



RISK MANAGEMENT: A practical guide for dentists

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The information in this syllabus is obtained from sources generally considered reliable, but accuracy and completeness are not guaranteed. While this information does not establish the standard of care, its purpose is to reduce the potential for patient injury and as such may be useful in your clinical practice. Variations from the recommendations in this syllabus may be made in accordance with the clinical judgment of the clinician.

An introduction to risk management

1

The basics

Risk management is the identification, control and prevention of risks that can have an adverse effect on patient care. The goals of healthcare risk management are always to improve the quality of patient care and reduce the frequency and severity of malpractice claims.

Malpractice claims

National data indicates that the most common dental malpractice claims include the diagnosis and treatment of infection, delay in diagnosis and treatment of periodontal disease, procedures performed on the incorrect tooth, paresthesia secondary to third molar extraction, and the operative management of temporal mandibular disease (TMD).

From patient to plaintiff

Any patient can become a malpractice plaintiff with sufficient motivation. A patient can sue for any reason. Some of the most common reasons include dissatisfaction with the result of treatment, financial incentives, a dentist criticizing the care provided by

a previous dentist, unrealistic patient expectations, problems with patient-dentist communication, a poor or negative attitude on the part of the dentist in dealing with patients, or patient anger with the dentist or staff. When these issues arise, communication between dental care providers and their patients is critical.

Communication tips for dental care providers:

- Do not make excuses.
- Try not to react defensively.
- Do not mislead the patient or family.
- Offer an apology.
- Answer any questions.
- Maintain open communication.

Dental charting and electronic records

Detailed documentation is vital in providing quality patient care and reducing malpractice risk. A guiding precept for charting is if it isn't in the chart, it didn't happen.

Dental charting techniques

Everyone in a practice should follow good dental charting and organization techniques. All entries in the chart should be legibly handwritten. All handwritten chart entries should be dated and

signed with either the first and last initials or the full name of the writer. The chart notes should be done in a timely manner and recorded in chronological order within the chart. Never use sticky notes; make your entries permanent in the record. The patient's name and any medical alerts should be on every page.

Dental chart entries

The dental record should be an objective record of facts, impressions, clinical judgment and treatment. Your entries should be detailed enough that anyone with similar experience would be able to read your notes and understand the treatment provided or planned and why. Inappropriate charting, such as pejorative, insulting or subjective remarks or acronyms, should be avoided.

Correcting charting errors

If the chart needs to be corrected, the proper way is by drawing a single line through the error, adding the correction, and dating and signing the change. If information was omitted, an addendum may be added after the most recent chart entry. You should never obliterate, cut out, erase, overwrite or squeeze words into an existing chart entry. By doing so, you run the risk of alleged fraudulent chart tampering.

Retention of dental records

The 6/10/21 rule should be followed as the minimum standard for retaining dental records: six years from the date of patient death, 10 years from the date of the last patient visit for an inactive patient, or 21 years from the date of birth of a child to whom you provided pediatric care, or care to a pregnant patient. The same guideline applies to the retention of X-ray films and other imaging studies. Appointment books should be kept for a minimum of 10 years. The records of a potentially litigious patient should be saved indefinitely.

Clinical issues

Health history questionnaires

Every patient chart should include a health history questionnaire completed by the patient. This is a valuable supplement to the oral history obtained by the clinician at the first visit. New patients should fill one out at the first visit and then update annually.

Allergies/adverse reactions

Positive or negative allergies and adverse reactions

to drugs, foods, iodine, radiographic contrast or other substances should be prominently noted in the chart and should be updated at each subsequent visit. Medications should not be prescribed or refilled without first pulling the chart and checking for a patient allergy. For after-hours service, covering for another dentist, and on-call prescriptions and refills where the chart is unavailable, the patient should be asked about any known allergies, adverse reactions and potential interactions with other drugs before providing prescriptions or refills.

Medications

All medication orders or prescriptions should be clear and specific to avoid confusion and tampering. For example, if a prescription is written with no refills, spell out "zero" refills on the script to keep the patient from fraudulently putting a 1 in front of the zero to make it a 10. If a medication causes significant side effects, the patient should be cautioned, and the warning should be documented in the chart. Prescription pads and schedule drug samples should be secured away from patient access to prevent theft or prescription forgery.

Charting should include:

- The name of the drug prescribed (i.e., penicillin)
- The strength (i.e., 500 mg)
- Dosage and time intervals (i.e., one tab every 12 hours for 10 days)
- Number of tablets (i.e., 20)

Diagnostic testing reports

Many malpractice cases result from diagnostic studies not seen and acted upon, such as reports from biopsies of lesions sent to pathology. A system such as a log or tracking system should be maintained for outside diagnostic studies to ensure that reports are received. The log or tracking system should note the name of the patient, the test and the date the test was ordered. When the report returns to the office, the log or tracking system is checked off. The dentist should review and initial all diagnostic study reports prior to filing in the chart. Any needed follow-up should be documented in the chart and a chart note should be made when a patient is informed of test results.

Telephone care

All substantive, clinically related telephone contacts such as prescriptions, refills, test reports, recalls or patient problems reported by phone should be noted in the chart. As much as possible, dentists should avoid diagnosis and treatment by telephone unless the patient's dental history is sufficiently well known to the dentist. If, in the judgment of the dentist, a provider must see the patient, it can be perfectly appropriate to refuse to provide telephone treatment and insist that the patient be seen in the office or referred to the emergency room.

Informed consent

You are required by law to obtain informed consent to treat your patient. Some of the more common informed consent claims in dentistry include lack of consent, paresthesia, endodontic complications and periodontal disease. The key elements of informed consent are having a *PARQ* dialogue with the patient, use of a procedure-specific consent form and documentation in the chart.

PARQ refers to the *procedure*; any *alternative* treatments, including delaying treatment or nontreatment; and the potential *risks* and complications of the procedure. These must be discussed with the patient and all *questions* must be answered. An appropriate note about the *PARQ* dialogue should be made in the chart. The dentist has an obligation to advise the patient of the ideal treatment plan — not just the plans the patient can afford or that are covered by insurance or a managed care contract. For commonly performed procedures or therapies with significant potential *risks*, a consent form specific to that particular treatment should be completed, signed by the patient and filed in the chart. Consent forms are available at no charge on our website.

Informed refusal

Many informed refusal cases arise out of instances such as when a patient refuses to follow up, refuses treatment for periodontal disease or refuses X-rays. When a complication arises, the patient then claims they were not told of the potential complications that could occur if treatment were refused.

If a patient refuses treatment, the dentist should inform the patient of the potential risks and complications of refusing treatment and document the chart accordingly. If a patient rejects a treatment

plan because of cost, document the chart using quotation marks. For cases of serious potential risks and consequences from refusing treatment, the patient should be asked to sign a refusal of recommended treatment form.

Practice management

Dental office staff tasks

To help avoid malpractice and poor patient relations, the office staff should always create a favorable first impression with the patient, use good telephone manners, exercise discretion and confidentiality while discussing health or financial information, ensure that telephone messages for the provider are handled in a timely manner, use good appointment triage and patient scheduling, observe the reception area for problems, demonstrate respect for patients, be sensitive to patient dissatisfaction and report it appropriately, and create a favorable last impression.

Office staff and malpractice insurance

The malpractice insurance of the dentist or practice covers all employees of the insured. The dentist and employees share the policy limits. The employees are covered only for their usual and customary duties performed within the scope of their employment.

Billing and collections

Some malpractice claims are filed in retaliation for collection actions. Before sending an unpaid bill to collection, the dentist should review the chart for any mitigating circumstances before approving collection. To reduce the possibility of a surprise retaliatory malpractice suit, the collection agency should be instructed to file no collections lawsuits without the dentist's permission.

Dismissing patients

The unilateral discharge of a patient without sufficient notice or notification of alternative sources of care is grounds for an abandonment claim or a complaint to the local or state dental society.

Generally, you may terminate your relationship with a patient at any time and for any reason. However, you may not discharge certain patients without first making arrangements for someone else to provide the care. You also cannot discharge a patient for

discriminatory reasons, i.e., because of race, religion, national origin, disability, age, sex or any other protected socioeconomic status.

Remember that patients with a chronic but stable health problem or handicap may be disabled under federal or state anti-discrimination laws and should not be terminated from your practice by reason of their health problem or handicap.

