unauthorized copying, modification or disposal.

In particular, PHIPA requires health information custodians to:

- appoint a contact person, who is accountable for privacy matters;
- prepare and make available to the public a written statement setting out the custodian's information practices;
- ensure that their agents (i.e. employees and other persons acting on their behalf) only collect, use and disclose personal health information as permitted by the custodian and in accordance with the rules set out in PHIPA;
- ensure that personal health information is only collected, used and disclosed with the consent of the patient or as permitted by PHIPA;
- provide patients with the ability to access and request correction of their own personal health information.

If personal health information is lost, stolen or accessed by unauthorized persons, health information custodians must notify the affected patients at the first reasonable opportunity. In addition, health information custodians must notify the Information and Privacy Commissioner about certain privacy breaches.

For more detailed information, refer to the Personal Health Information Protection Act, 2004, and the regulations made under the Act, available on the website of the Information and Privacy Commissioner at www.ipc.on.ca. Also see the College's document on [Compliance with Ontario's Personal Health Information Protection Act](#).

Comprehensive Clinical Examination

Patient records should include descriptions of the conditions that are present on examination.

VITAL SIGNS

Relevant vital signs may include pulse, blood pressure, oxyhemoglobin saturation (via pulse oximetry), respiration and temperature. The need to measure and record vital signs will depend on the patient's age, medical history, level of anxiety, the nature and complexity of forthcoming dental treatment and whether the use of sedation or general anesthesia is contemplated.

EXTRA-ORAL EVALUATION

1. General Survey: Height, weight, posture, mobility.
2. Limbs and Extremities: Skin, joints, finger nails, presence of clubbing, tremors, lesions, scars, other abnormalities.
3. Head and Neck: Symmetry, movement, skin, lymph nodes, sinuses, muscles of mastication and orofacial region, thyroid, temporomandibular joint, salivary glands.

INTRA-ORAL EVALUATION

1. Soft Tissues: Lips and labial mucosa, buccal and vestibular mucosa, hard and soft palates, oropharynx and fauces, tongue, floor of the mouth.
2. Hard Tissues: Bone structure, asymmetry, abnormality, growth, presence of tori/exostoses, ridge form.
3. Dentition: The evaluation of the teeth should be recorded by means of an odontogram and/or a list of clinical findings for each tooth. If applicable, the following areas should be addressed:

- a. Missing and Misplaced Teeth: Congenitally missing, extracted, unerupted, impacted teeth, tipping, drifting, rotation.
 - b. Occlusion: Arch relationship/Angle classification, over-bite, over-jet, crowding, spacing, growth/development evaluation.
 - c. Abnormal Surfaces of Teeth: Abrasion, abfraction, erosion, attrition, hypocalcification, hypoplasia, intrinsic/extrinsic stains.
 - d. Mobility of Teeth: M I, II, III grading
 - e. Percussion Sensitivity
 - f. Apical Palpation Tenderness
 - g. Gingival Recession (This may be recorded as part of a comprehensive periodontal examination.)
 - h. Existing Restorations: Type, surface, material.
 - i. Decayed and Fractured Teeth: Surface, new/recurrent, involvement/degree of progression.
 - j. Integrity of Interproximal Contacts
 - k. Thermal and Electric Pulp Test Findings
4. Gingiva and Periodontium: A comprehensive full-mouth periodontal examination and charting is acknowledged as the most desirable means of evaluation and documentation, and should be carried out, whenever possible. Alternatively, dentists may use a recognized periodontal screening tool, such as the Periodontal Screening and Recording (PSR) Index, and proceed with a comprehensive periodontal examination and charting for those whose screening results warrant more in-depth follow-up.

The extent of the extra-oral and intra-oral evaluation and the thoroughness of the related documentation will depend on each patient's circumstances, the dentist's clinical judgment and the treatment contemplated.

As part of a complete clinical examination, it is important to document in the patient record that each of these areas has been addressed during the examination. For those areas demonstrating an absence of abnormality or anomaly, notations such as "within normal limits" or "no significant findings" may be recorded.

The odontogram must be large enough and/or have the ability to allow for the charting of all pertinent clinical findings. Once

completed, the odontogram establishes a permanent record of the patient's initial conditions and, therefore, must not be altered.

