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Orthodontic chart documentation

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Comprehensive records for orthodontic patients should include diagnosis, problem list, treatment objectives, treatment plan, treatment alternatives, normal and abnormal clinical findings, description of the treatment rendered, any referrals made, follow-up treatment, and recommendations, as well as documentation of all consultations, financial agreements, and insurance forms. The purposes of the patient's clinical chart are to maintain continuity of care, register procedures performed in an ordered manner, remind the doctor of what was done and what needs to be done, and justify and support the medical necessity of the treatment provided to appropriate parties of interest. Appropriate documentation also includes communications between the orthodontist and other health professionals who are contributing to the patient's care; thus, the dental record also protects the overall legal interest of all interested parties.

Quality orthodontic chart documentation can indicate quality care. Excellent documentation speaks volumes about the orthodontist's competence and organization, which in turn increase credibility. Laypeople are not expected to document treatment, but an orthodontist is expected to keep permanent records of what acts and activities transpired during doctor-patient encounters.[1] In addition to documenting the diagnosis, treatment plan, mechanotherapy, archwires, and elastometrics, there are several strategies on what else to document and what not to. The following strategies are presented to help the orthodontic community more accurately reflect the patient's orthodontic care, whether this documentation is in paper or electronic format. These guidelines should be modified as needed for each practitioner and patient.

1. **Document facts, findings, treatment, and incidences objectively.** Objectively documenting both positive and negative clinical findings is essential and supports the notion that the orthodontist constructed a comprehensive diagnosis and treatment plan before providing orthodontic care.[2] Orthodontic therapy can, on occasion, result in a poor outcome, a dissatisfied patient, or unexpected complications (eg, root resorption, excessive tooth pain or mobility, enamel destruction, periodontal deterioration). Documenting relevant facts without obscurity, humor, sarcasm, or personal comments goes a long way toward supporting one's actions relating to any difficult situations subsequently encountered. Throughout documentation, it is essential to avoid derogatory or disparaging comments about any patient, parent, colleague, or anyone else involved with the patient's care.
2. **Document the patient's chief complaint, diagnosis, signs, symptoms, and all existing conditions.** The patient's chief complaint, diagnosis, all clinical findings from a comprehensive oral examination, as well as interpretations from photographs and radiographs should all be documented. Document existing or deteriorating conditions such as TMD signs or symptoms, gingival conditions, evidence of bruxism, and other findings perceived by the doctor or reported by the patient. The patient should be apprised of these findings to negate the perception that they were caused by the treatment rendered.
3. **Document the pros and cons of all treatment options, including no treatment and the patient's choice.** The treatment plan should address each item noted in the problem list. It is essential to document that the patient or the parent was informed of the ideal treatment plan, all alternative treatment options, a no-treatment option, any probable complications or limitations associated with each proposed treatment plan, and the patient's final choice. This establishes evidence of providing patient-centered care. Patients should always be informed that if the clinical presentation changes in any substantive manner, the treatment plan or the planned outcome may need to be revised during treatment. Any treatment plan alteration during treatment requires documentation of the reason or justification for the change.

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4. **Document obtaining patient informed consent.** In addition to having the patient sign standard informed consent forms, fully disclose and document any specific risks associated with the treatment. The esthetic and functional benefits of orthodontics are more known among laypeople than the risks and limitations. If the proposed treatment is elective, it is even more imperative to disclose and document all probable risks and limitations. Note in the chart that these risks were explained in simple layman's terms. A treatment with a high potential for risks, limitations, or relapse needs to be carried out with caution, and only when the patient voluntarily consents based in a well-informed decision. This documentation proves that a 2-way exchange of information took place. Document that the patient understood and accepted the treatment and was given time to ask questions, and that all questions were thoroughly answered. In all cases, remind each patient that achieving an ideal smile and bite cannot be promised, but improvements can be made. It is prudent to make a note in the chart that the patient's consent was obtained in both written and verbal forms.
5. **Document informed refusal.** Refusing or delaying recommended treatment should also be documented. Rejecting a proposed treatment or choosing an alternative option over an ideal recommended treatment because of cost or any other reason requires documentation. In addition, a patient's refusal of a recommended medical or a dental procedure, along with the probable consequences of that decision, requires documentation. Examples include refusing to allow radiographs to be taken, to consult with a periodontist about periodontal conditions before orthodontic therapy, to extract teeth, or to comply with any medical advice or referrals.
6. **When the patient chooses specific appliances or a treatment course, disclose and document the limitations.** Patients, especially adults, may request a specific treatment such as ceramic brackets, lingual braces, or clear aligners. The improvements in these treatment modalities have been remarkable. However, if there are specific limitations or risks suspected with any of these methods, the patient must always be informed. If a patient requests a specific treatment in contradiction with the orthodontist's recommendation, the orthodontist has 2 choices. The first is to acquiesce. This obviously cannot be done if the treatment will result in harming the patient. The patient cannot consent to or allow the doctor to perform negligent treatment. The second alternative is for the doctor to refuse to treat the patient, citing practitioner autonomy as the basis for that decision. All of this requires accurate and careful documentation.
7. **Record all entries accurately and in a timely manner.** The patient's chart is a legally recognized document of every encounter between the patient and the doctor, including treatment provided to family or staff on a pro bono basis. Failure to document every encounter could lead to questions about other relevant omissions. The veracity of the entries in a patient's record should never be in question. Entries should be timely, comprehensive, accurate, clear, and trustworthy. Avoid excessive or ambiguous abbreviations, especially if not commonly used. Notes should be written so that others can understand them, especially orthodontists. Entries into the chart should be made contemporaneously when the services or consultations were rendered. Late or erroneous entries should be clearly identified as such, including the correct time and description of services rendered. It is better to add an amendment to an entry rather than to delete or change an entry. Alterations to the patient's paper or electronic chart made after the fact to hide mistakes or add facts are fraudulent and carry significant consequences both civilly and administratively.
8. **Document the thought process and the reason or rationale for taking actions.** Careful assessment and documentation of actions undertaken, including extenuating circumstances and any rationale behind them, are important.[3] The addition of a few words about the thought process can improve documentation and justify the actions, especially in complex and interdisciplinary cases. Short statements usually suffice. Examples might include the following: the severe dentoalveolar protrusion requires premolar extraction; the continued worsening of the oral hygiene with no treatment progress justifies treatment termination; and so on.
9. **Document treatment progress and next-visit observations.** It is valuable in complex cases, or in those requiring significant tooth movement, to document how the case is progressing, especially if photographs are not taken. For example, document occlusal relationship improvement, reductions in spaces and overjet, resolving of

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