For circumstances in which you can terminate the dentist-patient relationship, you should send a letter setting the date of termination at 30 days from the date of the letter and inform the patient that emergent care will be provided for the next 30 days. Refer the patient to other dentists via the yellow pages or dentist referral service, and offer to provide a copy of the chart to the new dentist. Send the letter by regular and certified mail with return receipt requested and file a copy of the letter in the chart. You do not need to indicate in the letter why you are terminating care. You do need to indicate why in the chart notes.

Conclusion

Focusing on the quality of care you provide your patients, the rapport you establish with them, thorough chart documentation and attention to administrative detail will reduce your malpractice risk.



After reading *An introduction to risk management*, please proceed to:

Exam/Module 1 before moving on to the next chapter.

Note: You cannot move forward without completing and passing the exam. If you exit the program before completion, you will not be able to enter a previous chapter.

Exam/Module 1: An introduction to risk management

1. A patient can go from patient to plaintiff for which of the following reasons:
 - a) A dentist criticizing care given by a previous dentist
 - b) Financial incentives
 - c) Problems with patient-dentist communication
 - d) Unrealistic expectations
 - e) All of the above

2. Everyone in the practice should follow good charting techniques. Which of the following should never be done?
 - a) Entries should be detailed and thorough.
 - b) A single line should be drawn through an error.
 - c) Entries should be timely and in chronological order.
 - d) Addendums should be posted on sticky notes.
 - e) None of the above

3. Medication orders and prescriptions should be clear and specific to avoid confusion and tampering. For example, if the prescription is written with no refills, spell out “zero” refills on the script.
 - a) True
 - b) False

4. The doctor has an obligation to advise the patient of the ideal treatment plan — not just the plans the patient can afford or that are covered by insurance.
 - a) True
 - b) False

5. Some malpractice claims are filed in retaliation for collection actions. Before sending an unpaid bill to collections, you should:
 - a) Confront the patient
 - b) Review the chart for mitigating circumstances before approving collections
 - c) Send the patient a warning letter
 - d) Instruct the collection agency to file no collection lawsuit without the dentist’s permission
 - e) A and C
 - f) B and D
 - g) All of the above

Patient communication

2

Four pearls of wisdom

- Communication is always key.
- It's always about the money.
- If it isn't in the chart, it didn't happen.
- Practice informed consent — PARQ.

Preparing your patient from the beginning

Setting the stage

We believe the best strategy for dealing with patients is to prevent unwanted behavior by communicating office policies and expectations about the dentist-patient relationship early on. In addition, patients are quick to complain to the state licensing board if they cannot promptly speak, or think they cannot speak, to the dentist. The following tips may help establish a positive, healthy relationship from the start.

Practice tips for your patients

- Send new patients a Welcome to the Practice letter and let them know that you are available by phone.
- Make sure patients understand that you will usually be in the middle of a procedure when they call; have your staff arrange for a convenient time for you to call the patient back.

- Refer the patient to your website or provide an informational brochure about your practice that includes:
 - › Short biographies of you and your staff members
 - › Basic services provided by the practice
 - › Office address and hours of operation
 - › Phone numbers, including main number and appointment line, if different
 - › Instructions regarding after-hours care and prescription refills
 - › When to call for an appointment and when to go to the emergency room
 - › Patient rights and responsibilities, including missed appointments, tardiness and billing
 - › Basic rules of behavior, including child supervision in the reception area
 - › Guidelines addressing the use of email for communicating with the dentist and staff, including expected response time
 - › A map locating the practice
- Discuss fees and financial arrangements before treatment.
- The dentist, not the staff, should deal with the patient's dissatisfaction with treatment.

- Handle patient problems and concerns immediately.
- Seek help from your malpractice carrier.

Practice tips for your staff

In addition to making sure patients understand expectations, it is important to make sure that everyone in the practice is on the same page. Encourage staff to participate in creating a safe patient-care work environment.

- Make sure that everyone in the practice is familiar with the information provided to patients on your website, in brochures and in other documentation regularly provided.
- Define inappropriate behaviors so that everyone understands what is acceptable and unacceptable. Inappropriate behavior might include:
 - › Manipulative behavior
 - › Demeaning language or actions
 - › Swearing
 - › Threatening language or actions
 - › Making sexual advances or using suggestive or vulgar language
- Provide staff with training and strategies for dealing with inappropriate behavior when confronted with a difficult situation.
- Implement a system or chain of command to handle difficult patients.
- Make sure staff members understand that they should refer difficult situations to the person who is equipped to address the problem.
- Document behaviors objectively.
- Assure your staff that they will be listened to, that situations will be addressed and that staff will be supported when appropriate.
- Use conflict resolution strategies to help prevent escalation.

Just say “no”

Finally, recognize and accept that there are limits to what can be done for patients. It is appropriate and advisable to say “no” to a patient who is asking you to do something that is outside your limits of expertise or level of authority. Beware of patients who want to direct their own care.

When setting limits from the start just isn’t enough

While clear and early communication can prevent a lot of unwanted or inappropriate behavior, sometimes you will be faced with the stress of a difficult patient situation. Frequent lateness, aggressive behavior, drug-seeking behavior and noncompliance to dental advice are among the challenges commonly faced in dental practices.

Additional red flag behaviors we see include:

- Using dental terminology
- A parent making treatment or financial decisions for adult children
- Seeing multiple dentists — a dental office “shopper”
- Refusing to pay for new X-rays, comprehensive exam, etc.
- Only wanting temporary treatment or treatment to get out of pain
- Taking notes or keeping a diary
- Being rude or threatening to staff
- Dictating their care to you
- Having been terminated by previous dentist(s)
- Wanting care that you don’t provide
- Wanting special appointments
- Wanting special billing arrangements
- Wanting special handling
- Missing appointments

Also pay attention when something just doesn’t feel right — your experience and instincts can often identify problem patients even before you notice specific red flag behaviors.

Family members also may challenge every recommendation you make. These situations call for a well-planned response to avoid a drain on time and energy, as well as further erosion in the dentist-patient relationship.

Consideration should be given to whether to continue treating the patient. However, in some cases, terminating the patient relationship may not be a viable option. For example, the patient may have an acute condition that requires treatment — and no other provider in your area agrees to accept the care of the patient.

Effectively working with difficult patient-care situations requires a team effort. We recommend that dentists consult with all members of the patient’s dental care team to develop a management

plan. In some situations, it may be prudent to consult with a patient's guardian, caregiver or other individual involved in decisions relating to the patient's dental and healthcare.

The following are some additional strategies to consider when addressing these situations. These recommendations are geared toward helping the dental care team manage the patient relationship professionally.

- Clearly identify and define the noncompliant or inappropriate behaviors.
- Develop a strategy for stopping or modifying the behavior. Clearly define the objectives of the strategy for later reference.
- Make sure the patient receives a consistent message from everyone on the team, including front office staff.
- As a part of the plan, identify a “point person” — someone who can oversee and coordinate communication and dental care team efforts to work with the patient.
- Consider using a patient care agreement to ensure patient understanding of expectations, including what is acceptable and what is unacceptable.
- After a period of time, evaluate whether implementation of the strategy is working. Are the goals and objectives previously identified being met? Is there improvement in the patient care relationship?
- Modify the strategy as necessary.

Patients who refuse your recommended treatment plan

Examples of patient noncompliance include:

- The patient who can't afford the recommended treatment and is having it done piecemeal.
- The patient who only comes in on an emergent basis.
- The patient who won't get films, prophylaxis, etc., as needed.
- The patient who declines referrals to specialists, oral exams, periodontal care and pain medications.

The noncompliant patient can be the least reliable and the most litigious. These patients frequently will have a limited memory of the actual treatment plan recommended and the care provided. They will

not “remember” your warning regarding a lesser treatment plan when your predictions come true. At some point you will stop giving in to the patient's demands or treatment refusal and your parting will not be amicable. If the patient is treated by a subsequent provider, that dentist may be critical of the initial care rendered, not knowing the full circumstances surrounding the initial treatment.

What should you do?

Document! Document! Document!

It is imperative to fully document the treatment advised; the risks associated with the treatment, lesser treatments or no treatment; the discussion with the patient and any questions asked; and the consent process. If the patient elects a lesser treatment, fully document your treatment, observations, concerns and conversations with the patient during each visit.

If the patient refuses the treatment, objective details of the patient's refusal, including the patient's comments in quotes, should be documented in the patient's chart. And finally, you should have the patient initial or sign either the chart or a refusal form.