Changes in clinical findings noted at subsequent re-examination or emergency appointments should be recorded in writing in the patient record or noted on a separate odontogram. An electronic records management system should provide an accurate visual display of all previous versions of any record, as well as the associated metadata, at any point in the past.

In some cases, a dentist may wish to obtain additional diagnostic records (e.g. extra-/intra-oral photographs, diagnostic study models) to supplement their records for a patient. As noted previously, such records should be dated and properly associated to the correct patient by name, and the interpretation of the findings documented when considered appropriate by the practitioner.

Radiographic Examination

The concepts of justification and optimization, which encompass the ALARA principle (As Low As Reasonably Achievable), are fundamental when considering the use of ionizing radiation. The use of radiographs must be approached in a responsible way that maximizes the benefits of diagnostic value given the clinical context, but without exposing patients to unnecessary amounts of ionizing radiation. The dentist must exercise professional judgment to achieve the best balance between these two considerations. A decision about the number, type and frequency of radiographs should be based on each individual patient's age, medical and dental history, clinical signs and symptoms, and oral health status.

INITIAL EXAMINATION FOR NEW PATIENTS

- Where possible, copies of recent radiographs should be obtained from other practitioners who have cared for the patient.
- A clinical examination must be performed.
- Once any recent radiographs have been assessed and a clinical examination has been performed, if indicated, the dentist may exercise reasonable clinical judgment to prescribe appropriate radiographs on an individual basis to help formulate an initial diagnosis for the patient.

RECALL OR RETURNING PATIENTS

- A clinical examination must be performed before prescribing additional radiographs.
- A dentist's decision about the number, type and frequency of radiographs should be based on existing disease and the expected occurrence of disease. For example, the frequency of bitewing radiographs should be determined on the basis of caries risk assessment and/or the presence and severity of periodontal disease.
- Radiographs should never be prescribed based on inflexible time periods alone, such as bitewing radiographs every six months or a panoramic radiograph every three years.

RADIOGRAPHIC QUALITY

Film radiographs should be clearly labelled with the date they were taken, and the patient's and dentist's names. Similarly, digital radiographs should be accurately and permanently associated with the date they were taken, and the patient's and dentist's names. All radiographs must be of acceptable diagnostic quality.

All dentists and staff taking radiographs should make efforts to develop and refine their technical skills to control operator errors, such as:

- distortions
- elongated or foreshortened images
- overlapping of interproximal surfaces
- inadequate view of the apex or apices
- cone cuts
- foreign marks or artifacts
- inadequate exposures

Dentists using film radiographs should avoid possible handling and processing errors that can result in discolorations, stains, inadequate contrast and excessive/insufficient darkness or brightness, which can all affect diagnostic quality. Similarly, dentists using digital radiographs should replace sensors that have degraded.

Dentists using digital radiographs may use enhancement tools available in their software to manipulate factors, such as contrast, brightness and sharpness, to improve the diagnostic quality of the images. However, enhancement tools should be used with caution, as they may introduce artifacts and distortions that do

not accurately represent the imaged anatomy. It is important to note that while digital images may be manipulated and enhanced, the original unaltered images must be saved, properly associated with the patient's record and preserved for the required retention period (see section on **Retention of Records**).

To maintain optimal radiographic diagnostic results, regular quality assurance tests should be conducted, as required by the Ministry of Health and Long-Term Care. A record of these tests should be retained for the required retention period.

A dentist's decision about the number, type and frequency of radiographs should be based on each individual patient's age, medical and dental history, clinical signs and symptoms, and oral health status.

Radiographs should only be taken when judged necessary. They should never be taken on a routine basis or solely for administrative purposes.

Radiographs should be dated and properly associated to the correct patient by name, and the interpretation of significant findings documented.

Whenever a patient, or a patient's guardian or substitute decision-maker refuses recommended radiographs, the dentist should explain the rationale for their recommendation and the consequences of not taking them. If the patient, or a patient's guardian or substitute decision-maker still refuses, then the dentist should document the informed refusal in the patient's record.

