



PATIENTS

Dental Records



ADA Center for
Professional Success™

Dental Records

Acknowledgments

This publication was developed by the Council on Dental Practice and the Division of Legal Affairs.

The Mission of the Council on Dental Practice is to recommend policies and provide resources to empower our members to continue development of the dental practice, and to enhance their personal and professional lives for the betterment of the dental team and the patients they serve.

Disclaimer

This ADA publication is designed especially for dentists and the dental team to provide helpful information about the dental record. This publication is not intended or offered as legal or other professional advice. Laws vary from state to state and thus, readers should consult with their personal legal counsel and malpractice insurer to access the applicable laws in their state. *Dental Records* is based in part on questions frequently asked by our members. It is our hope that dentists and their team members will find this publication, helpful but in no way a substitute for actual legal advice given by an attorney in your state.

Dental Records

Introduction

The dental record, also referred to as the patient's chart, is the official office document that records all of the treatment done and all patient-related communications that occur in the dental office. State and federal laws or regulations determine how it is handled, how long it is kept and who may have access to the information. The dental record provides for continuity of care for the patient and is critical in the event of a malpractice insurance claim. This publication will provide some helpful information but the first step should be to review your state dental practice act.

Dental Records

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Records Management

The recording of accurate patient information is essential to dentistry. The **dental record**, also referred to as the patient chart, is the official office document that records all diagnostic information, clinical notes, treatment performed and patient-related communications that occur in the dental office, including instructions for home care and consent to treatment.

Protecting health information—and diligent and complete record keeping—is extremely important for many reasons.

First, it can contribute to providing the best possible **care for the patient**. Patient records document the course of treatment and may provide data that can be used in evaluating the quality of care that is provided to the patient.

Records also provide a **means of communication** between the treating dentist and any other doctor who will care for that patient. Complete and accurate records contain enough information to allow another provider who has no prior knowledge of the patient to know the patient's dental experience in your office.

Beyond providing patient care, the dental record is important because it may be used in a court of law to establish the diagnostic information that was obtained and the treatment that was rendered to the patient. It can be used in **defense of allegations of malpractice**. Information found in the record may then be used in determining whether the diagnosis and treatment conformed to the standards of care in the community.

Another way the dental record may be used is to help provide information to appropriate legal authorities that will **aid in the identification of a dead or missing person**. The most common element of forensic dentistry that a general practitioner is likely to encounter is to supply antemortem (before death) records for a **forensic odontologist**.

Regulations

State: A few dental practice acts or regulations issued by state boards of dentistry specify requirements for dental records. In the vast majority of states, however, patient record keeping requirements are contained in laws or regulations that apply to health care professionals in general and also in more generic state legislative/regulations. Check with your state dental society for information on record keeping requirements in your state. To obtain a copy of your state dental practice act, contact either your state's board of dentistry, also known as the board of dental examiners at www.aadexam.org or go to <http://ebusiness.ada.org/mystate.aspx> to find a link to your state. Many states post the practice act online and it is now easily accessible. (*Hint:* Google "[name of state] dental practice act.")

Your State Practice Act

Clicking on any state listed below will take you to the licensing institution's Web site for that state.

[Alabama](#): [Alaska](#): [Arizona](#): [Arkansas](#): [California](#): [Colorado](#): [Connecticut](#): [Delaware](#): [District of Columbia](#): [Florida](#): [Georgia](#): [Hawaii](#): [Idaho](#): [Illinois](#): [Indiana](#): [Iowa](#): [Kansas](#): [Kentucky](#): [Louisiana](#): [Maine](#): [Maryland](#): [Massachusetts](#): [Michigan](#): [Minnesota](#): [Mississippi](#): [Missouri](#): [Montana](#): [Nebraska](#): [Nevada](#): [New Hampshire](#): [New Jersey](#): [New Mexico](#): [New York](#): [North Carolina](#): [North Dakota](#): [Ohio](#): [Oklahoma](#): [Oregon](#): [Pennsylvania](#): [Rhode Island](#): [South Carolina](#): [South Dakota](#): [Tennessee](#): [Texas](#): [Utah](#): [Vermont](#): [Virginia](#): [Washington](#): [West Virginia](#): [Wisconsin](#): [Wyoming](#). This can also be accessed at <http://ebusiness.ada.org/mystate.aspx>

HIPAA/Protecting Health Information

There is a tendency to regard HIPAA regulations for Privacy and Security with apprehension, and not without some justification, as the civil and criminal penalties for violators can be quite stiff. While HIPAA Privacy and Security Regulations are serious matters deserving serious attention and focused implementation efforts, they are no reason to panic and certainly are not intended to discourage the use of electronic transactions by small health care providers.

Two HIPAA regulations, the Privacy Rule and the Security Rule, impact how a dental office uses and maintains its patients' records. Under the HIPAA regulations, dentists who use electronic transactions are referred to as

“Covered Entities”. Most electronic transactions are benefits-related (e.g. claims, eligibility, etc.) communications exchanged between health care providers and health plans via some kind of electronic medium. Voice communications by telephone and most fax communications are not considered to be electronic, at least as far as HIPAA is concerned, but because voice and fax communications may contain individually identifiable health information (“Protected Health Information” or “PHI”), the disclosure of such information must be safeguarded. In the HIPAA context, “electronic” almost always means some kind of computer-to-computer method of communication, either via the internet, private network, a modem-to-modem communication, or physical removal and transportation of a data storage device or medium like a tape, disc, or hard drive. Currently, dentists most commonly perform “electronic transactions” related to electronic claims transactions and electronic eligibility inquiry transactions (whereby dentists can inquire about the status of previously submitted electronic claims).

Use of any one of these transactions, even once, invokes the HIPAA rules regarding electronic transactions with respect to that transaction, which subjects a dentist to HIPAA (although a dentist is always covered by HIPAA with respect to the PHI he or she maintains and transmits). If HIPAA electronic transactions rules do not apply because a dentist does not use electronic transactions, state privacy laws still apply (check with your state dental association!). Even in the absence or relative weakness of state privacy rules, it is still an excellent idea to comply with the HIPAA Privacy and Security Rules. Patients will want to feel that doctors respect their privacy and take care to ensure that sensitive health information remains confidential.

The HIPAA Privacy Rule, which went into effect April 14, 2003, requires covered health care providers, including covered dentists, to protect patients’ PHI, inform patients of their rights under the HIPAA Privacy Rule, provide an accounting of uses and disclosures of information and maintain accurate records of Privacy-related incidents. These topics and more are covered in great detail by the ADA HIPAA Privacy Kit, available from the ADA catalog (www.adacatalog.org or call 800-947-4746). With regard to standards for maintaining paper records, the Privacy Rule requires health care providers to make “reasonable efforts to limit protected health information to the minimum necessary to accomplish the purpose of the use, disclosure or request” of the information. These “reasonable and appropriate safeguards/minimum necessary” standards aim to protect information from unnecessary disclosure without inhibiting a health care provider’s core business operations, i.e., treating patients, obtaining payment for services, and legal, financial, and administrative tasks that are all part of running a health care provider’s business. The most reasonable and appropriate safeguards should be determined by the covered health care provider through a careful analysis of risks and available resources to cope with those risks. A safeguard that inhibits timely and effective care, interferes with obtaining payment for services or creates excessive costs and disruptions may be considered unreasonable and unnecessary for a provider with relatively few risks.

For instance, locking file systems are not specifically required by the HIPAA Privacy Rule, but may be necessary to protect access to paper records using, reasonable and appropriate safeguards. Imagine for a moment that a large health care provider (like a hospital) does a risk analysis of its filing system and decides that since some of the cabinets may be vulnerable to snooping, they should be locked at all times. A much smaller provider (like a dental office) may, after performing a similar risk analysis, decide that since its filing system is under staff supervision at all times and that unauthorized persons have no access to its files, there would be no need for the practice to acquire locking file cabinets. Both approaches are correct because health care providers are permitted to tailor their privacy policies to their specific risks and available resources.

As with filing systems, the HIPAA Privacy Rule does not prohibit the use of so-called “allergy alert” or “medical alert” stickers, as such a prohibition may interfere with a provider’s ability to provide timely and effective health care. An office should exercise some caution in its handling of patient records, and the use of generic alert indicators that serve only to prompt caregivers to take a closer look at the patient’s health history may be desirable in many instances.

Dentists have had to comply with the **HIPAA Security Rule** since April 21, 2005. There is a key difference between the HIPAA Security and HIPAA Privacy Rules. The HIPAA Privacy Rule applies to individually identifiable health information in any form, written, spoken, or electronic. In contrast, the Security Rule applies only to *electronic* PHI (“ePHI”) and requires that covered dentists who store health information in electronic form maintain its confidentiality, integrity, and accessibility.

Confidentiality means that the information is available or disclosed to persons or entities authorized to receive it.

Integrity means the information has not been altered or destroyed without proper authorization; if it changes, there is a record of the change and only authorized user can make a change; and finally, that there are means to verify

that data is only changing according to entries made by authorized users. Data integrity helps prevent GIGO (“Garbage In, Garbage Out”) data entry problems and is a safeguard against data corruption, which may be caused by bugs, malware, system crashes, etc.

Accessibility means that data is retrievable under any circumstance. Maintaining data accessibility means sound, thorough business continuity planning.

The American Dental Association published its HIPAA Security Kit to help members comply with HIPAA security regulations and is available from the ADA Catalog (www.adacatalog.org or call 800 947-4746).