Your patient has an adverse outcome: Now what?

One certainty in dental practice is that there will always be a percentage of cases where treatment does not result in the perfect outcome. Regardless of the clinical expertise of the provider, adverse outcomes and unexpected results can and do occur. Most often, these events are not the result of substandard care or malpractice but are the known potential risks or complications associated with the procedure, test or treatment.

Patients have high expectations and are understandably disappointed when adverse outcomes are the result. However, a claim or lawsuit is not the predestined result of a complication with care. Experience has shown that how the dentist responds to the event has the greatest impact on whether the matter will result in a claim.

The following guidelines should assist dentists in dealing successfully with patients who have experienced a less-than-perfect result:

Communicate

As soon as possible, fully inform the patient of the complication using language the patient understands. Provide a basic outline of what has occurred, avoiding overly technical terminology. Certainly, communicating this information to the patient is much easier if good informed consent was obtained prior to treatment. Good informed consent allows the dentist to open the conversation with a statement such as, “Well, unfortunately one of the potential complications we discussed did occur. Now this is where we go from here.”

Be open and available

Do not avoid the patient or the patient’s family members. Avoiding difficult situations is a natural human reaction, and sharing bad news about an adverse outcome or complication in treatment is difficult. It is equally true that patients typically react better than anticipated. With an appropriate explanation, patients can understand and accept that bad outcomes do occur.

What they do not accept is poor communication. A dentist who communicates poorly after a bad outcome is typically seen as uncaring, and it is the primary reason patients pursue the legal option. Patients want answers and often feel that litigation is their only recourse.

Express your concern

Demonstrate your empathy and concern for the patient. Doing so is not an admission of liability. Your outward expressions of care and concern are extremely important to the patient and can actually strengthen the dentist-patient relationship. Many patients have more confidence in their dentists after working through such an event — because their dentist demonstrated care and concern.

Do not blame others

Do not point fingers at others involved in the patient’s care. Despite your concerns regarding another provider’s treatment, consider whether it is fair and professional to critique another’s treatment without knowing all the circumstances the dentist faced. Follow established procedures for quality improvement and peer review when you have such concerns. Remember it is never useful to place blame or incite the patient. Doing so usually results

in a distrustful patient and a lawsuit rather than a patient ready and willing to focus on treatment for the complication.

Present a plan

Outline for the patient your plan for continued treatment in the near and long term. Let the patient know you have thoroughly considered all relevant options and have a detailed plan if additional treatment is necessary. Remember you are obligated to advise the patient of the ideal treatment plan — not just the one the patient can afford or that is covered by insurance or a managed care contract.

Does the patient understand? After your presentation, question your patient on the key points. Be certain he or she has a clear understanding of what has occurred and what the future course of action entails.

Document

Clearly document your conversations with the patient and family members, their response to the information (use patient quotes with quotation marks, if warranted), and the agreed-upon (or proposed) plan of action.

How to work with a difficult patient

In the middle of a very busy day, you find yourself in the exam room face-to-face with an angry patient who complains about the “attitude” of your front office staff, how difficult it is to see you and how your last treatment was unsuccessful. You have not had any bad experiences with this patient in the past, but it is clear the patient is now agitated and aggressive. Caught off guard, you may feel a bit confused and defensive at first, but as the patient continues complaining, you become angry. What is your plan to deal with this situation? Simply fold your arms, stare at the floor and listen in silence? Aggressively challenge the patient point by point and defend yourself and your staff? Ask the patient to leave your office and never return?

Granted, it’s difficult to fight our natural instincts when we feel we are being attacked. But it is important to remember that, more often than not, the real reasons for this patient’s behavior are often far removed from anything you or your staff did. Often the patient is reacting to a variety of stressors

and you happened to be in the right place at the wrong time — a convenient target. Or maybe the patient is legitimately frustrated about your staff, your treatment or your office policies.

The manner in which you initially respond to this patient's anger will have a great impact on the ultimate outcome of this situation. Regardless of the merit of the accusations, the techniques you employ to deal with this incident are the same.

Here is a list of time-tested techniques for managing conflict:

- Remain calm in tone and posture. An angry patient will tend to mirror your demeanor. Be objective; do not take the anger personally. Expressing an angry or defensive tone will effectively end the communication. There is nothing to be gained by jousting with the patient.
 - Listen, listen, listen. It is important that you try to identify the real issue that is frustrating your patient. Careful listening involves the use of appropriate body language that demonstrates you are focusing on the patient's statements. Nodding, maintaining eye contact and sitting at the same level as the patient demonstrate a caring attitude and help defuse anger.
 - Be patient. Avoid interruptions and do not tell the patient to "get to the point." Some patients take a while to express themselves.
 - Paraphrase the patient's statements back to him or her to confirm that you understand. Periodically repeat back what you have heard until you are satisfied that the patient is finished.
 - Confirm and validate. You can validate the patient's feelings without admitting wrongdoing or agreeing with the patient. Statements such as, "You sound upset about the slow healing of your infection," help communicate your understanding. If it is clear the patient has a valid concern, acknowledge it. The facts are the facts.
 - Be honest. Tell the patient exactly what options are available, what you can do and — most importantly — what you cannot or will not do. If another member of your practice needs to be involved in a decision, let the patient know that you need to consult with that person before providing an answer.
- Follow through. Do not forget promises you have made. The patient will not forget. If you agree to take action, take it.
 - Certainly, all staff should be familiar with these techniques. Designate in advance key individuals within your practice to intervene when these situations develop, either in person or over the phone. If you have one point person, be sure to designate an alternate.
 - Develop a standardized protocol in advance that the entire office knows.
 - › Have a patient informational brochure, website and welcome letter.
 - Have a neutral corner for patients to discuss their concerns. Your personal office can be seen as too intimidating and authoritative. Consultation rooms or the waiting room before or after hours are good neutral areas.
 - Once a patient has created a problem, you need to decide whether this is a patient you would like to rehabilitate or terminate from care. If you choose to rehabilitate the patient, the point person should meet with the patient and explain the practice's expectations. Here are some guidelines for the meeting:
 - › Clearly identify the inappropriate behavior or actions. Explain why the behavior is not acceptable.
 - › Listen carefully to the patient's response to identify any unresolved or previously unidentified issues.
 - › Describe and document your expectations of the patient. Also document the patient's acceptance or rejection of your expectations.
 - › Communicate these expectations to the staff so that everyone is on the same page regarding this patient.
 - › Consider limiting the patient's staff contact to the designated point person to ensure compliance.
 - › Create a "patient contract" or "dental treatment plan" that memorializes the patient agreements. The contract should identify the consequences, such as termination of care, for breaching the terms.
 - › Have the patient sign and date the patient contract, give him or her a copy, and place the original in the chart.

Charting unruly behavior:

- Document the behavior in the patient’s chart.
- Be as clear, descriptive and objective as possible.
- Use patient quotes with quotation marks in the chart.
- Make sure you chart the date and times.

Addressing these issues is important for the overall health of your practice. The time you invest in dealing with these issues will provide many rewards, including office harmony and happier patients.

At-a-glance tips for dealing with conflict

Delivering decisions

- Listen – avoid interrupting.
- Say “yes” or “no.”
- Give a reason.
- Provide alternatives.

Listening to concerns, problems or complaints

- Listen – avoid interrupting.
- Empathize – avoid assigning blame or accepting responsibility.
- Ask what the patient would like done about the problem.
- Tell him or her what you will do.
- Take action or delegate to the appropriate person.
- Follow up.

Revisiting concerns, problems or complaints

- Observe and prepare.
- Greet.
- Empathize.
- Question.
- Share information and identify limits.
- Disengage.
- Refer to supervisor or consult with a colleague.
- Direct the information into problem-solving efforts.
- Explore alternatives.
- Follow through.

Understanding difficult patients

In the delivery of high-quality dental care, dentists are challenged by time demands, business and financial demands, maintaining clinical competence, the erosion of autonomy, and patient demands and expectations. While all of these can be difficult to

manage, few challenges are more frustrating than dealing with a difficult patient. Difficult patients may be routinely angry, demanding, manipulative, controlling, noncompliant or constantly complaining. Unfortunately, these behaviors are not always reserved for private, behind-closed-door meetings but are often displayed in your busy reception area to the dismay of your staff, your other patients and you. Difficult patients can have a negative impact on the dentist, office staff and other patients. Moreover, difficult situations with patients can lead to a breakdown in the dentist-patient relationship – resulting in mistrust, poor communication and perhaps even a malpractice claim.