Diagnosis and Treatment Planning

A **diagnosis** should be formulated, based on the collected clinical and radiographic findings from the dentist's examination, as well as the patient's medical and dental history, and supplemented where necessary with clinical photographs, diagnostic study models and/or the results of any tests or consultations. A diagnosis should be clearly documented in the patient record, as it forms the foundation for a treatment plan.

It is particularly important to record a diagnosis when the reason for proposed treatment is not readily apparent from the patient's history or the documentation of the clinical and/or radiographic examination.

Treatment options that are reasonably available, taking into account etiology, risk factors and prognosis, should be presented to the patient for discussion and obtaining informed consent (see following section on **Informed Consent**).

A proposed **treatment plan** should then be developed, which is patient-specific, evidence-based and, where possible:

- achieve and maintain the patient's dental/oral health; and
- prevent recurrent disease and future degenerative changes.

Once accepted by the patient and finalized, the treatment plan should list the services to be performed, taking into account the relative urgency and severity of the patient's condition. For extended or complex treatment, the treatment plan may also include a schedule of visits, estimated timeline, and provide a brief description of the services to be performed at each appointment. Note any conditions that are being monitored, and that the patient was informed accordingly. The extent to which the patient has accepted or rejected the recommended treatment or any referral, where indicated, should also be recorded.

The diagnosis and accompanying treatment plan, supplemented with checklists if needed, may be documented in several ways:

- a separate diagnosis/treatment plan section of a patient's paper chart
- a separate diagnosis/treatment plan module of a patient's electronic record;
- a separate document or spreadsheet that may be incorporated into a patient's paper chart or electronic record;
- in the progress notes.

As treatment progresses, any changes to the original treatment plan should be clearly documented, along with the reasons for doing so, such as a change in diagnosis or patient preference.

EMERGENCY/SPECIFIC EXAMINATION FOR NEW PATIENTS

In some cases, a new patient initially presents to the practice with an emergency or specific problem. In such cases, a thorough evaluation of the patient's soft tissues should be completed, while the evaluation of the patient's dentition and periodontium may be limited to the problem area, where indicated. The minimum number of radiographs should be taken to obtain an accurate diagnosis of the patient's chief complaint. Findings from the clinical and any radiographic examination, as well as the results of any tests, should be recorded. A limited diagnosis and treatment plan is then developed to address the patient's emergency/specific needs.

If the individual wishes to return to the practice for comprehensive care, the dentist should discuss the need for a comprehensive clinical examination to develop a full diagnosis and treatment plan, and the details of this discussion should be documented.

Informed Consent

A person is considered "capable" if they are able to understand the information relevant to making a decision about treatment, and they appreciate the reasonably foreseeable consequences of a decision or lack of a decision. All capable patients have the right to accept or refuse health care, regardless of its risks or benefits. Without sufficient information about proposed treatment, a patient cannot make an educated choice.

Obtaining informed consent requires effective communication. Once the dentist has formulated and communicated a diagnosis, and before the treatment plan is finalized, the patient must be informed about:

- the nature of the proposed treatment;
- the expected benefits of the treatment;
- material risks and side effects of the treatment, taking into account the individual circumstances of the patient;
- reasonably available alternative courses of action, including no treatment, and the likely consequences of not having the proposed treatment;
- answers to any questions the patient has regarding the proposed treatment or the alternatives.

The patient must also be informed about any and all costs of proposed treatment, as part of the disclosure process.

The patient should be given time to consider the options before proceeding, especially when the proposed treatment is extensive, risky, elective or expensive. The dentist should also be satisfied that the patient understands the information, giving consideration to the patient's age, condition and language skills. The nature and scope of the informed consent discussion should be fully documented in the patient's chart.

Although both verbal and written consent are acceptable, verbal consent should be documented. Regardless of whether the patient consents verbally or in writing, the dentist should keep a record of the nature of the conversation, the information provided, and the patient's decision.

OTHER SIGNIFICANT CONSENT INFORMATION

- There is no age limit for providing consent in Ontario. If the dentist believes that a patient is capable of providing consent, then the dentist may rely on that consent.
- A parent, legal guardian or other substitute decision-maker must consent to dental procedures for patients who are considered "incapable", because they are not able to understand information that is relevant to making a decision about the treatment and appreciate the reasonably foreseeable consequences of a decision or lack of a decision.

