



## Dental Chart Notes and Recordkeeping Didactic Program

This course is intended to provide Learners with a systematic approach to preparing chart notes to ensure robust recordkeeping in the dental practice. This four-hour program will include a virtual/live presentation with a Subject Matter Expert, and a homework component that will allow you to work specifically on the course objectives using your skills in recordkeeping as a baseline.

### Course Agenda

This 4-hour program is broken down into 3 virtual sessions with a Subject Matter Expert. Prior to starting the virtual sessions, you will be asked to complete a pre-assessment using two cases of your choosing in the following areas:

One (1) case – new patient exam

One (1) case – adult prophylaxis

These cases need to be redacted so that no identifying patient information is visible and sent to the Subject Matter Expert prior to scheduling the first session.

Call One: Review of current practices

Call Two: Lecture – fundamentals of recordkeeping

Call Three: Discussion – putting it into practice

At the conclusion of this program, you will receive four (4) continuing education credits, and a final report that includes all your test scores, and a summary for the dental board. The fee for this program is \$1200.

### Course Objectives and Expectations for Cases

**When capturing a patient's clinical chart notes, it is essential to include the following information:**

1. **Patient Information:** Include the patient's name, date of birth, contact information, and any relevant medical history or pre-existing conditions.
2. **Chief Complaint:** Document the reason for the patient's visit, including any specific symptoms or concerns they have expressed.

3. **Medical History:** Record the patient's medical history, including any chronic illnesses, allergies, medications, or previous surgeries that may impact dental treatment.

4. **Dental History:** Document the patient's dental history, including previous treatments, restorations, extractions, orthodontic work, or any ongoing dental issues.

5. **Extraoral and Intraoral Examination Findings:** Describe the findings from the extraoral examination, such as facial symmetry, TMJ evaluation, lymph node assessment, and any abnormalities observed. Additionally, include detailed intraoral examination findings, including the condition of the teeth, gums, soft tissues, occlusion, and any signs of decay, infection, or oral pathology.

6. **Diagnostic Tests and Results:** If any diagnostic tests were conducted, such as dental x-rays, periodontal probing, or oral cancer screening, record the tests performed and the results obtained.

7. **Diagnosis:** Clearly state the diagnosis based on the examination findings and diagnostic tests. Use standard dental terminology to describe the specific dental conditions or diseases present.

8. **Treatment Plan:** Outline the recommended treatment plan based on the diagnosis. Include the specific procedures, the sequence of treatment, and any alternative options discussed with the patient.

9. **Treatment Progress and Modifications:** Document the progress of treatment as it unfolds, including any modifications or adjustments made to the initial treatment plan. This helps track the patient's response to treatment and ensures continuity of care.

10. **Medications and Prescriptions:** Note any prescribed medications, dosages, and instructions given to the patient. Include any medications administered during the visit, such as local anesthesia or sedation.

11. **Patient Instructions and Education:** Provide clear instructions to the patient regarding post-treatment care, oral hygiene practices, and any lifestyle changes necessary to maintain oral health. Document any educational materials provided to the patient.

12. **Follow-Up Appointments:** Schedule any necessary follow-up appointments and note them in the chart. This helps ensure regular monitoring and ongoing care for the patient.

**Remember, accuracy, clarity, and thoroughness are crucial when documenting clinical chart notes. Clear and comprehensive chart notes facilitate communication between dental professionals, ensure continuity of care, and provide a legal record of treatment provided to the patient.**



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