To terminate or not?

When faced with a troublesome patient, you may want to simply terminate the patient from the practice. However, while termination may be the action that is ultimately necessary, it should not be the automatic response. We strongly encourage you to take some time to work with the unhappy patient. Your goal will be to resolve the immediate issues, communicate your expectations of patient behavior, and discuss how you and your patient will address future problems. If successful, you will have reduced the likelihood that this angry patient will become a plaintiff in a malpractice action, and the patient will see that his or her unacceptable behavior is self-destructive and unlikely to bring about the desired results.

An abusive or threatening patient needs to learn early on in the relationship that these behaviors must not continue. If not addressed immediately, these behaviors often escalate. The verbally abusive patient should improve his or her behavior immediately or be discharged from the practice.

For the patient who threatens, ask yourself: Did the patient physically threaten a member of the healthcare team or was it simply a threat to “file a complaint with a supervisor”? Threats of violence should never be tolerated; immediate dismissal is an appropriate response. If necessary, do not hesitate to notify law enforcement and warn those within your group who may come into contact with this patient.

Why is the patient being so difficult?

Several surveys conclude that patient dissatisfaction commonly stems from patients’ perceptions that they are being rushed through the office visit, that

their concerns are not being addressed, and that the provider has little interest in their problems. Another common source of dissatisfaction is the lack of information regarding treatments, tests or prognosis. This feeling of being “unimportant” or “discounted” is often exacerbated by a long wait in the reception area, followed by a long wait in the operatory before the provider ever appears. In addition, patients often report that staff rudeness and “billing issues” have been the catalysts for an unpleasant exchange.

Other patients may become difficult because of overwhelming fear, high stress, confusion, depression or unrealistic expectations. Even more difficult to manage are the patients afflicted with a personality disorder such as a dependent personality, antisocial personality, borderline personality or addicted personality. For these patients, appropriate referral to mental health professionals or behavioral health specialists may be required to assist you in delivery of care.

How can I prevent a patient from becoming difficult?

One very effective tool to prevent good patients from becoming difficult is patient education — at the beginning of the dentist-patient relationship — regarding office policies and expectations. Efforts to educate patients can dramatically reduce the many misunderstandings that typically occur when expectations, protocols and office policies are not adequately communicated to patients. One way to communicate to new patients is to direct them to your website or through a patient information brochure. This can be used to inform patients about services offered and office policies regarding hours of operation, phone numbers, no-shows and tardiness, after-hours care, prescription refill protocol, billing, and patient rights and responsibilities. In addition, a brief biography of the professional staff creates an instant familiarity that reduces patient anxiety and assists in building rapport. Finally, it is always a good idea to allow additional time for a new patient during the first visit; with more time, you can familiarize the patient with your practice and answer any questions.

To promote consistency in the information provided to your patients, be sure that all of your office staff members fully understand your office policies, expectations and protocols.

Violent or illegal activity

It goes without saying that you have a duty to keep your staff safe. If a member of your staff notifies you of a hostile work environment or of sexual harassment from either a patient or third party (e.g., a delivery person), you must act upon it. Harassment from anyone should not be tolerated.

Communicate with your staff

With a difficult patient, chances are that your staff is already all too aware of the situation. But if you sense that the patient’s conduct may further deteriorate, call a staff meeting to voice your concerns.

Conclusion

The distressing actions of a single patient can sometimes overshadow the fact that the majority of patients greatly appreciate the care they receive.

Border patrol: patient-care agreements

Sometimes repeated communication alone isn’t enough to substantially improve a difficult patient-care situation, and termination of care is not an immediately available or desired option. There is an alternative. You might want to consider implementation of a patient-care agreement to strengthen your dental care team’s efforts to maintain a professional and safe environment. Asking a patient to sign an agreement communicates to the patient that you and the rest of the dental care team are serious about making the relationship work.

A patient-care agreement is a unique contract negotiated between the care provider and individual patient for the purpose of addressing issues specific to that relationship. It should define ground rules for continued care, expectations about future behavior and consequences for failure to comply with the agreed terms.

We have created a sample document for your reference. This document is generic and can be used to address a wide variety of situations.

Sample/Dental care agreement

This document is designed to be used by dental care providers as an example only. This is just one demonstration of how a patient care agreement might look. This document is not intended to be copied and used as is. It is recommended that the terms of agreement be customized by the dentist to specifically address the unique nature of individual provider-patient relationships.

Patient name _____ Date of birth _____

Dentist name _____ Date _____

Dental care requires that the patient and dentist or dental care team work together. This document lays down the rules that I agree will be used by my dentist and the dental care team in providing care to me.

If I do not understand any part of this agreement, I will discuss it again with my dentist. I understand that if I do not fulfill my part of the agreement, the dentist and dental care team will be less effective in helping me and may have to stop treating me altogether.

*The following language is **not** intended to be used verbatim. These terms of agreement are intended to be used as examples only. This section should contain agreements negotiated according to the individual issues affecting specific provider-patient relationships.*

Please read and follow this agreement carefully. Help us help you.

- I agree to arrive on time for appointments. If I am more than 15 minutes late for a scheduled appointment, I will not be seen that day and will need to reschedule.
- I agree to wear appropriate clothing (e.g., shirt, pants, shoes) to my appointments and any time I visit the office/clinic. If I come to the office/clinic wearing inappropriate clothing, I will not be seen or I may be given the option of putting on clothes made available by the office/clinic.
- (Perhaps include a sample clause regarding appropriate times and methods for initiating contact or communication.)

By signing below, I have read and understand the expectations and agree to follow them. I have had my questions answered to my satisfaction. If I feel I cannot honor any part of this agreement, I may notify my doctor now or at any time. I understand that if I cannot live by the agreement, my care with this doctor and clinic may be ended. If this occurs, I understand that an attempt will be made to notify me either in person or at my last known address or phone number.

Patient/legally authorized representative Date _____

Dental care provider Date _____

Sample/Agreement for use of medication in pain management

Patient name _____ Date of birth _____

Dentist name _____ Date _____

Effective pain management requires that the patient and the clinician work together. This agreement is designed to make sure that you understand the rules we will use in your care. If you do not understand any part of this agreement, please discuss it again with your dentist. It is important to understand that if you do not fulfill your obligations in your care, we will be less effective in helping you and might have to stop treating you altogether.

- You must have a primary care provider (PCP). The name of the PCP is _____.
- You may fill your initial prescription at the pharmacy of your choice. However, all refills must be made with the same pharmacy.
- Pharmacy name _____ Phone _____
- You must take your medications as prescribed. If you would like to change the way you are taking your medicine, please discuss it with your provider beforehand.
- You agree to take only your own medication. Do not take someone else's medication, even if you think it is the same medicine. Do not share your medication with anyone else.
- You agree that we will be the only clinicians prescribing pain medication and other controlled substances (narcotics, tranquilizers, muscle relaxants or sedatives) for you. You must let us know about any medicines prescribed for you by other healthcare providers.
- You must agree not to take any street or recreational drugs during the course of treatment.
- You agree to advise us of any over-the-counter drugs, vitamin supplements and herbal remedies you are taking.
- You give consent for on-demand, unscheduled toxicology screening (drug testing).
- Usually we will prescribe enough medication to last until your next visit or next scheduled medication refill date. We will not provide additional refills before then. You are responsible for notifying us at least three (3) days before your narcotic medication runs out. You must call during regular office hours for your refills. Refills for medications are not given on an emergency basis. Refills are not given after hours, on weekends or on holidays.
- Prescriptions are like money. If you lose your medication or the written prescription, it will not be replaced. You will have to wait until your next visit or scheduled refill date.

By signing below, you are agreeing with these rules and agreeing that you have read and understand them. In addition, you are indicating that your questions have been answered to your satisfaction. If you feel you will not be able to honor the commitments made in this agreement, you may notify us now or at any time. If you are not able to live by the agreement, we may need to terminate your care with us. If this occurs, we will attempt to notify you either in person or at your last known address or phone number.

Also, by signing below, you are giving us permission to share this agreement with your primary care provider and pharmacy.

Patient/legally authorized representative Date _____

Dental care provider Date _____

Termination of care

If you have a patient who becomes a “problem patient,” you can terminate your therapeutic relationship with that patient. However, this action should be taken only in extreme or unusual circumstances. If you decide to terminate the relationship, ethically and legally you should write the patient saying you will no longer be his or her doctor and you should provide adequate time to find a new doctor. You also might need to transfer the patient’s dental records to the new doctor.