For more information about informed consent, refer to the College's Practise Advisory on [Informed Consent Issues Including Communication with Minors and with Other Patients Who May Be Incapable of Providing Consent](#).

Progress Notes

Progress notes should be well-organized, legible and provide a clear and comprehensive description of the patient's ongoing care. They should also indicate the reason for any treatment that is not readily apparent from the patient's history or the documentation of the clinical and radiographic examination.

Progress notes should be made at the time of each visit and include:

- date of treatment;
- treating clinician's identity;
- type and quantity of local anesthetic used, as well as the method/mode of administration;
- materials and methods used, detailing procedural steps;
- any other drugs that are prescribed, dispensed or administered and the quantity and dose of each;
- all recommendations, instructions and/or advice given to the patient;
- notes of any discussion with the patient regarding possible limitations of treatment and/or problems encountered, and the possibility of complications, compromised results and/or adverse outcomes.

Alterations to the initial and/or recommended treatment plan should be clearly documented with a notation that they were discussed with and agreed to or declined by the patient.

TIPS FOR CHART ENTRIES

- Paper chart entries should be made in chronological order. Similarly, electronic chart entries should be made in chronological order and "locked" on the date to which they are attributed.
- When composing chart entries, adopt a methodical style. For example, the individual steps for each service may be documented in the order that they were performed.
- If electronic template chart entries are used, they should be adapted and/or revised to accurately reflect the specific patient appointment.
- Chart entries should be objective and professional. Comments made by a dentist about an existing dental condition or previous dental work should be factual and verifiable. If deemed necessary, specific statements made by a patient may be recorded in quotation marks.
- Abbreviations and short forms should be easily decipherable and used in a consistent way.
- A dentist may rely on office staff to document chart entries. This is an acceptable practice, but the dentist should review each entry to ensure that it captures the necessary information.

- Any complication or adverse outcome should be well documented. The chart entry should specifically note the patient was advised about the incident and the available options to address it.
- Chart entries about a previous patient appointment may be recorded to expand on specific details, provided they are properly attributed to the date on which they are made.

Referral Documentation

General dentists are usually responsible for providing comprehensive dental care. There are many circumstances when a referral to a dental specialist (or a more experienced general dentist) is required for consultation and/or treatment. The referring general dentist remains the “most responsible dentist” or “primary coordinator” in the patient’s ongoing care.

Referrals should be in writing and may include, but are not limited to:

- patient’s name and contact information;
- relevant treatment and background information, including medical conditions or concerns;
- clear instructions on the nature and scope of the referral, including expectations of the referring dentist;
- additional materials, when available, which may include diagnostic quality radiographs, diagnostic/working models, reports and/or any other information that would assist the treating dentist.

Communication and collaboration are critical to maintain continuity and quality of care; consider speaking directly with the referral dentist. Consent must be obtained before sending any information to another dentist or discussing the patient’s conditions and/or treatment needs with a third party.

The patient should understand:

- the reason, nature and scope of the referral;
- the credentials of the referral dentist;
- the anticipated outcome(s) of the treatment;
- treatment may or may not commence at the first appointment;
- additional records, including radiographs, may be recommended at additional cost;

- the need to return to the most responsible dentist;
- the need to return to the practitioner who is responsible for follow-up evaluation, when necessary.

Notes of a referral to a specialist by name or practice, if known, as well as copies of any reports/correspondence to and from specialists, must be kept on file. A summary of any oral conversations with another dentist or specialist should also be noted in the chart. A patient’s refusal of a referral recommendation, and the potential risks/consequences that were reviewed with the patient, must be documented.

For more information about referral documentation, refer to the College’s Practice Advisory on the [Most Responsible Dentist](#).

Patient Follow-Up and Recall Examinations

Patients must be notified about their need for ongoing care, especially regarding the completion of treatment, postoperative checks and treatment follow-up. The recommended return date, if applicable, should be noted in the patient’s record. Missed appointments or cancellations should also be recorded.

When patients are seen on a recall or episodic basis, the chart entries should include:

- the type of examination conducted (recall, emergency, specific area);
- a notation that the medical history was reviewed and updated;
- findings of the examination and diagnosis;
- details of any treatment recommended and rendered, as well as documentation of consent.