There is no such thing as a certified “HIPAA Compliant” product, seminar, technology, or design feature that is effective “out-of-the-box” for all dentists in all circumstances because of the of scalable, technology-neutral nature of the Security Rule. Covered dental offices must determine the most reasonable and appropriate safeguards for their particular circumstances and risk profile.

With regard to electronic security standards required by HIPAA, it is essential that any electronic health record be accurate, easy to retrieve under any situation, and that some means of tracking who made changes and when is always available. More information on this can be found in the ADA’s *HIPAA Security Kit*, available through the *ADA Catalog*. Your office may need to consult with your software system vendor for assistance in completing tasks related to maintenance of electronic records.

Dental offices subject to HIPAA should have policies, procedures and forms for HIPAA compliance. Your entire office should stay current and informed about HIPAA and state laws regarding the privacy and security of PHI and ePHI. This informational resource is not intended to comprehensively cover all HIPAA related questions.

For additional information on HIPAA privacy, go to:

<http://www.ada.org/en/member-center/member-benefits/practice-resources/dental-informatics/electronic-health-records/health-system-reform-resources/hipaa-privacy-security>

Or order The HIPAA Security for Dental Professionals Seminar DVD, or the ADA’s *HIPAA Privacy Kit* and the *HIPAA Security Kit*. You can order these products by contacting ADA Catalog, 1-800-947-4746, or visiting the ADA Catalog’s Web site, www.adacatalog.org.

*Common Sense Privacy and Confidentiality Steps*¹

- Avoid leaving patient information where others can read the content – whether on paper or electronic. Charts should not be left out in public areas. Confidential information should be marked as such and protected from view of others. Try to keep computers reflecting patients’ information out of view, or use screen savers or other methods to protect the information as reasonably as possible.
- Avoid asking patients sensitive questions where other patients can hear the conversation.
- Avoid discussing confidential patient information with other dental team members where other people can hear the conversation.

Organization of Dental Records

Most dentists make notes in paper dental records. However, more and more dentists are making use of computerized filing systems to maintain patient dental records. Electronic records have great quality and patient-safety benefits, and will likely increase as more dental offices become computerized. Because many dental offices use the traditional paper charts, traditional filing systems are discussed first.

Generally, patient records are housed in file folders for protection. These files are labeled with the following information (in the following order):

- Patient’s surname;
- Patient’s first name;
- Patient’s middle name; and
- Patient’s degree or seniority (i.e., Senior, II).

The files are then arranged in a way for easy retrieval—usually in a lateral, open-shelf filing system.

Color Coding

Many dental offices use a color-coded filing system for patient record files. Color-coded labels—usually the first two letters of the patient's last name and active date of treatment—are placed on the patient's file. This can help make record retrieval fast and easy.

Active and Inactive

Most offices have two categories of patient records files: 1) Active and 2) Inactive.

Active files hold the records of patients currently having their dental care provided by the practice. Inactive patients are considered to be those who have not returned for 24 months. Keep files of active patients on-site. These records should be conveniently located in the office.

Inactive files hold the records of patients who have been treated in the office in the past but are not currently under care in the office. These files are generally located in the office, but in a remote area.

As defined by policy of the American Dental Association, (Trans. 1991:621), an active dental patient of record is any individual in either of the following two categories: Category I - patients of record who have had dental service(s) provided by the dentist in the past twelve (12) months; Category II - patients of record who have had dental service(s) provided by the dentist in the past twenty four (24) months, but not within the past twelve (12) months. An inactive patient is any individual who has become a patient of record and has not received any dental services(s) by the dentists in the past twenty four (24) months.

The above definition is typically used in practice appraisals and may not be the same definition of an active patient used in a dental office in records maintenance.

A system should be established in your office to identify a change from active to inactive status on a timely basis. All records, active and inactive, should be maintained carefully to be certain that they are not destroyed or lost.

Content of the Dental Record

The information in the dental record should primarily be clinical in nature. The record includes a patient's registration form with all the basic personal information.

The dental team should be very meticulous and thorough in the dental office recordkeeping tasks. All information in the dental record should be clearly written, and the person responsible for entering new information should sign and date the entry. The information should not be ambiguous or contain many abbreviations. In practices with more than one dental practitioner, the identity of the practitioner rendering the treatment should be clearly noted in the record.

All entries in the patient record should be dated, initialed and handwritten in ink and/or computer printed. While no specific color of ink is required, any copy of the record should be easy to read. Handwritten entries should be legible. If a mistake is made, do not correct it with "white-out." A single line should be drawn through the incorrect info, the new corrected info added, and again, the entry should be signed and dated.

The following are examples of what is typically included in the dental record:

- database information, such as name, birth date, address, and contact information
- place of employment and telephone numbers (home, work, mobile)
- medical and dental histories, notes and updates
- progress and treatment notes
- conversations about the nature of any proposed treatment, the potential benefits and risks associated with that treatment, any alternatives to the treatment proposed, and the potential risks and benefits of alternative treatment, including no treatment,
- diagnostic records, including charts and study models
- medication prescriptions, including types, dose, amount, directions for use and number of refills
- radiographs
- treatment plan notes
- patient complaints and resolutions

- laboratory work order forms
- mold and shade of teeth used in bridgework and dentures and shade of synthetics and plastics
- referral letters and consultations with referring or referral dentists and/or physicians
- patient noncompliance and missed appointment notes
- follow-up and periodic visit records
- postoperative or home instructions (or reference to pamphlets given)
- consent forms
- waivers and authorizations
- conversations with patients dated and initialed (both in-office and on telephone, even calls received outside the office)
- correspondence, including dismissal letter; if appropriate

No financial information should be kept in the dental record. Ledger cards, insurance benefit breakdowns, insurance claims, and payment vouchers are not part of the patient's clinical record. Keep these financial records separate from the dental record.

Other information best left out of the record would be personal opinions or criticisms. Stick to facts, especially those related and relevant to providing dental care. Imagine what you write in a record being read in a court of law (remember that this is a legal document). Do document a patient's refusal to accept the recommended treatment plan and cancelled appointments.

The outside cover of the chart should only display the patient's name and/or the account number, unless more is required by state law or you need to flag a chart on the outside cover. If this is the case, use an abstract, in-office system (color or symbol coding) so that only your office staff will be able to decipher it.

For all offices, but especially those subject to HIPAA, a single sticker on the outside cover can alert the team to look on the inside for important information regarding allergies, medications, antibiotic pre-medications, and clinical conditions that can affect dental treatment. All medical notations belong inside the chart for only authorized personnel to see.

Your professional liability insurance company and or personal legal counsel may have additional recommendations. Many insurance companies make this information readily available on their Web site or may be contacted for the information. A list of professional liability companies is available on ADA.org (www.ada.org).

Retention and Storage

State laws and participating provider contracts generally specify the time following the last patient visit that records must be maintained. There is usually a different requirement for the retention of records of children; these records must be kept for a certain period after the child reaches the age of majority. HIPAA also affects recordkeeping requirements for offices that are covered by generally requiring that such offices maintain patient records for six (6) years and two (2) years after a patient's death. The dental office should have a records retention policy and all staff should understand it. The office's professional liability insurance company will likely have recommendations about retention.

In a multi-practitioner practice of any nature, determining the party responsible for maintaining the original patient record of any patient treated at the practice facility may be dependent on the type of professional corporation (PC) or structure of the practice. Unless the agreement specifies differently, the professional corporation would likely be considered the owner of the dental record, whether paper or electronic. This applies whether or not the owner was involved in the patient's treatment.

If the structure of practice is an office-sharing arrangement and the dentist is an independent contractor rather than practice employee, each dentist would likely be considered as practicing under a separate legal entity, whether a PC, limited liability company, partnership or sole proprietorship. Associate agreements, either for employee associates or independent contractors, should include language that specifies the associate's access to patient charts and ownership issues.

State law may also specify the obligations of buyer and/or seller regarding record ownership, maintenance and/or retention in the event of a practice sale. If the practice has been sold, the sales agreement itself may spell out the terms for record retention and access.

If space for records becomes a problem, dental records may be preserved on microfilm or microfiche, stored with a records storage service (fairly common in many jurisdictions) or scanned for electronic storage. The great benefit of storing records electronically or on microfilm or microfiche is that they take up less space than paper records. Diagnostic and/or treatment casts may be photographed and stored in some cases. However, prior to completely converting records to one of these methods, a dentist should consult with his/her own attorney and professional liability insurance company. In those dental offices that are considered covered entities, a HIPAA business associate agreement may be required if outsourcing records storage. Again, state law must be followed. State law can be quite specific on regulations related to health care recordkeeping.

Health/Dental History

The accurate health/dental history may provide important and valuable information for the dentist prior to beginning treatment. All dentists should take health histories initially and update the same periodically as necessary.² A health history form can address:

- health conditions or illnesses that may affect or be affected by dental treatment;
- medications that a patient is currently taking that will have a potential drug interaction with the local anesthetic or other drugs the dentist may prescribe that may affect dental treatment or a patient's other health condition(s); and
- reason a patient is seeking care.

Dentists have a responsibility to obtain and maintain current health histories of patients. Team members are most often responsible for having patients complete their health/dental history forms but that is only part of the process. It is also important that a patient understands the questions, provides answers where appropriate and sign the completed form. Patients should be encouraged, if they do not understand the form, to discuss it with the dentist or office staff. A health history form provides a starting point for the dental team to fulfill its professional obligations.