Some reasons to terminate:

- Failure to follow the treatment plan
- Failure to comply with referrals
- Failure to follow hygiene recommendations
- Failure to keep appointments
- Failure to pay bills
- Failure to cooperate with staff
- The patient sues you

Be aware of language in your managed care plans about dismissing patients. You may need to involve the plan in this process.

Generally, you can terminate your relationship with a patient at any time and for any reason. The exceptions are that you may not stop treating a hospital inpatient, a patient in an unstable condition, or patients from certain special populations or socioeconomic groups. Following these guidelines will protect you from charges of abandonment or discrimination. Be aware that some plans restrict your ability to discharge plan patients. Furthermore, the traditional right to discharge a patient may be subject to new ethical and legal developments. For example, it has been suggested that patient noncompliance is so common that it does not ethically justify a denial of further care. In addition, the Americans with Disabilities Act, passed in 1990, may prevent discharging a patient whose noncompliance is the result of a physical or psychological disorder.

If you decide to terminate the dentist-patient relationship, these guidelines should be followed:

- Notify the patient in writing that you intend to terminate the relationship. You do not have to reveal the reason for the termination.
- Chart the reasons why.

- You can state in the letter that you will continue to provide emergency dental care to the patient for 30 days while he or she looks for another doctor.
- Include in your letter the name and number of a local referral service. This can often be found in the yellow pages under “dental referral and information service.”
- Explain in your letter that you will send a copy of the patient’s dental records and radiographs to the new doctor.
- Send the letter by regular mail and by certified mail with a return receipt requested.
- Put a copy of the letter and the delivery receipt into the patient’s chart.
- Tell the staff.
- Do not take the patient back.

Under some circumstances, a verbal notice may be sufficient, but always document the discussion in the chart. An example might be a patient who frequently moves or has no permanent address.

Informed consent

A dentist has the responsibility to inform and educate patients of proposed treatments and to obtain consent from each patient for specific treatments. The doctor also has an obligation to advise the patient of the ideal treatment plan — not just the ones the patient can afford or that are covered by insurance or a managed care contract.

The process of informed consent includes a PARQ dialogue:

- Explain the proposed Procedure in understandable language and terms.
- Review Alternative treatments.
- Review the Risks of the treatment and the Risks of declining or delaying treatment.
- Allow the patient ample time to ask Questions and make a decision.

If the dentist has a consultation appointment with the patient and explains each component of PARQ, it is not necessary to document PARQ at each subsequent appointment when treatment is provided as long as treatment does not deviate from the treatment plan that the patient originally agreed to.

Sample/Dismissal letter

(Date)

(Patient Name)

(Address)

(Address)

Dear (patient's name):

I would like to thank you for selecting me (or insert the name of your business) to provide your dental care. (Always open with a pleasant statement.) However, it has become apparent, because of a breakdown in the doctor-patient trust relationship, that your dental needs would be better met elsewhere. Therefore, we will have to discontinue your patient care here. (Never include anything personal; best to be vague unless the reason is missed appointments. Otherwise, you may be left to provide a specific answer to the Board.)

In the meantime, (Here, remind the patient to complete any known dental needs and include a reminder for regular exams and cleanings. This is important! It prevents patient abandonment issues.).

A free copy of each of your dental records will be provided to your next doctor upon request by that doctor with a signed release. (You can add that you will provide emergency treatment for 30 days, but it isn't mandatory. Also, remember that a referral is as good as bringing them into the office if they have an emergency need.)

Again, it was a pleasure serving you and we wish you well. (As you started with a pleasantry, end with one.)

Respectfully,

(Your name), DDS/DMD

Watch out for Band-Aids

If a patient — especially a noncompliant patient — chooses a less-than-optimal treatment plan, be sure to clearly explain and document that he or she will not be receiving definitive care. It's important to document that the patient has opted for a Band-Aid and why. Otherwise, if the treatment fails, the patient could place the blame on the dentist later for not making the correct recommendation. Document the need for follow-up after the Band-Aid.

Simplify wherever possible

Patients generally are not familiar or comfortable with dental nomenclature, so when discussing treatment, use dialogue in understandable terms.

- Along with PARQ:
 - › Identify the problem.
 - › Propose a solution.
 - › Discuss the expected result, along with all possible outcomes.
- Use educational materials:
 - › Brochures
 - › Videos
 - › Diagrams

Take the time needed for the patient to be comfortable and to discuss all questions and concerns with you. Have the patient either sign or initial the chart or sign an informed consent form. You can find these forms at the end of this manual.

Document everything!

Informed refusal

If a patient chooses to decline treatment after you have explained your recommended treatment plan, whether it's for something as basic as an exam, radiographs or pain medication, do the following:

- Inform the patient of the risks and complications of the treatment they are refusing, including the risks of delaying treatment.
- If the patient rejects the treatment because of cost, document this reason in the chart with the patient's comments in quotation marks.
- Thoroughly document everything in the chart.
- Either have the patient initial the chart or consider having him or her sign a refusal of treatment form.

The last word

Don't confuse obtaining informed consent with the importance of building rapport with your patients and meeting their expectations. Informed consent is a good vehicle to promote both. Because it provides the opportunity to talk and encourages dialogue, informed consent dialogue also builds rapport and trust.

Aside from meeting legal requirements, obtaining informed consent promotes good practice management and quality of patient care.

The key is to be consistent and to develop a formal process for obtaining informed consent from each of your patients.

Treating the pregnant patient

A great deal of confusion and fear surrounds the topic of when and how to treat pregnant women. Concerns about putting the mother or fetus at risk or possible allegations of negligent care related to birth defects, premature birth, low birth weight or other complications can give dentists pause.

The most recent evidence-based information* indicates that it is important for these patients to be treated during all trimesters of their pregnancy. The CDAF Evidence-Based Guidelines Perinatal Oral Health Consensus Statement reads: "Prevention, diagnosis and treatment of oral diseases, including needed dental radiographs and use of local anesthesia, are highly beneficial and can be undertaken during pregnancy with no additional fetal or maternal risk when compared with the risk of not providing care." In addition, the claims statistics show that there have been very few, if any, meritorious professional liability claims made because of dental treatment rendered during pregnancy.

Pregnancy is not a reason to defer routine dental care or treatment of oral health problems. Pregnant women who do not receive dental care have a higher incidence of self-medicating with potentially unsafe over-the-counter drugs (OTCs) such as aspirin to control pain. An untreated oral infection can become systemic, creating a higher risk for both the mother and fetus.

* CDAF Evidence-Based Guidelines, 2010

Invasive, elective and restorative procedures are permissible during the entire pregnancy for healthy patients. No medical work-up is required before providing dental treatments to healthy patients. If treating patients with diabetic, hypertensive, pulmonary disease or any other disease that compromises the patient or her unborn baby, consult with her prenatal care provider.

Pregnant patients should receive routine prophylaxis to decrease maternal cariogenic bacterial load. Avoid extraction of nonproblematic third molars during the first and third trimesters; it can be too stressful for these patients. Restorative care is appropriate (placements and removals, including amalgams) during all phases of pregnancy.

Radiographs should be used to examine, diagnose and treat your pregnant patients during all trimesters of pregnancy. As with any patient, pregnant patients should be protected with a lead apron and thyroid collar and exposed to proper levels of radiation. We do recommend keeping radiographs to a minimum by filming problem areas only. If the patient is a first-time patient or has obvious signs of decay or pain, more films may be necessary. If the patient is an established patient with low risk of decay or has had recent films, waiting until the second trimester or even after pregnancy to take additional films is recommended.

Patients can be more anxious during their pregnancy and may be good candidates for nitrous oxide. Nitrous oxide has impressive safety results and is excellent for providing minimal and moderate sedation for apprehensive dental patients. Note that pregnant women have lower minimum alveolar concentration (MAC)** so they will require less nitrous.

The CDAF Evidence-Based Guidelines recommend the following: “Prior to planned use of nitrous oxide/oxygen during dental treatment, consultation with the patient’s obstetrician or maternal-fetal subspecialist is recommended to check for pulmonary concerns ...”

