

Patient records may be manual paper records or electronic records but the same information needs to be recorded.

Personal information

Given name, Family name, Date of Birth, Title (Miss Ms Mrs)

Home address, occupation –place of work

Contact Information, home phone number, work phone number, mobile number, e-mail address

Medical information

Any past infections, diseases, illnesses, injuries

Current medical treatment and any drugs, medicines

The patient's medical practitioner

Dental charting to show

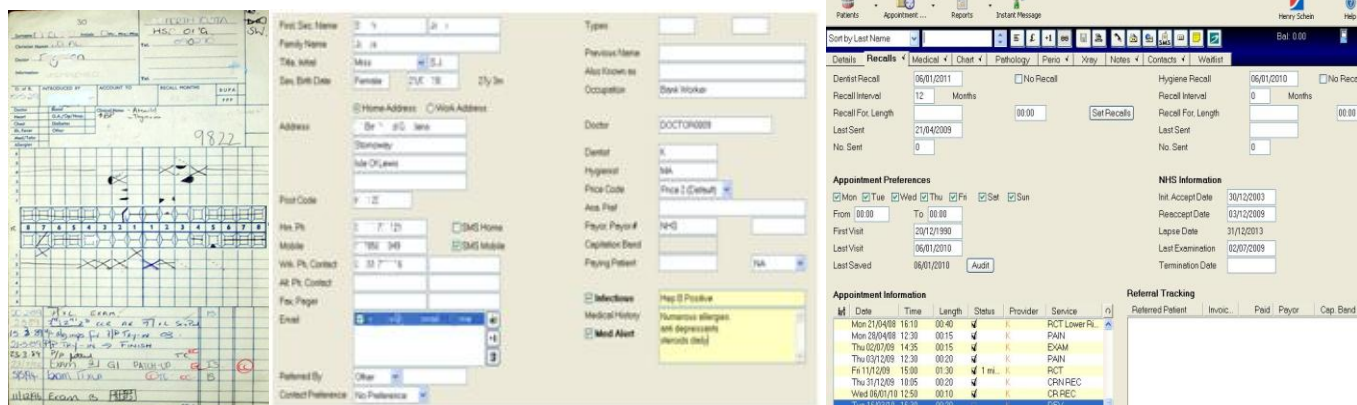
Initial charting when patient is first seen

Current charting

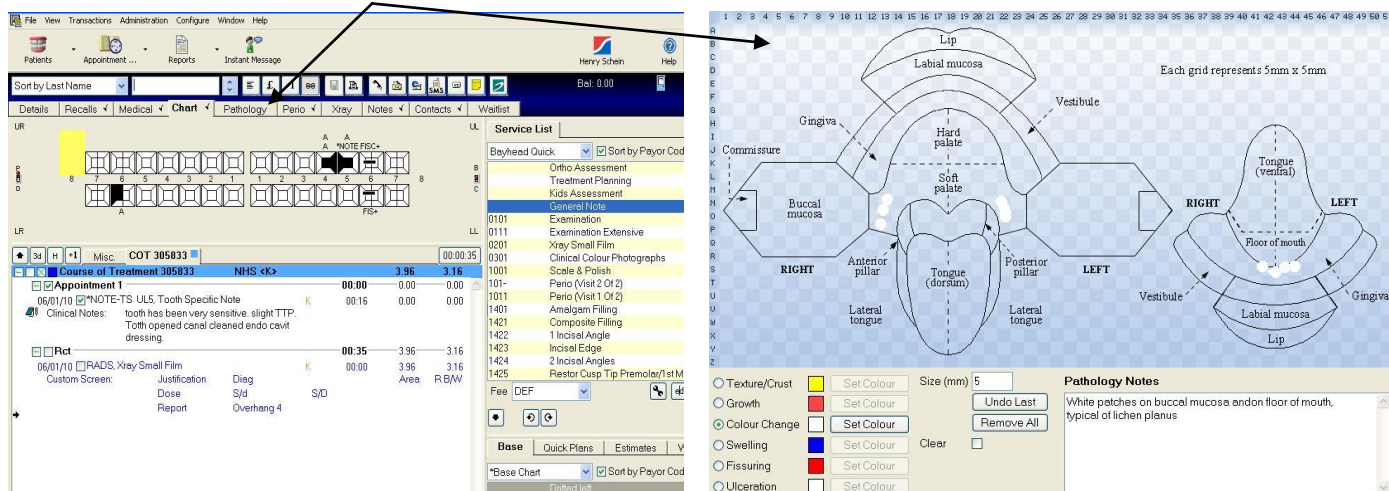
Details of every visit and the treatment carried out.

Details of any pathology that is present in the mouth

The record will also contain any radiographs, referral letters, cost estimates, photographs, location of study models, any letters to or from the patient, any comments made by the patient.



You can see that along the top of the electronic record card are tabs with different windows (pages) that contain different information.



We need to keep records to help plan the best treatment for the patient. The dentist needs to know about a patient's health before considering treatment. It is useful to know what treatment has been tried in the past - was it successful or not. What treatment the patient finds difficult –such as impressions. Is the patient nervous? Does the patient prefer white fillings to metal fillings? Has the patient had a blow/knock/trauma to their teeth that may make them non-vital in the future.

Clinical information about a tooth is very useful for diagnosis or treatment planning. Did the patient have pain before the filling was placed? Was the tooth vital before the crown was made? What was the depth of that periodontal pocket last year? Is the radiolucent area on the x-ray larger or smaller than last year. Good notes of all the treatment given and advice and information given to a patient ensures better treatment for the patient. It can also be useful to explain to a patient why there may be a problem. Sometimes a patient will forget the advice or information given by a dentist and claim they were not told or given a choice. Good records means good dentistry and less chance of legal action against the dentist. A good charting may help identify someone who has died and save the family from that terrible task.



As the patient record cards contain a lot of personal information the cards must be kept in a secure place. Before treatment begins on a patient the assistant must ensure the correct record is available.

Records are usually stored by family name in alphabetical order. If a lot of family names are similar, then they are ordered by given name.

Many clinics manage a recall system that ensures the patient is given a reminder letter/phone call/e-mail/text message to come to the clinic for a routine examination.

Appointment books used to be written neatly in pencil (so that changes can easily be made)

The information required in an appointment book is:

Patient's full name (so that their records can easily be found and be ready before they arrive).

Contact phone number (in case we need to contact them to change their appointment)

What the appointment is for (this allows the clinic staff to have the correct equipment or materials ready)

How long the dentist requires for that appointment (in case the appointment has to be moved to another day or other patients have to be fitted into the appointment book)

Any comments (patient has wheelchair/to be given an estimate of costs/has to be phoned with reminder about appointment)

Computer systems can be used for the appointment book and the receptionist can find any spaces for patients very quickly even when there are a lot of dentists and over 200 patients each day.