Once a patient has completed the questionnaire/health history, it is recommended that the patient's health information be reviewed carefully. The dentist should review and discuss the form with the patient, then sign or initial the form once this review is completed. Interviewing the patient is an important part of the medical history taking process and space should be provided on the medical history form for recording findings gathered during the interview.

The dentist should be prepared to answer any questions that a patient may have regarding the form. No questionnaire addresses every aspect of a patient's health. For example, additional or more focused questioning may be appropriate for patients with specific health concerns. The interaction between the dentist and dental team members, during the health history process, can be equally or more important than the form itself.

Updates to Health History Form

A patient should be questioned at each visit to determine if the health status or medication taken has changed. The record should have a dated notation that the patient was asked about recent health and medication changes and any changes should be updated in the patient's record. A patient's medical status should be monitored at intervals appropriate to the patient's age and medical history.³ The decision about the frequency is professional, not legal. Your professional liability insurance company and/or attorney may be consulted for more information.

The ADA Catalog (<http://www.adacatalog.org> or 1-800-947-4647) also offers both an adult and a child's health history form, both available in English as well as Spanish. These particular questionnaires need not be used by all dentists, and may or may not lead to compliance with all applicable laws.

Health History Forms in Multiple Languages

With the increasing diversity in patient populations, it may be desirable to provide a health history form in multiple languages. The University of the Pacific Dental School in California and Met Dental have both supported the development of a free downloadable standard health history form in over 21 languages, available at:

http://www.dental.pacific.edu/Professional_Services_and_Resources/Dental_Practice_Documents.html

University of Pacific Web site includes instructions for use. Be sure to download the English version too. The questions and sequence for all languages correspond to the English version.

Who Makes Entries in the Record?

Attorneys and doctors debate who should make the entries in the dental record, but state law will determine this in most cases. Keep in mind that the dentist is ultimately responsible for the patient's chart.

Some entries may be delegated to office staff if allowed by state law. The administrative assistant can record telephone calls; prescription changes; and canceled, changed, and failed appointments. The dental assistant records the patient's comments, concerns and disposition; vital signs; medical history notations; radiographs and other diagnostic tools taken and used; and instructions given to the patient, etc. Dentists add clinical impressions, treatments performed and any pertinent information. All entries should be initialed and/or signed by the team member writing the entry and the dentist.

If the dentist opts not to make his or her own entries, he/she should dictate what to write to the assistant. The dentist should review the contents of the entry as soon as possible for accuracy and then sign or initial it.

How to Write in the Record

Always think before you make an entry, especially if the remarks are complex in nature. You may want to jot down some of the facts on a piece of paper and then transcribe them in an organized way into the record. It is best to document while the patient is still in the office, or as soon as possible after the patient leaves. The record is the single most important source of evidence in a liability claim. All entries in the patient record should be dated, initialed and handwritten in ink and/or computer printed. While no specific color of ink is required, any copy of the record should be easy to read. Be aware that if different colored ink is used by staff members (i.e., the hygienist's uses red ink); this coding method will not appear on a copy of the record unless a color copier is used. Handwritten entries should be legible.

Make sure all of your entries are objective in nature. Confine your comments to necessary information about the patient's treatment. A patient has a right to request to see their record (including "personal notes" you may keep in a separate chart). Keep in mind that in the case of a malpractice claim, the record could appear in a court case and a judge and jury could read your notes. Imagine the record magnified and displayed in a courtroom. Stick to facts, especially those related and relevant to providing dental care.

Be sure that any attachments are included in the patient's record, especially radiographs. It provides a resource for the dentist to evaluate the short-term and long-term results of treatment performed, the cooperation of the patient and the effects of any complicating factors. Do document a patient's informed consent for treatment. Should a patient refuse to accept the recommended treatment plan, notate the patient's reasons for refusing care in the record. Consult your attorney or liability company for additional steps that should be undertaken when a patient refuses treatment. More information on informed consent and informed refusal can be found in the member section of the ADA Web site (<http://www.ada.org/>) under the topic "Informed Consent".

Use of Abbreviations and Acronyms

If you must use abbreviations or acronyms, make sure they are in common use (or can be easily explained) in your practice and avoid their overuse in record keeping. Those that are used should be clearly understood by those employees in the office with access to the record. Avoid the use of arcane symbols in record keeping. Also be aware that such usage could delay identification in a forensic investigation. It is a good idea to have a universal "key" readily available to all staff, or included in the chart, providing definitions for all abbreviations and acronyms.

Corrections or Alterations

There are times when it is necessary to make a correction. There is nothing wrong with a correction if handled properly. Some state laws may allow you to simply cross out the wrong entry with a thin line, and make the appropriate change. Date and initial the each change or addition. **Never obliterate an entry.** Do not use markers or white-out. The important factor is that you must be able to read the wrong entry.

Do not leave blank lines between entries with the intent to add something at a later date. It could be construed as an alteration. Do not insert words or phrases in an entry; this could be construed as an alteration. If you remember something you wish to record at a later date, just make the entry chronologically and refer to the date of the visit in question.

Professional liability insurance companies have long asserted that errors or inadequacies in the patient record prevent them from successfully defending some dentists against unfounded allegations of malpractice. To identify where there is the greatest need for improvements in record keeping, a 2005 survey conducted by the ADA Council on Members Insurance sought to determine the frequency, severity and causes of dental malpractice claims reported between 1999 and 2003. The following question was posed to the insurers with respect to both general practitioners and specialists:

Please indicate the degree to which your company has noted the following types of problems with its insured's' patient records (whether or not the problem was a primary cause of a paid claim.)

To quantify the responses to this subjective question, a value of ten was assigned to any problem that was indicated as being "very common." If a problem was "fairly common," it was assigned a value of five. If the insurer said that the problem was "not common," it was assigned a value of zero. The average scores for each problem, reflecting the opinions of fourteen insurers weighed equally, are listed below:

Insurers Views as to the Frequency of Various Record Keeping Errors	
Type of Error in Descending Order of Frequency	Average Score
Treatment plan is not documented	6.5
Health history is not clearly documented or updated regularly	6.1
Informed consent is not documented	5.9
Informed refusal is not documented	5.0
Assessment of patient is incompletely documented	4.9
Words, symbols, or abbreviations are ambiguous	4.9
Telephone conversations with patient are not documented	4.6
Treatment rendered is not clearly documented	4.5
Subjective complaints are not documented	4.1
Objective findings are incompletely documented	4.1
Treatment plan is not supported by documented subjective and objective findings	4.0
Reasons for deviation from the original treatment plan are not documented	3.9
Patient non-compliance or failed appointment(s) are not documented	3.7
Records are not legible	3.7
Routine full-mouth periodontal probing not documented	3.4
Insufficient records given the complexity of the issue	3.2
Post-operative instructions are not documented	3.2
Referral to or consultation with another practitioner or physician is not documented	2.8
Comments about the cost of treatment and the patient's payment history	2.6
X-rays were inadequate for the procedure	2.3
Prescription orders are not documented	2.2
Deletions, additions, or corrections are not made properly	2.0
Risk management notations included in the chart	1.4
The name and relationship of the person who gave consent is not documented for minors or patients who are incapacitated	1.4
Alteration of records	1.1
Lost records/X-rays	.7
Records are not written in ink	.7
Record contains notations relating to discussions with an attorney or insurer regarding a possible malpractice lawsuit	.4
Critical or subjective personal comments about the patient in the chart	.4

These results indicate that, in the opinion of professional liability insurance companies, it is fairly common to find that their dentists that have presented claims are not adequately documenting treatment plans, the patient's medical history and the informed consent/refusal process. Whether this result is indicative of the need for improvement in record keeping among all dentists is conjectural. However, the Council believes all dentists should review their own record keeping practices to identify whether any of the issues shown in the survey need to be addressed.

Ownership (see also Retention and Records section for multi-practitioner practice)

The dentist owns the physical record of the patient. He/she is the legal guardian of the chart. Patients do not have the right to possess their original record. They do have the right to see, review, inspect, request, and obtain a copy of their record. The dental team should be aware of HIPAA and the laws of their particular state governing this issue. If the patient requests a copy, the dentist is obligated to provide those records (including radiographs) within a reasonable time frame, which may be specified under state law.

In most cases, reasonable, cost-based fee may be charged for copying records. The fee should be limited to cost of supplies and labor for copying and postage (if mailed). However, state laws vary widely on this issue and may specify a limit on what can be charged. Federal HIPAA regulations generally preempt state law but state law may have a more prescriptive restriction on fees that can be charged.

Do I have to give a patient a copy of his or her records if the patient hasn't paid his or her bill?

Yes, under HIPAA privacy regulations and quite possibly under your state law as well. Your office will most likely have customized policies and procedures for HIPAA compliance in place. Due to the confidential nature of the dental record, before you send out any copies to either the patient, a patient representative and/or another provider, make sure that you have necessary permissions. Under HIPAA, this refers to an "Acknowledgment" form (and perhaps subject to the "minimum necessary standard"), and in some cases, a specific "Authorization" form. Some states may have more strict requirements. In addition, only send, or copy, the portion of the patient record that is requested. Prompt transfer to another practitioner can avoid any interruption of care for that patient.