Avoid prolonged dental treatments (appointments should be shorter) and nitrous oxide exposure. In addition, avoid positioning the patient on her back during the third trimester to prevent postural

** MAC a measure of the potency of inhalation anesthetic agents

hypotensive syndrome. Instead, position the patient in a semi-reclining position and encourage frequent position changes or place a small pillow under her hip.

Make sure you go through the proper informed consent process, as you would with any patient. Have a thorough PARQ conference, use procedure-specific consent forms, and document the consent process and any educational materials given to the patient. Keep the patient fully informed of all procedures during every visit, inviting good dialogue and questions from the patient.

Conversely, if the patient refuses a procedure, inform her of the risks and consequences of refusing, postponing or choosing a lesser treatment and document everything in the chart.

Medically there is no reason to deny care to a patient because she’s pregnant, and if you do deny care for this reason, you could be increasing your liability risk. If you are uncomfortable treating a pregnant patient, make sure you refer her to another provider for care.

Providers and interpreters: Working with patients with limited English proficiency

All patients are entitled to confidential, effective communication and fully informed consent. For many healthcare providers, this means developing strategies for working with patients for whom English can be a challenge.

The DHHS Office of Civil Rights has concluded that inadequate interpretation for patients with limited English proficiency (LEP) is a form of prohibited discrimination on the basis of national origin under Title VI of the Civil Rights Act of 1964. Over the past few years, the Civil Rights Division of the U. S. Department of Justice has been charged with coordinating, reviewing and enforcing rules established to ensure that LEP individuals have access to essential services. In addition to the Civil Rights Act, a variety of state and local laws apply to LEP individuals.

One or more of these laws will require you to provide a qualified interpreter or auxiliary aids to ensure effective communication at no cost to the patient. In addition, your ability to continue receiving federal or state reimbursement may be affected by your

compliance with these laws.

People with LEP may be defined as individuals with limited ability or an inability to speak, read or write English well enough to understand and communicate effectively in normal daily activities. The client decides whether he or she is limited in his or her ability to speak, read or write English. This includes people whose primary language is not English as well as those who may have hearing, sight or speech limitations.

Who decides what aid is necessary?

While the patient decides whether he or she is limited in his or her ability to speak, read or write English, the provider, in consultation with the patient or patient's representative, determines what strategies are necessary to communicate effectively.

If an interpreter is not immediately available, can I ask that the appointment be rescheduled?

In many cases, yes. However, if the patient would suffer because of the delay, you will want to have an alternative strategy available. The laws require "timeliness." Though there is no specific definition of "timeliness," the nature of the consultation and the urgency for treatment are factors that must be taken into consideration. A delay should not take place if the delay would reasonably deny the patient access to quality care. For emergent needs, when it is not possible to have an interpreter assist in person, resources such as Language Line Services, which has interpreters available on a 24-hour basis, can be used.

Can we ask the patient or the patient's representative to bring in a family member?

Family members or friends should not be used unless the patient so chooses and only after you advise the patient of your obligation to provide an interpreter at no cost to the patient. While patients may be comfortable with family members, it is important to remember that a family member may not have appropriate skills necessary to convey complicated healthcare information. There also may be situations in which the family member could have a conflict of interest.

Are we obligated to use an interpreter selected by the patient?

No. You are not required to use an interpreter designated by the patient. You can require the patient use a qualified interpreter selected by you.

Who pays for the interpreter?

The provider or practice cannot charge the patient for interpreter services. Patients must be fully informed of the availability of a qualified interpreter at no cost to the patient. Some providers who care for Department of Social and Health Services patients do qualify for reimbursement. However, coverage varies, and you should not rely on reimbursement without first contacting the DSHS Medical Assistance Administration.

How do I identify a qualified interpreter?

Check your state's guidelines for identifying qualified interpreters and translators, in both foreign languages and American Sign Language. Through a certification process, interpreters and translators are tested to demonstrate communications proficiency in both English and the other language. Good sources of referrals also can be found in hospitals and at local public health offices.

Where can I learn more about LEP?

We have put together a list of websites to help you identify resources and develop policies for working with LEP patients.

Beware the literacy gap

Communication mishaps between dentist and patient can have a profound effect on treatment and can increase the risk of a malpractice lawsuit.

The early days

In the 1960s and 1970s, effective communication assumed increased legal significance with the recognition, state by state, of the informed consent doctrine. This new cause of action made it possible to sue dentists for not adequately disclosing information to patients concerning significant risks and complications, benefits and alternatives related to a proposed treatment or procedure. Failure to give the patient enough information to make a reasonably informed decision could subject the dentist to liability for harm or injury, even though the treatment or procedure was clinically appropriate and performed properly.

In essence, informed consent laws meant that dentists had a legal obligation to act as effective patient educators. In 1972, in an often quoted and influential opinion, a federal judge wrote that only an "exceptional" patient cannot comprehend a

United States federal government websites:

- Interagency Working Group on Limited English Proficiency, www.lep.gov
- The Office of Minority Health Resource Center, www.minorityhealth.hhs.gov
This link provides a list of resources related to minority health issues
- U.S. Department of Justice, www.usdoj.gov/crt/cor/13166.htm
A comprehensive collection of federal legislation related to LEP
- www.justice.gov/crt/about/cor/Pubs/ISpeakCards.pdf
A printable flashcard that can help providers identify which language a patient speaks
- Federal Citizen Information Center, <http://www.usa.gov/multilingual/index.shtm>
- U.S. Food and Drug Administration, Center for Food Safety and Applied Nutrition, www.fda.gov/Food/default.htm
Documents about basic nutrition and health information available for download in many foreign languages
- Office on Women's Health, www.womenshealth.gov/publications
Patient information available in some languages

Other resources:

- Language Line Services, www.language.com
- National Council on Interpreting in Health Care, www.ncihc.org
- Diversity RX, www.diversityrx.org
Resources on cross-cultural healthcare including translation, interpretation and other issues

nontechnical explanation of therapy alternatives, goals and risks, adding that so informing the patient hardly taxes the doctor.

Though the imposed informed consent responsibilities may not have been unduly taxing in 1972, today's task of adequately informing and advising patients is not so easy. National illiteracy is a communication obstacle that should not be overlooked.

The impact of illiteracy

Two highly touted 1990s literacy studies suggest that the general English-speaking population comprehends the written and spoken word at a low level. The landmark 1993 National Adult Literacy Survey found that 40 million to 44 million adult Americans are "functionally illiterate," meaning they were determined incapable of performing tasks such as reading a note from a teacher or instructions on a prescription label. An additional 50 million adult Americans are only slightly better off, possessing "marginal" literacy skills. It is estimated that 16 percent to 20 percent of high school graduates lack reading skills sufficient to cope with everyday situations.

A new way to communicate

The implications are important. Dentists and their staff are well advised to:

- Ensure that any patient-education materials, including handouts, pre-op and/or post-op instructions and consent forms, are free of unnecessary dental jargon. Necessary dental terms should be defined in simple, ordinary language. For example, "caries" should be "cavities," a "radiograph" should be an "X-ray" and so on. Remind yourself and your staff that even highly educated patients may be totally unfamiliar with dental terms.
- Use plain language when explaining clinical issues to patients. If a patient displays a sophisticated dental vocabulary or understanding, you can instantly adjust the level of discourse.
- Use pictures, diagrams and anatomical models whenever possible to assist a patient's understanding. Many patients pretend to understand more than they do, perhaps because they are embarrassed to admit that they don't know something, such as what an amalgam is.

Conclusion

Numerous studies indicate that patients who have a genuine understanding of a procedure or treatment, including its risks, are much more accepting of the truth that complications can and do occur even with the best of dental care. Taking extra care to explain dental concepts using basic, everyday language is not being condescending. Rather, this type of communication is effective and efficient — something greatly valued by patients, whether they say so or not.



After reading *Patient communication*, please proceed to:

Exam/Module 2
before moving on to the next chapter.

Note: You cannot move forward without completing and passing the exam. If you exit the program before completion, you will not be able to enter a previous chapter.