At some point, the accumulation of changes to the patient’s initial conditions or the simple passage of time may suggest to the dentist that the patient should be re-evaluated and undergo a fresh comprehensive clinical examination. Reasonable clinical judgment must be used to determine when this is appropriate.

Financial Records

Records must be maintained about financial arrangements and agreements made with the patient, parent, legal guardian and/or other party responsible for the settlement of accounts.

The financial record for each patient must include a copy of any written agreement with the patient and provide an accurate statement of each patient's account, including the date and amount of all:

- fees charged;
- commercial laboratory fees that were incurred;
- payments received, including the method of payments;
- adjustments to the account.

Financial records must provide an accurate reflection of the current status or running balance of each patient's account, in keeping with standard accounting practices.

If dental treatment is provided for a patient on a basis other than fee-for-service, or where the responsibility for payment is with a person other than the patient or patient's guardian, you should be aware of the following additional recordkeeping requirements. Any such agreement must:

- be in writing;
- be maintained as part of the patient record;
- identify the person or persons entitled to dental services under it;
- the dental services to which they are entitled;
- state the period of time it will be in force;
- specify the obligations of the parties in the event the member is unable to provide covered services, including the obligations to make further payments and the application of payments that were previously made.

If payments for dental services are made on behalf of a patient by a third party, the financial record must include the identity of the person or agency making payment, such as XYZ Insurance Company, Workplace Safety and Insurance Board, Healthy Smiles Ontario.

Drug Records

Dentists must take reasonable precautions to ensure all drugs in their possession are protected from loss or theft. Drugs stored in a dentist's office must be kept in a locked cabinet, where only authorized employees have access to them. Dentists are advised to avoid storing drugs in any other location, including their homes, and never leave drug bottles unattended.

All narcotics, controlled drugs, benzodiazepines and targeted substances that are stored in a dentist's office MUST be kept in a locked cabinet.

A drug register must be maintained that records and accounts for all narcotics, controlled drugs, benzodiazepines and targeted substances that are kept on-site. The register should contain the name and quantity of the drug purchased, the date and location of purchase, and the invoice number. The register should also be kept in a secure area in the office, preferably with the drugs, and reconciled on a routine basis, depending on the nature of the practice and reasonable clinical judgment.

Whenever drugs in the above-mentioned classes are used or dispensed, a record containing the name of the patient, the quantity used or dispensed, and the date must be entered in the register for each drug. Each entry must be initialled or attributable to the person who made the entry. This same information must be recorded in the patient record, along with any instructions for use. See [Sample Drug Register](#).

When dispensing monitored drugs for home use by patients, dentists are also required to record appropriate patient identification (e.g. OHIP number) in the drug register, as well as in the patient record. For monitored drugs that are administered or dispensed for use in the office, dentists are not required to record patient identification.

The Narcotics Safety and Awareness Act (NNSA), 2010, affects the prescribing and dispensing of monitored drugs, and creates requirements to record prescriber and patient identification for prescriptions of these drugs. Monitored drugs include any controlled substance under the federal Controlled Drugs and Substances Act, such as narcotic analgesics and benzodiazepines, as well as other opioid drugs not listed in the Act, such as tramadol.

Dentists are required to report within ten days of discovery the loss or theft from their office of controlled substances, including opioids and other narcotics, to the [Office of Controlled Substances, Federal Minister of Health](#).

[Controlled Drugs and Substances Act](#)
[The Narcotics Safety and Awareness Act](#)

SECURELY ISSUING WRITTEN PRESCRIPTIONS

When issuing a written prescription for a drug, consider the following precautions:

- If using a paper prescription pad:
 - write the prescription in words and numbers;
 - draw lines through unused portions of the prescription;
 - keep blank prescription pads secure.
- If using desk-top prescription printing:
 - use security features, such as watermarks;
 - write a clear and unique signature.
- If faxing a prescription:
 - confirm destination and fax directly to the pharmacy, ensuring confidentiality;
 - destroy paper copy or clearly mark it as a copy.

A dentist's privileges to prescribe and dispense drugs are limited to the scope of practice of dentistry, and only for patients of record. This means that dentists may only prescribe or dispense drugs for the purpose of diagnosing, treating or preventing conditions of the oral-facial complex for patients that they are treating.