"A dentist has the ethical obligation on request of either the patient or the patient's new dentist to furnish, either gratuitously or for nominal cost, such dental records or copies or summaries of them, including dental X-rays or copies of them, as will be beneficial for the future treatment of that patient. This obligation exists whether or not the patient's account is paid in full."⁴

Dentists also own radiographs; since they are an important part of the clinical record made by the doctor and cannot be interpreted by laymen. Patients do have the right to obtain copies of their radiographs.

Transfer or Copies of Records

Due to the confidential nature of the dental record, before you send out any copies either to the patient, a patient representative and/or another provider, make sure that you have necessary permissions. Under HIPAA, this refers to an "Acknowledgment" form (and perhaps subject to the "minimum necessary standard"), and in some cases, a specific "Authorization" form. Some states may have more strict requirements.

Your office will most likely have customized policies and procedures for HIPAA compliance in place. In addition, only send, or copy, the portion of the patient record that is requested.

What permission, if any, must a patient give to transfer records?

This depends on whether you are covered by HIPAA, your state law and also on the specifics of the case. Because of the confidentiality of the dental record, it is important to make sure you have the necessary permissions before you send out any copies, either to the patient, a patient representative and/or another provider.

Release Form

A simple release form for release of the record to either the patient or another health care provider may be signed by the patient and become a part of the dental record. This release form, signed by the patient, should specify to whom the records are being delivered and identifying the records. Signing such a form is generally not required by HIPAA to send records to another health care provider, but in some states consent is required before releasing

health information. Check with your state dental society about what is required in your state. Your professional liability insurance company may also consider such a release a component of good record keeping.

Who Can Consent to the Release?

State law may determine the permission needed to release medical record information. Generally, the authority to release dental information is granted to: (1) the patient, if a competent adult or emancipated minor; (2) a legal guardian or parent if the patient is incompetent or a minor child; and (3) the administrator or executor of the patient's estate if patient is deceased. The patient's right to authorize release of dental records is codified in many state statutes. These statutes all state that dental records are confidential and cannot be disclosed, except in specifically provided circumstances. However, the extent of the patient's right to access varies from state to state. Some states allow the health care professional or provider to determine patient's right of access. In comparison, some states expressly grant patients access to the dental information contained in their dental records.

General releases may not suffice for records containing HIV or other sensitive material. Most state laws prohibit the disclosure of HIV status test results to a third party without a specific written authorization by the patient or the patient's representative. Any information regarding health issues should be handled with caution and special regard for the patient's privacy. Even if appropriate authorization and consent is received, dentists and other health care professionals may be legally precluded from releasing HIV/AIDS records without specific reference to that information in the release. Some states have heightened confidentiality provisions for sensitive information, such as HIV status.

Typical elements of a valid general release include:

- Patient's name and identifying information;
- Address of the health care professional or institution directed to release the information;
- Description of the information to be released;
- Identity of the party to be furnished the information;
- Language authorizing release of information;
- Signature of patient or authorized individual; and
- Time period for which release remains valid.⁵

When sending records, make a notation in the patient's chart as to the date, where and to whom the copies were sent. There may be office policy restricting sending anything out of the office without the dentist's knowledge and approval. By using certified return receipt requested U.S. Postal Service or another service that provides proof of delivery, you will be able to prove the records were sent. Keep copies of certified receipts or proof of delivery in the chart.

Should original records be sent when a copy is requested?

Never release original records to anyone but rather send copies, including radiographs. There is one exception: you may send the originals if you are required to do so by a government agency with proper authority, such as a court order, or in some states, a subpoena. If this situation were to occur, you should make copies for your office.

Are there exceptions when information in a dental record would be disclosed without a patient's consent?

Below are exceptions that allow disclosure without consent, for these purposes:

- Defense of a claim challenging the dentist's professional competence; peer review process
- Claim for payment of fees
- Third party payer relating to fees or services furnished
- Court order to a police or federal agency as part of a criminal investigation
- Identify a dead body
- Report a legal violation of another health care professional if the dentist reasonably believes it is necessary to disclose the information to comply with Public Health Code⁶

Under HIPAA, covered entity dentists who are otherwise in compliance with the law may transfer records for certain purposes without the patient's explicit permission. For example, covered entity dentists may share records with other health care providers for treatment purposes and transfer patient records to dentists who are purchasing their practice. Also, covered entity dentists may share portions of the patient records as needed to obtain payment for their services. However, disclosures of this type must be limited to "minimum necessary" amount that must be shared for the intended purpose (i.e., obtain payment).

In response to a valid court order, HIPAA regulations (and possibly state law) may not require an authorization to release a patient's record. However, if the subpoena is not accompanied by a court order, the subpoena alone is not a valid basis to disclose the information (unless a subpoena has the force of a court order under state law). Because these situations are complicated and require careful analysis, check with your state dental society or attorney about what is required.⁷

The ADA in 2007 updated its *General Guidelines for the Referral of Dental Patients*, included as an Appendix in this publication.

Informed Consent

What exactly is informed consent? In general, it is required that dentists provide information to patients about the dental health problems that the dentist observes, the nature of any proposed treatment, the potential benefits and risks associated with that treatment, any alternatives to the treatment proposed, and the potential risks and benefits of alternative treatments, including no treatment. Some procedures call for a separate consent form to be signed, but there are many times when procedures and options are discussed and a consent form may not be utilized. In some offices, notes of the discussion with the patient are entered in the record at the time the discussion is held and the patient is asked to initial the entry.

The dentist must secure informed consent before providing care. The exact requirements vary by state and by the type of procedure being performed. Certain procedures, such as invasive or requiring extensive treatment, should have a signed, written informed consent. In those cases, the appropriate staff person should be sure that a signed written consent form has been obtained before the treatment is provided. Your practice's professional insurance company and/or attorney may also have recommendations and resources, such as sample forms.

Consent for treatment provided to children or an incompetent adult requires special consideration.

The dental record should contain a notation concerning the granting of informed consent to do the treatment proposed, or that consent was not granted (and treatment not done).

Informed Refusal

If the patient refuses the proposed treatment, the dentist must inform the patient about the consequences of not accepting the treatment and get a signed informed refusal. However, obtaining an informed refusal does not release the dentist from the responsibility of providing a standard of care. If, for example, the patient refuses to have radiographs taken, the dentist should refer the patient to another dentist when the original dentist believes that radiographs are a necessary prerequisite to proper care in that case.

Obtaining informed consent/refusal can involve complex issues. You may wish to take continuing education courses on this subject.

Use of Social Security Number

With identity theft occurring at escalating rates, you may find many patients reluctant to provide their social security number (SSN). There are legitimate reasons to ask patients for social security numbers. For example, these numbers may be helpful in determining if the patient is credit worthy. If patients are not financing their dental care, and the number is not needed to file a claim for a dental benefit program, you may not need the patient's social security number. Many third-party payers have created unique IDs for this reason. Your practice may wish to consider using a unique patient ID other than the Social Security number (SSN).

There is a law in California that restricts the use of SSNs in some circumstances. This law restricts businesses and state and local agencies from publicly posting or displaying Social Security numbers. It also bans embedding SSNs on a card or document using a bar code, chip, magnetic strip or other technology. The law takes effect gradually, from 2002 through 2010. The CA Office of Privacy Protection has a good summary of that law: <http://oag.ca.gov/idtheft/facts/your-ssn>.

Destruction

If your office decides to destroy records as allowed by state law, caution must be used in the destruction of records. Confidential information is included in the dental record. You have an obligation to protect the patient's privacy and personal health and financial information.

For those inactive patient records (passed the Statute of Limitation) that will not be transferred or returned to patients, a more secure way of eliminating these unwanted records generally involves shredding. There are professional shredding services available to do this for you. You could also rent an industrial-grade shredder and destroy the records yourself. Small paper clips and staples generally do not have to be removed prior to professional shredding.

Many medical facilities outsource the destruction of records. To find such a service, check in the Yellow Pages or use an Internet search under a topic such as "document destruction." A professional shredder service should sign your confidentiality agreement (or HIPAA "Business Associate Agreement," if applicable) and if they will agree, indemnify you in the event of a breach in confidentiality. Most services issue a Certificate of Destruction or the company may allow you or a staff member to witness the destruction. You may wish to check with personal legal counsel before destroying records.

NAID (National Association for Information Destruction, Inc.) claims that it is the international, non-profit trade association for the information destruction industry. Membership includes companies (including suppliers) and individuals involved in providing information destruction services. See <http://www.naidonline.org/> for further details if you need a commercial shredder firm. You might get recommendations for such a service from a larger health care provider in your area, such as a hospital.

CAUTION: Do not burn patient records containing radiographs as the heat could release dangerous metals. Silver recovery by a professional recovery firm might be a better option that pays you for recovering the silver content from x-rays. Check your telephone book or with your state or local dental society for a silver recovery firm or certified waste hauler.

Paper re-cycling is not a good option if you have to get rid of inactive paper dental and business records in order to close a practice. Under most circumstances, recycling companies merely collect then sort paper that comes to the company. In general, the collected paper is bound and sold to the highest bidder weeks or months later (even years later). There is no guarantee of confidentiality and there is no way to ensure just when the paper, potentially containing confidential or sensitive information, was destroyed.

Recycling without destroying patient records for a retiring dentist closing his/her practice and improperly disposing of the records might be viewed as negligent by the court in the event of an allegation of breach of confidentiality or in the case of a federal complaint to the Department of Health and Human Services Office of Civil Rights (for a supposed HIPAA violation by a covered entity) as an illegal practice under the Act. In either case, recycling without documentation of destruction is an example of poor risk management.