Exam/Module 2:

Patient communication

1. From the very beginning, preparing your patients for their best experience with your practice is essential. Effective ways to educate your patients are:
 - a) Provide an informational brochure about your practice.
 - b) Develop a practice website.
 - c) Send patients a Welcome to the Practice letter.
 - d) Require all new patients attend a new patient educational seminar.
 - e) A, B and C only
2. If your patient has an adverse outcome, the best plan is to:
 - a) Cross your fingers and hope things get better on their own.
 - b) Have an open conversation with the patient as soon as possible, and if appropriate, present a treatment plan and document everything in the chart.
 - c) Notify the patient of errors by other providers, so they can direct their anger appropriately.
 - d) Dismiss the patient from your practice, offering 30 days of emergent care.
3. The noncompliant patient can be the most unreliable and the most litigious. When treating this patient, you should:
 - a) Document the treatment advised, alternative treatments, risks and the patient's questions.
 - b) If the patient elects a lesser treatment, fully document the treatment, observations, concerns and conversations with the patient during each visit.
 - c) If the patient refuses treatment, document the details of the refusal and note patient's comments in quotes.
 - d) All of the above
4. A patient care agreement is a unique contract negotiated between the care provider and the patient for the purpose of addressing issues specific to that relationship. It should:
 - a) Include the provider's home phone number for contacting the provider after hours.
 - b) Define ground rules for continued care.
 - c) Include the patient's authorization to share the agreement with the patient's insurance carrier.
 - d) All of the above
5. Effective pain management requires that the patient and doctor work together. Patient noncompliance with an Agreement for the Use of Medication in Pain Management is a sufficient reason to terminate the dentist-patient relationship.
 - a) True
 - b) False

6. You may dismiss a patient from your practice for many different reasons. Which of the following do you need to do when dismissing a patient?
- a) Send the patient a letter using certified and regular mail.
 - b) Provide emergent care for 30 days.
 - c) Offer copies of the chart to the new provider.
 - d) Tell your staff.
 - e) Tell the patient why you are dismissing them.
 - f) All of the above
 - g) A through D only
7. Invasive, elective and restorative procedures are not permissible during the entire pregnancy for healthy women.
- a) True
 - b) False
8. To avoid postural hypotensive syndrome, pregnant women should be:
- a) Only treated in the first two trimesters
 - b) Given nitrous oxide
 - c) Placed in a semi-reclining position, encouraged frequent position changes or given a pillow under the hip
 - d) All of the above
9. A variety of federal and state laws require you to provide limited English proficiency (LEP) patients with an interpreter or auxiliary aids to ensure effective communication. The interpreter or auxiliary aids must be provided at no cost to the patient. Who decides if an interpreter or other aid is necessary?
- a) The patient makes the decision.
 - b) The provider makes this decision, but only after consulting with the patient or patient's representative.
 - c) Only an independent interpreter is authorized to make this decision.
 - d) None of the above
10. Is the provider obligated to use an interpreter selected by the patient?
- a) Yes
 - b) No

Practice management

3

Risk management for office personnel

Office staff can play a major role in reducing the risk of malpractice claims. The following guidelines are for office personnel to help reduce the risk of a malpractice claim:

Do not play doctor

Although most staff members know that only licensed dentists can diagnose patients, some do not realize that well-intentioned remarks can be interpreted as dental advice. Since patients tend to take seriously anything they are told in a dental setting, the staff should not volunteer opinions or comment on treatment.

Stay within the limits of delegation

All delegated duties should be performed under the dentist's supervision by an individual qualified to carry them out. A protocol should be established if feasible and practical.

Respect patient privacy

Information about a patient should never be given on the telephone unless the identity of the caller is known. If you are unsure of the caller's identity, you may want to obtain a phone number and return the call. A patient's written authorization for the release of information should be on file before details of any dental treatment are disclosed. However, in some

instances, a written authorization is not practical, such as when you receive an emergency phone call from a dentist or hospital requesting information on one of your patients. Use your best judgment. Patient care is almost always of higher priority than patient confidentiality.

Cooperate with law enforcement and Child Protective Services (CPS)

Law enforcement officers and CPS workers are entitled to obtain relevant dental record information that pertains specifically to an investigation of alleged child abuse or neglect. They do not have to have a signed authorization or a subpoena to obtain the child's records. The dentist and the staff are immune from breach of patient confidentiality if the information released is relevant to protect the child. We recommend that you verify the identity of the CPS representative or law enforcement officer and thoroughly document in the child's chart the information released, to whom it was released and the reason it was released. You may not release information pertaining to the parent(s) without authorization or court order.

Use these guidelines for release of records

Dentists should comply with record requests from attorneys and insurance companies on a timely basis. You and your staff must be careful to send only records that are authorized and requested. The release of records to parties other than those providing care to the patient relating to HIV/AIDS, sexually transmitted diseases, mental health treatment or substance abuse is authorized only upon receipt of specific patient consent. To satisfy these requirements, you may provide requesting parties with the healthcare information release form we've developed (see example). When responding to a proper request for a complete copy of the dental record, the records produced by the dentist's office should include copies of not only the office records but also dental and medical records received from other practitioners. A patient's request for records can mean there is a loss of rapport, so the dentist should be alerted to review such requests and take appropriate action.

Be respectful of patients

Some staff members believe that being casual and calling a patient by his or her first name puts the patient at ease, which it may do in some cases. However, some people resent such familiarity. Be sensitive to the patient's preference.

Avoid a lengthy waiting time

If you anticipate the patient will have a long wait, advise the patient and indicate how long you expect the wait to be. Let the receptionist know if appointments are running late. Some people may prefer to reschedule an appointment.

Make sure the patients in your office understand how to obtain care after hours

A practice brochure or information on your website can help, as well as providing details in your outgoing voicemail message or answering service.

Call oral surgery patients within 24 hours following the procedure

It is advisable (as well as helpful in continuing your rapport with the patient) to initiate a call to patients who have had oral surgery or any traumatic procedures within 24 hours. Document the follow-up call in the patient's chart.

Tell the dentist when a patient complains

Some patients are reluctant to complain directly to the dentist and instead vent their feelings to the office staff. Such complaints should be reported

immediately to the dentist, who can decide whether or not to talk to the patient to prevent minor matters from becoming major ones.

Before sending a patient's bill to collection, consult with the dentist

In some instances, it might not be appropriate to send the bill of a dissatisfied patient to collection.

Put it in the record

When a patient fails to come in for an appointment or cancels a follow-up visit, it should always be noted in the patient's chart.

Ask patients to complete a health history form to reduce your risk

We recommend that all new patients complete a health history form to supplement the comprehensive history taken by the dentist. This information can often be combined with the patient registration form that most dentists use. At the very least, the health history form should cover allergies, diseases and medications. We recommend that patients complete an updated health history form annually or if the patient undergoes a major change in health status. We have developed a health history form that is available at no charge to policyholders.

Documentation of medications reduces your risk

Without exception, all medication administered in the office, as well as all medication samples, prescriptions, over-the-counter recommendations and refills should be documented in the patient's dental record. The chart should indicate the name of the medication, the dose and time interval prescribed, the strength prescribed, how many tablets, and how many refills. It is acceptable for the staff to refill certain medications without checking immediately with the dentist, providing a protocol has been established.

Document the chart when a patient is contacted about follow-up treatment

An individual responsible for contacting a patient about follow-up treatment should document the contact in the patient's chart. Failure to report the results of diagnostic tests and X-rays to a patient in a timely manner can make a malpractice case difficult to defend. Do not file any clinical documents in the patient's chart unless the dentist has "signed off" on them.

Always retain original records and X-rays

You can make copies, but retain all originals. If you have to release original X-rays, document in the chart when, where and why the originals were released.

Use these recommendations for records retention

Our basic guideline is “6/10/21 years.” Dentists should keep records at least six years from the date of the patient’s death, at least 10 years after the patient’s last visit, and, in the case of minors, 21 years from the date of birth. If a patient is potentially litigious, keep the records indefinitely. We believe this guideline will protect the dentist even though the statute of limitations is frequently changing and is subject to judicial interpretation. The same guideline applies to the retention of X-ray films and other imaging studies. We recommend that appointment books be retained for at least 10 years. If you want to be absolutely safe, records should be retained indefinitely.

Written protocols reduce your risk

We recommend the establishment of written protocols for the dentist’s staff concerning basic clinical tasks such as refills of prescriptions and telephone triaging. Although many dentists have a good working relationship with their staff, written protocols can prevent misunderstandings about what hygienists, dental assistants or other staff members can do without first confirming with the dentist.

Write protocols that can and will be followed

Orient all new staff members to the written protocols, and periodically review them with the entire staff.

Notify patients by mail when you are going to terminate their care

Send a certified letter with return receipt requested, along with a copy via regular mail, to the patient explaining that your office will no longer provide care for him or her but that you will continue to provide emergent care for a specified length of time. The length of time depends on the availability of other dental care but should be no less than 30 days. The letter should provide a referral to another source of dental care. File the signed receipt and a copy of the letter in the patient’s chart.