There is no provision for dentists or their staff to access in-office supplies of narcotics, controlled drugs, benzodiazepines or other drugs that normally require a prescription for their own use or by family members.

The drug register should be kept in a secure area in the office, preferably with the drugs, and reconciled on a routine basis, depending on the nature of the practice and reasonable clinical judgment.

See the College's FAQs on [Prescribing and Dispensing Drugs](#).

Retention of Dental Records

In general, a patient's clinical and financial records must be kept for at least ten years from the date of the last entry in that record.

In the case of a minor, these records must be kept for at least ten years from the date the patient turned 18 years of age. This includes all radiographs, photographs, diagnostic study models, sedation/anesthetic records, notes of any referrals to specialists or other health care providers, copies of any consultation or specialist reports, and copies of any consent forms or written agreements signed by the patient, legal guardian or substitute decision-maker.

Other administrative or office records, such as appointment records, drug registers, sterilization logbooks and equipment service records, must also be kept for at least ten years from the date of the last entry in that record.

There are two exceptions to this requirement:

1. **Working models** do not have to be kept for any specific period of time. A decision to keep working models may be based on the nature or complexity of the case and is left to the judgment of the individual practitioner. Diagnostic study models are considered part of the permanent patient record and must be kept for the period prescribed by the regulations.
2. **Copies of dental claim forms** must be kept for at least two years from the date the claim was provided to the patient or submitted on the patient's behalf. An electronic copy of claim forms on a properly backed-up system is acceptable. Other material from insurance companies, such as predeterminations, explanations of benefits and cheque stubs, should be kept until final settlement of the account.

ADDITIONAL CONSIDERATIONS

For convenience, a paper record, dental radiograph or diagnostic study model for a patient may be scanned and saved electronically. A tamperproof digital image should be captured, which serves as a copy of the original. The paper record, dental radiograph or diagnostic study model may then be placed into storage and archived. Although they may be copied by scanning, the original paper records, dental radiographs or diagnostic study models for a patient must be retained and maintained as required by the regulations.

Dentists may store archived records off-site. However, privacy legislation requires that patients' dental records be stored in secure premises to prevent unauthorized access and dentists should take reasonable precautions to protect them from loss, theft and damage. If patients' dental records are moved to premises that are not under the dentist's control, such as a third-party record storage facility, privacy legislation requires that patient consent be obtained before their records may be stored in such a facility.

After the required retention period has passed, dentists may destroy records that are no longer needed, but must ensure that appropriate steps are taken to protect the patients' confidentiality when they are disposed.

Release and Transfer of Dental Records

Patients have a right to obtain copies of their complete dental record. Dentists are required to follow the direction, whether verbal or written, of a patient or their authorized representative and provide copies of records that have been requested. In the case of a child, a direction by the child's parent or legal guardian is sufficient. The original records, however, must be retained by the dentist for the prescribed retention period (see section on **Retention of Records**).

Patients are entitled to diagnostic quality duplicate radiographs on film, photographic paper or appropriate digital formats. Patients are also entitled to duplicate study models or equivalent diagnostic quality digital images of them.

If a patient requests that copies of their records be transferred to a new dentist or any other third party, the written request for the transfer, such as a form signed by the patient, must be retained with the original record. A verbal request by a patient is acceptable, but a notation about the direction should be made in the patient's record. In addition, dentists should document the date the records were transferred, the person to whom or the institution to which the records were transferred, a list of the records that were transferred, and the method of transfer used.

For more information, see the College's Practice Advisory on the [Release and Transfer of Patient Records](#).

Additional Recordkeeping Requirements

Dentists should be aware of additional recordkeeping requirements that may apply to the provision of specific types of dental treatment, including:

- [sedation and general anesthesia](#)
- [dental CT scans](#)
- [diagnosis and management of temporomandibular disorders](#)
- [implant dentistry](#)

Dentists should also be aware of additional recordkeeping requirements related to administrative or office records, such as sterilization logbooks, quality tests of x-ray equipment, and equipment service records.



Royal College of
Dental Surgeons of Ontario

6 Crescent Road
Toronto, ON Canada M4W 1T1
T: 416.961.6555 F: 416.961.5814
Toll Free: 800.565.4591 www.rcdso.org