Always insist on a certificate of destruction; furthermore, make sure that there are no sub-contractor companies involved which do not also agree in writing to adhere to the privacy policies of the practice.⁸

Access

Only authorized persons should have access to office records. Be sure the dentist has an office policy on this matter, and you understand and abide by that policy. Patient records should not be removed from the dental office without the knowledge and permission of the dentist.

Today, many dentists are still using paper patient records stored in file cabinets and shelves. Increasingly, dentists are incorporating new technologies into their practice to manage the large number of existing records. This information may also be stored on an off-site server that is shared with other users and accessed on a network.

The security of access to digital records and the costs of maintaining a system continue to be a concern. But with today's access technologies featuring fingerprinting, retinal scanning, electronic signatures, and voice recognition, records can be as safe as paper records if managed properly. Data encryption, a process in which data is scrambled before transmission then reconfigured with a special code by the end user, also adds security. The HIPAA Security regulation requires implementation of security measures to patient health information, such as:

- Administrative safeguards such as security policies and procedures
- Technical safeguards such as password protections and back-ups of patient records
- Physical safeguards, such as limiting access to PHI

Electronic Patient Records

The use of electronic records is dramatically affecting the dentistry profession. As a member of the administrative dental team, you must also take the initiative to learn the terms and the tools of the new electronic world—especially with regard to electronic records and HIPAA regulations.

Digital technology, the advancement of networked computing and the digitization of information, will continue to change the profession of dentistry in numerous ways—from the clinical to continuing education and, from practice management transactions such as payment and marketing to e-commerce.

Software programs allow electronic transmission of patient records with sound, text and images to dental specialists for second opinions and preauthorization for insurance purposes. Instead of written descriptions with tooth charts, digital clinical photographs may be attached. For more information on HIPAA Security regulations related to electronic records and communications, consult the *ADA HIPAA Security Kit* available for purchase through the ADA Catalog.

Communicating with Patients by E-mail

Electronic communications use in the dental office can be very beneficial. For example, it can help the dentist save time, and put an end to phone tag with patients. For patients, it may help them compose more detailed questions for the doctor and complete tasks such as scheduling appointments or refilling a prescription.

However, using e-mail for patient care purposes can also raise significant considerations. It is difficult to ensure confidentiality and to confirm the identity of the person when communicating via unsecured e-mail. E-mail could be misdirected in error, or forwarded to an unknown third party without proper controls. Patients should be made well aware of these risks and agree to accept them before use of electronic communications.

But will a patient's acceptance be a binding release? If patients agree, how will these communications be incorporated in the dental record? Can you minimize your exposure/risk or lessen your liability for business you conduct online? And, are you insured? Answers to these and many other open questions will take time to evolve, as users get more familiar with emerging technologies, and the courts grapple with how to resolve bad outcomes arising out of their use.⁹

Making the Transition to a Paperless Office

Digital patient records are an increasingly common practice management tool as technology advances and become more effective.

During the transition from a paper dental office to an electronic one, manual filing and record keeping continue to be extremely important. Dentists should educate themselves as to the legal, ethical, and technological issues that are related to an electronic medium — including whether state law mandates backup paper record keeping. Some states may have “quill” laws that fail to recognize certain types of electronic records as valid in legal proceedings. Carefully check laws related to electronic record keeping as changes in this area occur rapidly.

Even with advancing technologies, practitioners and staff must realize that the transition to “paperless records” is not seamless, totally safe, or problem-free and may not eliminate the need to keep paper records due to legal requirements in some states.

No matter what precautions are taken, there is still a possibility that someone might gain access to stored electronic information. Computer viruses and other computer hardware and software problems can cause information to be lost, as well.

An increasing number of dental offices are using electronic communication and information technologies. The field of dental informatics, “the application of computer and information science to improve dental practice, research, education, and management,”¹ is emerging to work with computer science and telecommunications to bring all of these concepts into workable tools of the future. Dental informatics is helping to develop ways to implement the “sharing” of medical information, yet keep it from unauthorized individuals and comply with HIPAA and other legal requirements.

Interprofessional communications will improve, as dentists will be able to consult more quickly and in greater detail electronically with other healthcare professionals such as physicians, radiologists, pharmacists, psychologists, and nutritionists to deliver the best possible dental care.

National Health Information Infrastructure

How the dental practice manages dental records will change rapidly in the future. There is currently a new initiative to create electronic health records for patients that could be accessed by all health care providers. The goal is for patient records to be available to all health care providers electronically, virtually anywhere in the country, through an interoperable system.

Scheduled for completion in 2015, the National Health Information Infrastructure (NHII) will be a communications system comparable to a network of highways, roads and pathways on which all health information will travel. Its purpose is to enable patients' electronic health records to be accessed and added to by all health care providers electronically (with patient authorization), virtually anywhere in the country, via the network. The electronic health record will include health information entered for a specific patient at a specific point of service. It will travel and be accessible on the NHII.

Falling under the purview of the Department of Health and Human Services, HHS envisions regional collaborations among health care entities, including dentists and other health care practitioners, so that a patient's information can be securely stored in the local community and made electronically accessible to all health care providers involved in treatment of a particular patient.

For updates on this evolving topic, go to the American Dental Association Web site, www.ada.org.

Record Handling When Closing a Practice

Some states have specific record retention and patient & employee notification requirements that apply whenever a dentist decides to retire or close a practice (i.e. Florida's Administrative Rule 59Q-17.001 Required Availability of Dental Records Upon Relocation or Termination of Practice, or Death of Practitioner). Check with your state or local dental society for specific information or with an attorney who knows about the requirements in your state. For contact information in your state, go to the constituent (state) dental organizations list on <http://www.ada.org/stateorganizations.aspx>. All constituent dental societies have Web sites and many provide a link to the state dental practice act.

Patient records must be handled in accordance with applicable laws. However, in most states, a dentist is usually allowed to charge a patient a reasonable fee for duplicating and transferring records to another practice. Under a circumstance of retirement, many dentists provide this service free of charge. They should not refuse to release needed patient treatment information due to the payment delinquency of the patient. Failure (or refusal) to release necessary information to another dentist for a patient's continuing care may be illegal and may be viewed as an unethical practice by your professional association.

If possible, the dentist who is planning to close a practice should notify patients well in advance that the practice is closing. In most states, letters to patients of record or an announcement in a community newspaper are ways in which a dentist might give advance notice of a closing. Notice of 30 - 60 days is sufficient for most patients and circumstances.

Patients should be notified how to obtain a copy of their dental records, notified of the location they are stored or given the option of transferring records. This notification can be by letter and have wording such as:

At your request, copies of the pertinent information from your record can be made available to a dentist of your choosing. If you wish to make a request regarding your patient record, please contact the office before the permanent closing day, as your written authorization is needed to make your records available to another dentist. After that day, you will have to direct your inquiry about the record to (name of dentist or record custodian), located at (complete address, phone number).

Your states' laws actually govern whether a dentist must send originals, however, in most cases, the practice should only send copies of a patient's record to another dentist, and only with the patient's or their representative's (e.g. a legal guardian) permission. Make a note of where copied records are sent. Unless your state laws direct otherwise, original records should remain with the retiring dentist (or with the surviving spouse or his/her legal representative, since a dentist's estate can be sued years after a dentist's death) in accordance with a state's record retention laws.

A proper patient transfer from a retiring dentist who must discontinue treatment in advance of completion may have at least these four requirements: 1) identifying a skilled practitioner who will accept the unfinished case; 2) providing that dentist with necessary clinical information so that he/she knows enough about the patient to continue or alter treatment, if necessary; 3) the patient agreeing to the referral; and 4) the patient actually submitting to the treatment in a cooperative fashion. Short of achieving all four, a dentist could still have trouble defending against an abandonment allegation, depending on applicable law.

Remember of course, that record retention is a matter of state law and risk management. In general, records may be destroyed for inactive adult patients who have not been seen in seven years (longer in some localities) or at the expiration of the statute of limitation on contract and tort actions. The oral health record of inactive minors generally should NOT be destroyed until seven years after a child reaches majority (21 years plus 7 years, or 28 years of age in some localities). Always check your local law. Records should be stored in a moisture and fire resistant container. Check with your attorney or state dental association to learn the record retention requirement in your state and with your insurance company for risk management recommendations. (See section on Destruction).

Record Handling During Sale of a Practice

When selling a practice, three main methods are available to the dentist for a transfer of patient records:

1. The dentist may choose to keep the original patient documents and provide the buyer with a copy of all the patient charts and radiographs. This method would provide the dentist with the best protection in the event of a future malpractice claim, since the old records would be maintained by the seller.
2. The dentist may choose to keep copies of all the patient charts and provide the original records to the buyer. This method may not give the seller the same liability protection as in the previous method.
3. The dentist could obligate the buyer, in the sales contract, to allow the seller access to the records in the event of need. The buyer is typically required to maintain these records for a set period of time after the sale. Further contract language regarding damages for records not maintained could be included. The disadvantage of such a transfer is that even with this provision, the buyer may inadvertently destroy or lose records or make access difficult. In evidence law, there is nothing better than the original document and, therefore, be sure it can be obtained in the event of a question or a professional liability claim.¹⁰

The sales agreement clause related to patient records would typically permit the seller for a specified period of time to have access to the patient charts, records and x-ray file in connection with the practice sale transaction to allow review and making of copies for defense of malpractice litigation or to respond any inquiries from licensing or regulatory authorities.

