Patient Chart Documentation Checklist

Good chart notes are essential for:

- Providing efficient, seamless care.
- Supporting the necessity for services to get claims paid.
- Confirming the delivery and necessity for services during an insurance audit.
- Confirming the delivery of quality care and necessity for services if reviewed by a state dental board.
- Defending treatment (or non-treatment) in front of a prosecutor or jury.
- Forensic identification.

If it is not in the chart – it did not happen!

- Every chart entry must be dated and signed by the doctor or staff member providing treatment.
- Any staff member assisting the doctor or hygienist in treating the patient should also be listed in the chart note.
- If the treatment is provided by someone other than the doctor, that person should write the chart note and sign it. In this case, the doctor should then review the chart note and also sign it to show he is aware of all treatment provided to the patient.
- Every patient's chart should include (at a minimum):
    - Current/Updated Health History.
    - Date and Description of Examination.
    - Reason for Requesting Radiographs and the Radiographs Requested.
    - Diagnosis – in addition to an overall diagnosis (i.e., rampant caries, generalized moderate periodontitis), EACH tooth requiring treatment should have a diagnosis.
    - Date and Description of Treatment or Services Rendered.
    - Date and Description of Treatment Complications.
    - Date and Description of all Radiographs, Diagnostic Casts/Study Models, and Periodontal Charting.
    - Date, Name, Quantity, and Strength of all Drugs Dispensed, Administered, or Prescribed.
    - Record of Every Cancelled or Missed Appointment.
    - Record of Patient Refusing Treatment.
    - Record of Patient Accepting Treatment.
    - Recommendation for Treatment at Next Visit.