

Practice Points

Orthodontic Records: More Than Just Models and Photos

The importance of comprehensive orthodontic records cannot be overemphasized. When we consider the term “records,” the first thing that comes to mind is the initial work-up, which refers to the gathering of information of how the patient presents so the dentist can formulate an opinion (diagnosis). Although the initial records are a vital part of the patient profile, there are other issues in regards to records that all clinicians and staff must consider for diagnostic and medico-legal reasons.

First, the definition of records should be addressed. *The Miller-Keane Encyclopaedia of Medicine, Nursing, and Allied Health, 5th Edition*, describes records as “a permanent or long-lasting account of something (as on film, in writing, etc.).” Based on this definition, orthodontic records should not only include the initial work-up, but all information related to the patient’s treatment, throughout treatment. Permanent means lasting, durable and remaining unaltered. (I am not sure why the hair industry has used this term to add curls to hair!) Paperless practices must consider the definition of “permanent” and follow the recommended guidelines set out by their licensing bodies.

Initial diagnostic records should include a minimum of a patient history (medical, dental), clinical findings, TMJ examination, intra and extra oral photographs, panorex or FMS, ceph and ceph analysis, and study models. From these initial diagnostic records the dentist will come up with a written diagnosis and treatment plan, present it to the patient/parent/guardian and add a signed informed consent agreement and signed financial agreement to the patient profile (i.e. chart).

Progress records include all events including treatment rendered, financial activity, correspondence, and appointment history. This includes documentation of all appointments, including missed or cancelled appointments. If a patient fails to return for treatment, a registered letter must be delivered and a copy filed in the patient record. Correspondence to a third party such as an insurance company, medical doctor, etc. must only leave the patient record with a signed consent from the patient/parent/guardian.

Frequently, when treating orthodontic patients, the treatment requires re-evaluation and the dentist may require updated diagnostic records. The need for updated records (radiographs, models, photos) should be explained prior to the initiation of treatment. I do not recommend additional fees for updated records. A new fee attached to “another x-

ray” may lure the parent or patient to refuse the recommendation and this in turn will affect the dentist re-evaluation of the treatment.

When the dentist feels that the treatment may be coming to an end, it is a good idea to consider a pre-bond work-up to be sure all involved are satisfied with the treatment results.

This may include models (check the occlusion and tooth position), photos, panorex (check the roots) and TMJ examination. It is a clinician’s nightmare to complete a case and find out after the treatment is finished that the case could have been fine tuned.

Final records are also an important part of the patient profile. The day the treatment is finished (or discontinued), models, photos, panorex or FMS, and ceph should be taken prior to the patient leaving the office and retainers inserted. It is imperative to have a record of how the treatment was completed.

If a patient is relocating or being referred to another clinician, the patient’s records may need to be transferred. The most important consideration when transferring records is to get a signed transfer form from the patient/parent/guardian as well as a treatment release. Patient information is confidential and should never leave your practice without written permission. If the patient has not started treatment and the initial diagnostic records are to be transferred, keep a copy and send the originals. If the patient is in treatment, send duplicate records (excluding the dentist’s notes) with a summary of the treatment rendered. The IAO has a transfer form available to members. If the patient would like to take their records, document it in the patient chart.

Orthodontic record keeping is an important part of all of your practices. You can never document too much! Remember, if it isn’t documented, it didn’t happen. How long should you keep patient records? My suggestion is “forever.”



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