Releasing the Oral Health Record in Emergencies or Forensic Investigations

Dentists who are covered under the HIPAA Privacy Rule generally may release dental records or make disclosures from the record to law enforcement officials under the regulation without patient authorization provided they present a valid, properly served warrant; court order, subpoena or administrative request. In the case of an administrative request two conditions generally must be met: 1) the information sought must be related to a legitimate law enforcement inquiry; and, 2) be reasonably limited to the scope of that inquiry. The HIPAA privacy regulations also permit dentists covered by the Rule to release patient records and make disclosures to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by state law.

Under HIPAA, a covered entity may use professional judgment to determine when it is appropriate to release clinical records to a family member for identification purposes since the HIPAA regulations indicate that such disclosures may need to be limited to directly relevant information. The most prudent option might be that the dentist, in consultation with his or her attorney, limits a disclosure to just those records or data necessary for victim identification.

Depending on the circumstance of the request, the celebrity of the patient for example, prior to release, a dentist (or the Privacy Officer in a dental practice) might wish to seek permission from the person(s) named in the record as next of kin.

A dentist may need to collect emergency contact and next of kin information from each new patient, and ask existing patients at least annually about any need to alter or update emergency information in their dental record; or any special instruction or restrictions they may elect (allowable by law) concerning the release of their personal health information to others.

While dentists are the owner of the dental patient records in their possession (physical or electronic), a patient generally has a legal right of access to the information contained in their own dental record or in that of a dependent family member. They may have a further legal right to restrict disclosures or release of the record. Consequently, dentists need to become familiar with state and federal requirements and formulate record release policies and procedures specific to their practice. A record release and disclosure policy in an emergency could allow access to the dental records by family members of missing or unidentified persons, or to law enforcement. Written procedures based on your policy should appear in your practice's office manual. Such procedures could help ensure necessary access or disclosure while simultaneously protecting dental record privacy.

In most cases, photocopies of written records are acceptable to a recipient unless originals are specifically required or authenticity is in dispute. If investigators agree to accept photocopies of written dental records, you should provide crisp, clear copies that include both sides of any document containing or providing information on two sides. If a single document contains multiple pages, consistently number and duplicate each page. Prior to releasing copies, make sure that each page identifies the individual in question and the dentist providing the record. If necessary, use a rubber stamp with the dentist's contact information on it, but do not obscure content on the page.

When releasing originals; inventory which documents you intend to release. Some dentists indicate a count on the front of the dental record of how many pages are included if the number is more than just a few. Recording the count could help investigators receiving the records know that they received every document in a large dental file.

Whenever possible, a dentist should release original records and radiographs in person, not by mail. It may also be a good idea for the dentist to obtain a receipt. Always retain a copy of the record.

Subpoenas for Dental Records

A dentist with sufficient reason may choose to restrict (except to the patient) release or disclosure of some of the information contained in the dental records to authorized entities presenting a valid, properly served warrant, court order, subpoena or administrative request. Unless specifically directed, a dentist might choose, for example, to not disclose a summary in the record of a sensitive conversation that is unrelated to identification.

A dentist who gets a request to provide dental records in a forensic investigation should cooperate with authorities who properly identify themselves and who present the dentist with a valid, properly served warrant, court order, subpoena or administrative order. State laws and the HIPAA Privacy Rule, provide for the circumstances under which records may be released in the absence of a valid warrant or court order. Dentists may wish to consult with their private attorney in dealing with these situations.

Types of subpoenas:

- A “subpoena duces tecum” is an order for the dentist to appear in person with the required dental records. Check with your own attorney. In some states, a personal appearance may not be necessary.
- A “subpoena ad testificandum” is a written order demanding that a dentist appear and give testimony. This may be testimony at trial or a court hearing or by deposition. Again, consult with your attorney.

Before releasing any documents, original or copies, it is important to be certain to retain a duplicate set of any released documents. This will help the dentist to confirm the return of all records once the identification is made, and provide a record of what was produced while permitting the dentist at the same time, to maintain a file in the dentist’s possession.

If a requested record is “misfiled” or lost within your practice and cannot be located, the dentist should report the result of the unsuccessful search to requesting authorities as soon as possible.

Inactive dental records kept off-site or on microfiche may require more time to locate. However, a dentist responding to a valid subpoena may be required to produce the records by a date specified on the subpoena and within the time frame allowed by law. If the dentist is unable to comply with the subpoena or order within the specified time frame, he or she should immediately contact an attorney who may contact the requesting official to explain the situation.

A dentist who refuses to comply with a final, valid, properly served warrant, court order, subpoena or administrative request for records should appear in court to contest disclosure and explain the basis for refusing before any sanctions for failure to comply are imposed. Refusing to comply is very serious and not an ordinary option. You should not refuse to comply, for example, without first consulting your attorney for local court procedures because you do not want to be found in contempt of court.

Releasing Dental Radiographs

If requested, a dentist should release the original radiographs of a patient to properly authorized investigators. Even a very old radiograph in good condition might assist investigators in identifying a victim in a forensic identification case.

Most duplicate or printed radiographs are not of diagnostic value and could delay victim identification. Radiographs include bitewings, occlusals, periapicals, panoramics and cephalometrics. If other radiographs of the head and neck of a patient are known to be held by a hospital or specialist, a dentist should give contact information so that investigators can reach these colleagues or institutions to collect additional information.

Denote “right” and “left” on mounted radiographs or how you read the indicator bubble. Indicate the date of exposure as well. For copied two-dimensional paper records there is no raised bubble to read, so labeling left and right could become critical whenever the paper copy is diagnostic.

Label any envelope containing radiographs with the patient’s name, unique patient identification and a count of the number of individual radiographs contained inside. To prevent loss of content seal each envelope containing loose radiographs before releasing them to authorities. Again, keep track of precisely which records are released.

Frequently, authorized investigators who are working to identify a body, the remains of a recovered missing person, or mass fatality victims may wish to clarify or confirm information with the dentist who released the victim’s radiographs. You should place your name, telephone number and address prominently on any radiographic envelopes or mounts that you release.

Another way to denote radiographs as from your office is by securely attaching your business card to each mounted radiograph or envelope. However, do not staple through any radiographs.

A suspected victim’s diagnostic casts, if they are available, can be used in identifications. Incidental information, such as rugae patterns on submitted casts, has been used to confirm an identification.

Your patient's name and date of impression should appear on the casts. However, do not use pencil as pencil marks can come off or smudge during handling, possibly delaying a positive identification. Since diagnostic casts are breakable, before release they should be securely wrapped to prevent damage in bubble wrap or loose packing material inside a case box with the dentist's contact information on the outside.

The American Dental Association's policy **Dental Radiographs for Victim Identification** (2003:363) gives guidance with regard to dentists making available original records to authorized investigators attempting to identify a disaster victim:

Resolved, that the ADA actively promote to practicing dentists the importance of providing, as permitted by state law, radiographs and original records of patients of record that are requested by a legally authorized entity for victim identification which will be returned to the dentist when no longer needed, and be it further

Resolved, that copies of these records should be retained by dentists as required by law.

ADA Policy **Dental Identification Efforts** (1985:588) encourages dental societies and others to assist in forensic investigations. The policy states:

Resolved, that the ADA encourage dental societies, related dental organizations and the membership to participate in efforts designed to assist in identifying missing and/or deceased individuals through dental records and other appropriate mechanisms.

Retention of Other Business Records

In addition to being familiar with the complexities of patient recordkeeping, as a small business a dental office also needs to retain other records.

Records maintenance is important to help with the following:

- Monitor the progress of your business
- Prepare financial statements
- Identify sources of revenue
- Keep track of deductible expenses
- Prepare tax returns
- Support items reported on your tax returns.

Business Record Retention^{11,12,13,14, 15}

Retention period is the number of years from the date of the tax return filed.

All information is general only and not offered as legal advice.*

The proper retention period will vary from state to state and, maybe from practice to practice. Here is a typical schedule of retention periods. Yours may be different. Consult with an attorney to establish your own schedule.

Record Type	Retention Period
Tax & Financial Files**	
Accounts payable ledger & schedule	7 yrs
Accounts receivable ledger & schedule	7 yrs
Audit/accountant annual report	Permanently
Bank statements (monthly)	3 yrs
Capital asset records	Permanently*
Cash receipt journal	Permanently*
Checks (cancelled – see exception below)	7 yrs
Checks (cancelled for important payment – i.e. taxes, purchases of property; file with transaction)	Permanently
Contracts and leases (expired)	7 yrs
Contracts, mortgages & leases (still in effect)	Permanently
Deeds, mortgages & bills of sale	Permanently
Deposit books & slips (duplicate)	3 or 6 yrs*
Depreciation schedules	Permanently
Financial statements (yearly)	Permanently
General ledgers	Permanently
Income tax returns, worksheets and related documentation	Permanently
Insurance policies (expired)	3 yrs
Insurance records, current accident reports, claims, policies, etc.	Permanently
Inventory of products, materials & supplies	7 yrs
List of accounts (assets, liabilities, revenue, expenses, etc)	Permanently
Petty cash vouchers	3 yrs
Retirement plan records (documents, investment records, allocations)	Permanently
Vouchers for payments to vendors, employees, etc. (includes allowances & reimbursement of employees, etc. for travel & entertainment expenses)	7 yrs
Employment Records	
Applications (not hired)	3 yrs
Personnel records (after termination)	7 yrs
Payroll records, taxes & summaries	7 yrs
Time sheets, cards or time clock	7 yrs
Training manuals	Permanently
Workman compensation records	5 yrs
Patient	
Daysheets, schedule	7 yrs
Patient billing/payment or fee statements	7 yrs
Third-party insurance claims, records & correspondence (EOBs)	7 yrs
Other**	
Accident reports/claims (settled cases)	7 yrs
Controlled substance copy	2 yrs
Correspondence, routine with patients or vendors	2 yrs
Correspondence (legal or important)	Permanently
Legal agreements (partnership, associateship)	Permanently
Medicare billing records	7 yrs
OSHA records (log and summary)	5 yrs past the year to which it pertains

*Check with your personal advisor, such as accountant, attorney or professional liability insurance company. State and federal laws may apply, in addition to the state dental practice act.

**When your records are no longer needed for tax purposes, do not discard them until determining if you might need for a longer time period for other purposes. For example, your insurance company or creditors may require you to keep them longer than the IRS does.

Additional resources

To obtain the following resources, call the *ADA Catalog* at 1-800-947-4746 or order online at www.adacatalog.org. Following are just a few of the many titles available from the ADA Catalog Sales Department. You may order any of the publications by calling (800) 947-4746, or through the ADA's Web site at www.adacatalog.org.

Fast-Track Training: The Basics for Dental Staff. Chicago, Ill: Council on Dental Practice, American Dental Association; 2007.

Basic Training II: for New Clinical Personnel. Chicago, Ill; Council on Dental Practice, American Dental Association; 2002.

Basic Training III: for Dental Administrative Personnel. Chicago, Ill; Council on Dental Practice, American Dental Association; 2003.

Employee Office Manual: A Guide for Dentists. Chicago, Ill; Council on Dental Practice, American Dental Association; 2004.

Frequently Asked Legal Questions: A Guide for Dentists and the Dental Team. Chicago, Ill: Division of Legal Affairs, American Dental Association; 2004.

HIPAA Privacy Kit, American Dental Association; 2002.

HIPAA Security Kit, American Dental Association; 2005.

Starting Your Dental Practice: A Complete Guide. Chicago, Ill: Council on Dental Practice, American Dental Association, 2003.

Valuing a Practice: A Guide for Dentists. Chicago, Ill: Council on Dental Practice, American Dental Association; 2001.

Internet Resources

ADA Resources

www.ada.org

HIPAA <http://www.hhs.gov/ocr/privacy/>

Risk management article database (ADA members only)
<http://success.ada.org/en/practice/operations/risk-management>

Legal Adviser & law article database (ADA members only)
<http://www.ada.org/en/member-center/member-benefits/legal-resources>

Emergency Planning & Disaster Recovery in the Dental Office (ADA members only)
<http://success.ada.org/en/practice/operations/risk-management/emergency-planning-and-disaster-recovery-planning-in-the-dental-office>

Closing a Dental Practice (ADA members only)
<http://success.ada.org/en/practice/ownership-life-cycle/closing/closing-a-dental-practice>

ADA Policy on **Identification Through Prosthetic Devices** (1978:181)
<https://www.ada.org/~media/ADA/Member%20Center/Files/2013%20Current%20Policies%20Final.ashx>
(page 117) Legal & Ethical Frequently Asked Questions (FAQ)
<http://ebusiness.ada.org/productcatalog/product.aspx?ID=404>

Directory of Professional Liability Insurers (ADA members only)
<http://www.ada.org/en/member-center/member-benefits/insurance-resources/directory-of-professional-liability-insurers>

Identity Theft Resource (ADA members-only)

<https://success.ada.org/en/practice/operations/risk-management/protect-yourself-from-identity-theft>

Non ADA resources

The Dental Record <http://www.dentalrecord.com/>

Dealing with a Data Breach - Information Compromise and the Risk of Identity Theft: Guidance for Your Business, Federal Trade Commission, <http://www.ftc.gov/bcp/edu/microsites/idtheft/business/data-breach.html>.

American Records Management Association, <http://www.arma.org/>

Business Records Resources Related Web Resources

Drug Enforcement Agency (DEA)
www.justice.gov/dea/index.shtml

IRS
<http://www.irs.gov/>

OSHA Record Keeping
<http://www.osha.gov/recordkeeping/OSHArecordkeepingforms.pdf>

Small Business Administration
<http://www.sba.gov/>

BusinessTown – Accounting Basics
<http://www.businesstown.com/accounting/basic.asp>

SBDCNet <http://www.sbdnet.org/>

SCORE
http://www.score.org/template_gallery.html

Forensic resources — Training

Armed Forces Institute of Pathology
202-782-2100
Washington, D.C.
<http://www.afip.org>

University of Texas - Southwest Symposium on Forensic Dentistry
Health Science Center
San Antonio, TX
210-567-3177
<http://cde.uthscsa.edu/>

The Council on Dental Practice of the ADA sponsors training programs and conferences on basic dental forensic topics and techniques. Call the Council at 1-312-440-2895.

Organizations

Disaster Mortuary Operational Response Team (DMORT)

<http://www.phe.gov/Preparedness/responders/ndms/teams/Pages/dmort.aspx>

Professional Societies

American Society of Forensic Odontology

<http://www.asfo.org>

American Board of Forensic Odontology

<http://www.abfo.org>

The Diplomat's Manual produced by the ABFO is available at the site for free downloading.

American Academy of Forensic Science

<http://www.aafs.org>

References

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- ¹ *Frequently Asked Legal Questions: A Guide for Dentists and the Dental Team*. Chicago, Ill: Division of Legal Affairs, American Dental Association; 2004.
- ² Weber, R., J.D., Correcting and releasing dental records, *Journal of the Michigan Dental Association*, April/May 2000.
- ³ Pollack, Burton, R., *Law and Risk Management in Dental Practice*, New York, Quintessence Publishing Co, 2002.
- ⁴ ADA Principle of Ethics and Code of Professional Conduct.
- ⁵ American Medical Association, Patient Confidentiality, <http://www.ama-assn.org/ama/pub/category/print/4610.html>, accessed April 20, 2007.
- ⁶ Weber, Richard, Release of Dental Records, *Journal of the Michigan Dental Association*, (Vol. 83, No. 6), July/August, 2001.
- ⁷ *Frequently Asked Legal Questions: A Guide for Dentists and the Dental Team*. Chicago, Ill: Division of Legal Affairs, American Dental Association; 2004
- ⁸ *Closing a Dental Practice: A Guide for the Retiring Dentist or Surviving Spouse*, ADA, Council on Dental Practice, 2005.
- ⁹ *Frequently Asked Legal Questions: A Guide for Dentists and the Dental Team*. Chicago, Ill: Division of Legal Affairs, American Dental Association; 2004, p. 61-62.
- ¹⁰ *Valuing a Practice: A Guide for Dentists*, Council on Dental Practice, American Dental Association, 2006.
- ¹¹, Publication 538 "Starting a business and keeping records," Internal Revenue Service, Jan 2007.
- ¹² McGill, John, MBA, JD, CPA, How long should you keep your business records, *Journal of Clinical Orthodontics*, May 2003.
- ¹³ Paoloski, Susana, DDS, "When is it safe to pitch office papers," *Journal of the Greater Houston Dental Society*, Sept 2002.
- ¹⁴ Presavento & Pesavento, LTD, CPAs, "Records retention schedule," *Collier, Sarnier and Assoc Newsletter*, Berwyn, IL, May 15, 2005.

GENERAL GUIDELINES FOR REFERRING DENTAL PATIENTS

Revised June 2010

American Dental Association

Council on Dental Practice

At the direction of the Council on Dental Practice these *General Guidelines* have been designed as a discussion about appropriate procedures for referrals and are intended to promote an improved patient referral process. The information is necessarily general in scope and cannot cover every situation or detail. The information provided is not to be construed as legal advice or a legal standard, and cannot serve as a substitute for a dentist's own professional judgment or consultation with an attorney. These *General Guidelines* were developed by the Council on Dental Practice with input from many dental-related organizations and should not be interpreted as policy of the American Dental Association or any of its other agencies.

General Guidelines For Referring Dental Patients

Introduction

Appropriate referrals are an integral part of complete quality health care management. Referrals should be based on the education, training, interest, and experience of the referring dentist and the unique needs of the patient. Dentists are expected to recognize the extent of the treatment needs of their patients and when referrals are necessary. These General Guidelines assume the dentist has the requisite skill and knowledge in diagnosis and treatment planning to determine when a referral is needed.

The term "referring dentist," when used in this document, usually means the primary dental care provider as defined by the ADA in *Trans.*1994:668. The referring dentist may be a specialist.* In situations where two or more dentists are involved in the treatment of the patient, communication between all parties is essential. The referring dentist usually manages the overall dental health care of the patient, although there may be times when this role is assumed by another dentist.

The term "consulting dentist," when used in this document, usually means the dentist who is not the primary dental care provider.

Any care rendered by a consulting dentist should be coordinated with that of the referring dentist, and any other dentists involved in the treatment. Each dentist should have a clear understanding of the role each is playing in providing care to the patient.

*The American Dental Association officially recognizes nine specialty areas of dental practice: dental public health, endodontics, oral and maxillofacial pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics and dentofacial orthopedics, pediatric dentistry, periodontics and prosthodontics.

The following citations related to referrals are found in the American Dental Association's ***Principles of Ethics and Code of Professional Conduct***:

Section 1.A. **PATIENT INVOLVEMENT**

The dentist should inform the patient of the proposed treatment, and any reasonable alternatives, in a manner that allows the patient to become involved in treatment decisions.

Section 2.B. **CONSULTATION AND REFERRAL**

Dentists shall be obliged to seek consultation, if possible, whenever the welfare of patients will be safeguarded or advanced by utilizing those who have special skills, knowledge, and experience. When patients visit or are referred to specialists or consulting dentists for consultation:

1. The specialists or consulting dentists upon completion of their care shall return the patient, unless the patient expressly reveals a different preference, to the referring dentist, or, if none, to the dentist of record for future care.
2. The specialists shall be obligated when there is no referring dentist and upon completion of their treatment to inform patients when there is a need for further dental care.

Advisory Opinion

2.B.1. **Second Opinions.** A dentist who has a patient referred by a third party* for a "second opinion" regarding a diagnosis or treatment plan recommended by the patient's treating dentist should render the requested second opinion in accordance with this Code of Ethics. In the interest of the patient being afforded quality care, the dentist rendering the second opinion should not have a vested interest in the ensuing recommendation.

Section 4.B. **EMERGENCY SERVICE**

Dentists shall be obliged to make reasonable arrangements for the emergency care of their patients of record. Dentists shall be obliged when consulted in an emergency by patients not of record to make reasonable arrangements for emergency care. If treatment is provided, the dentist, upon completion of such treatment, is obligated to return the patient to his or her regular dentist unless the patient expressly reveals a different preference.

*A third party is any party to a dental prepayment contract that may collect premiums, assume financial risks, pay claims, and/or provide administrative services.

POSSIBLE REFERRAL SITUATIONS OR CONDITIONS

Patients may need to be referred for several reasons. Any one or combinations of the following situations or conditions may provide the dentist with an appropriate rationale for referring a patient. Some of these situations include, but are not limited to:

- Level of training and experience of the dentist
- Dentist's areas of interest
- Extensiveness of the problem
- Complexity of the treatment
- Medical complications
- Patient load
- Availability of special equipment and instruments
- Staff capabilities and training
- Patient desires
- Behavioral concerns
- Desire to share responsibility for patient care
 - Geographic proximity of the specialist or consulting dentist

ELEMENTS OF DENTAL PATIENT REFERRALS

Communication from the Referring Dentist to the Specialist or Consulting Dentist: The referring dentist should convey appropriate information to the specialist or consulting dentist. While this information may vary on an individual patient basis, it could include, but is not limited to, the following:

- Name and address of the patient
- Scheduled appointment date and time with specialist or consulting dentist
- Reason for the referral/diagnosis
- General background information about the patient which may affect the referral
- Authorization or release of records
- Medical and dental information, which may include:
 - Medical consultations and specific problems
 - Contributory dental history
 - Diagnostic casts
 - Radiographic or digital images
- Future treatment needs beyond the referral
- Urgency of the situation, if an emergency
- Information already provided to patient

Additional information may be found in the section on "Facilitating and Improving the Referral Process."

Communication from the Referring Dentist to the Patient: Many times the referral process is unfamiliar to dental patients who have become accustomed to receiving their routine care at one office. It is essential that all parties involved understand what is necessary to complete the referral successfully. The referring dentist may wish to consider the following points when communicating with the patient:

- An assessment of the patient's ability to understand and follow instructions
- An explanation of the reason for the recommended referral to the patient, patient's parent or legal guardian as appropriate
- An explanation of which area of dentistry or specialty is chosen and why
- If possible, making a specific appointment with the specialist or consulting dentist
- If known and if requested by the patient, providing information about the specialist or consulting dentist's fee for the consultation or evaluation
- Giving instructions that will assist the patient's introduction to the specialist or consulting dentist, i.e., preoperative instructions, educational pamphlets or a map with directions

Communication from the Specialist or Consulting Dentist to the Patient: The specialist or consulting dentist may wish to consider the following points when communicating with patient:

- Oral and/or written summary of the appointment
- Proposed additional and alternative treatment
- Details regarding the coordination of future treatment
- Follow-up appointments, if needed, and a return to the referring dentist for completion of other treatments and/or maintenance
- Consequences of no treatment
- Details of fees and payment options

Pre-Referral Communication Between Referring Dentist and Specialist or Consulting Dentist:

Both practitioners should discuss the referral treatment period and the return of the patient to the referring dentist. This arrangement may be enhanced by an exchange of business cards, referral forms and patient instructional materials. Availability for emergency treatment during the referral period should be discussed.

Post-Referral Communication Between the Specialist or Consulting Dentist and the Referring Dentist:

Communication between professionals is essential. Patients should receive clear, consistent information about their dental problems and treatment from all dental professionals. Mixed messages can confuse and frustrate patients. The following steps can facilitate the communication process:

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- Initial report from specialist or consulting dentist indicating the preliminary diagnosis and anticipated treatment
 - Progress reports as necessary, if treatment is extended over a considerable period of time
 - Final report, including factors that may alter the future course of therapy or affect the relationship between the referring dentist and the patient.
 - Diagnostic quality copies or duplicates of radiographic or digital images taken by specialist or consulting dentist
 - Return of any pertinent documents or forms provided by the referring dentist

FACILITATING AND IMPROVING THE REFERRAL PROCESS

Personal knowledge of the specialist or consulting dentist will allow patient needs to be met most appropriately. Inquiries about training and experience, including participation in continuing education and study clubs, may assist the referring dentist in determining where to refer particular dental patients. A visit to the office to observe treatment may be helpful.

Encouraging questions from patients about the referral and responding in lay terminology can ease some of the apprehension associated with unfamiliar treatments or providers. If language barriers exist, every effort should be made to ensure that the patient fully understands the reasons for the referral.

LEGAL AND ETHICAL ISSUES

The focus of this publication is on sound dental practice options relative to patient referrals. The examples given may or may not be appropriate legally, depending on a variety of factors. Some of the legal and ethical considerations pertaining to referrals are noted below

Legal Considerations:

The law may bear on whether and how a referral may be made. One example about “whether” comes from the Supreme Court, which has guided that under the Americans with Disabilities Act, the refusal to treat a patient with HIV would require a scientific basis; a referral to a clinic with more experience treating persons with HIV or any disability cannot be based solely on the dentist’s personal level of comfort.

As for “how,” state law varies regarding communication with the doctor to whom the referral is being made. In some states communication from the referring doctor may be mandatory, in others it may be permitted, and in others patient consent may be required.

The issue of consent, and the related but distinct issue of authorization as required by HIPAA, open a wide array of questions pertaining to confidentiality, privacy and security. While these issues are beyond the scope of this publication, it is important to know what laws apply to you, and that you secure any and all permissions required. Keep in mind HIPAA covers only certain dental offices – are you a covered entity? -- and state law varies.

Dentists should recognize that separate and possibly conflicting legal interests may be involved during a referral. Particular attention should be directed toward patients or providers whose interests and requirements are detailed in contract form. When dentists or patients participate in such arrangements related to dental services, these arrangements should be reviewed carefully with respect to restrictions that may be placed on the dentist's ability to refer patients to other settings or other dentists for care.

Note: In some situations, a dentist could be held legally responsible for treatment performed by specialist or consulting dentists. Therefore, referring dentists should independently assess the qualifications of participating specialist or consulting dentists as it relates to specific patient needs. The dentist is reminded that contract obligations do not alter the standard of care owed to all patients.

Ethical Considerations: In addition to the ethical provisions reflected on page 3, dentists have an ethical obligation to discuss their referral information with the patient in an appropriate manner. The ***ADA Principles of Ethics and Code of Professional Conduct*** contains the following:

Section 4.C. JUSTIFIABLE CRITICISM

Dentists shall be obliged to report to the appropriate reviewing agency as determined by the local component or constituent society instances of gross or continual faulty treatment by other dentists. Patients should be informed of their present oral health status without disparaging comment about prior services. Dentists issuing a public statement with respect to the profession shall have a reasonable basis to believe that the comments made are true.

Advisory Opinion

4.C.1. Meaning of "Justifiable." Patients are dependent on the expertise of dentists to know their oral health status. Therefore, when informing a patient of the status of his or her oral health, the dentist should exercise care that the comments made are truthful, informed and justifiable. This may involve consultation with the previous treating dentist(s), in accordance with applicable law, to determine under what circumstances and conditions the treatment was performed. A difference of opinion as to preferred treatment should not be communicated to the patient in a manner which would unjustly imply mistreatment. There will necessarily be cases where it will be difficult to determine whether the comments made are justifiable. Therefore, this section is phrased to address the discretion of dentists and advises against unknowing or unjustifiable disparaging statements against another dentist. However, it should be noted that, where comments are made which are not supportable and therefore unjustified, such comments can be the basis for the institution of a disciplinary proceeding against the dentist making such statements.

Reading List:

ADA Principles of Ethics and Code of Professional Conduct, Council on Ethics, Bylaws and Judicial Affairs, American Dental Association, see: <http://www.ada.org/en/about-the-ada/principles-of-ethics-code-of-professional-conduct>