Fee reduction is not an admission of liability

It is important to remember that it is not an admission of liability to discount a professional fee, and we do not believe patients perceive this to be an admission of liability. However, if you write off all or some of the fee, you must refund the proportionate share to the insurance company as well.

Bring legal documents immediately to the dentist’s attention

Conclusion

These guidelines outline some of the measures to reduce liability risks in a dentist’s office. Orient new staff members to these guidelines, and review them at regular intervals. Throughout this chapter are sample forms to assist you in developing your own guidelines and protocol.

Sample/Authorization to use or disclose healthcare information

Patient name _____ Date of birth _____

My authorization

You may use or disclose the following healthcare information (check all that apply):

- All healthcare information in my medical record
- Healthcare information in my medical record for these date(s) _____
- Information in my medical record relating to the following treatment or condition:

- Other (e.g., X-rays, bills), specify date(s) _____

You may use or disclose healthcare information regarding testing, diagnosis and treatment for (check all that apply):

- HIV (AIDS virus)
- Sexually transmitted diseases
- Psychiatric disorders/mental illness
- Drug and/or alcohol use

You may disclose this healthcare information to:

Name (or title) and organization or class of persons _____
Address (optional) _____

Reason(s) for this authorization (check all that apply):

- At my request
- Check only if (practice/facility) requests the authorization for marketing purposes
- Check only if (practice/facility) will be paid or get something of value for providing health information for marketing purposes
- Other (specify)

This authorization ends:

- On (date) _____
- When the following event occurs _____
- 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment).

My Rights

I understand that I do not have to sign this authorization to get healthcare benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study
- To receive healthcare when the purpose is to create healthcare information for a third party

I can revoke this authorization in writing. If I do revoke this authorization, it will not affect any actions already taken by (name of practice or healthcare facility) based on this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from the (practice/healthcare facility).
- Write a letter to the (practice/healthcare facility).

Once healthcare information is disclosed, the person or organization that receives it may redisclose it. Privacy laws may no longer protect it.

Patient/legally authorized representative

Printed name if signed on behalf of the patient

Date

Relationship

Staff reminders

- Do not advise patients about treatment.
 - Stay within your limits of delegation.
 - Release child-patient information only with the parent's consent or as provided by law.
 - Cooperate with law enforcement and Child Protective Services.
 - Comply with properly authorized record release requests.
 - Be careful about calling patients by first names.
 - Tell patients how long they will have to wait.
 - Tell patients how to obtain care after hours.
 - Make follow-up calls to oral surgery patients.
 - Tell the dentist when a patient complains.
 - Consult with the dentist before sending accounts to collections.
 - Chart all cancelled appointments and no-shows and inform the dentist of no-shows.
 - Use patient-completed health history forms.
 - Document all medications.
 - Chart when patients are called regarding follow-up treatments.
 - Always retain original records and X-rays.
 - Use the "6/10/21" year guideline for retention of records.
 - Follow written protocols.
 - Notify patients by mail when the office is going to terminate care.
 - Fee reduction can be appropriate.
 - Show any legal documents to the dentist immediately.
- › Pregnancy status
 - › Assessment
 - › Plan of care
 - › Medications prescribed or recommended
 - › Advice or instructions for further access to dental care
- Guidelines on when to chart telephone calls:
 - › When changing or ordering medications
 - › When giving significant dental advice, including all significant changes in dental status
 - › When a patient has significant anxiety
 - › When giving administrative advice or directions, such as "stay at home," "return to work" or "come to the dentist's office"

Risk management for telephone dental care

Staff members often conduct telephone assessments with patients. Information obtained or given during this call can be critical to the dentist as well as to a plaintiff. What happens or does not happen over the telephone can serve as a basis for a malpractice action. Some points to keep in mind:

- Consider the limits of your expertise.
- Standard of care — always ask yourself what a reasonably prudent person would do in each situation.
- Essential elements of documentation:
 - › Clear definition of the problem
 - › Symptom analysis as related to current dental problem
 - › Allergy status if medications are involved

Sample/Telephone triage form

Name of caller _____ Phone _____

Patient name _____ Date of birth _____

Is the caller the patient?

- Yes
- No

Name of patient's provider _____

Pharmacy name and phone _____

Type of insurance _____

Has the patient been seen before?

- Yes
- No

If yes, when? _____

Describe the patient's current problem

Medications the patient is currently taking (*including prescriptions, over-the-counter medications, herbal remedies*)

Allergies _____

Treatment plan _____

Patient contacted (date) _____ (time) _____

Signature _____ Date _____

Releasing a sedated patient

When releasing a sedated patient from your practice, the chart notes should reflect:

- That the patient was conscious and coherent
- That the patient was assisted to the car by an escort, along with the name of the escort
- That the escort (name of the escort) was properly instructed
- Instructions given to the patient

Rx for avoiding drug scams

Many factors are driving the increased abuse of prescription drugs, but the fact remains that drug seekers are in every community and will eventually make their way into your practice.

Abusers of prescription drugs come from all parts of the socioeconomic and psychosocial spectrum. While most drug-abusing patients seek drugs for personal use, there are also “professional” drug-seeking patients and organized groups who sell prescription drugs. To avoid becoming a drug-abuser’s prime drug supplier, you should watch for behavioral signs characteristic of drug-seeking patients:

- Patient makes an urgent or walk-in visit for pain complaints
- Patient schedules an appointment for late afternoon, particularly on a Friday
- Patient is from out of town and claims to be just passing through
- Patient from out of town requests maintenance narcotic analgesics for a chronic condition
- Patient calls in after hours with pain complaints, yet does not want to be evaluated in the emergency room
- Patient requests a specific, controlled substance by name
- Patient claims that noncontrolled drugs either do not work, produce an allergy or are otherwise contraindicated
- Patient claims that the original prescription was lost or stolen
- Patient refuses a diagnostic work-up
- Patient reports subjective oral or tooth complaints
- Patient gives evasive or vague answers to questions about medical history

- Patient asks the on-call or covering dentist for a specific controlled drug and claims that his or her attending dentist, who happens to be unavailable, always gives a prescription for the requested drug
- Patient presents to the emergency room – during the busiest times – with pain complaints
- Blank prescription pads are missing from the operatory or office after a patient leaves

Dentists can take several steps to minimize the chance of being victimized by drug scams:

Drug monitoring

Record all medication taken by or prescribed for a patient in the patient’s chart. This enables the dentist to easily monitor drug usage and avoid providing excessive refills.

Refill protocols

Dentists should carefully consider how to best handle refill requests. Many drug-seeking patients count on busy practices with office staffs that give automatic approval to refill requests. If your practice allows medications to be refilled by someone with prescriptive authority other than the dentist, a written protocol should be adopted. This should include a list of medications suitable for refills by nondentists, guidelines for questioning the patient to determine the patient’s present medical status, and a decision tree determining whether or not a patient should be seen before a refill is authorized.

Charting

The best defense against claims of inappropriate prescribing is to document the indications and rationale for treatment. Any signs of medication dependence or drug-seeking behavior should be charted objectively.

Prescription pads

Make your prescriptions forgery-proof by writing out quantities in words as well as numbers. For instance, since “12” can easily be changed to “42,” it is better to write “#12 (twelve)” on the script. When writing the number of refills, it is also better to write the number to avoid forgery. For example, the number 0 can easily be changed to 10. In addition, dentists should never pre-sign blank prescription pads. To prevent theft, remove any blank prescription pads from operatories and public access areas. The safest locations for prescription pads are in the dentist’s

coat pocket, the dentist's office, a drawer in the operatory or at the front desk.

Coordination with other providers

Drug-abusing patients count on healthcare providers and pharmacists being too busy or reluctant to talk with each other. Patient consent is usually not required to disclose healthcare information needed by the patient's other providers. In addition, information given to a clinician in an attempt to unlawfully procure a legend drug is not a privileged communication. Therefore, you and the patient's other healthcare providers can discuss suspected or actual prescription drug fraud, diversion and forgery. Because pharmacists detect the majority of such cases, dentists should always respond quickly to a pharmacist's telephone inquiries.

Telephone diagnosis and treatment

When it is practical, dentists should avoid making diagnoses or prescribing controlled substances by telephone without examining patients. If the situation is urgent, patients should be directed to the hospital emergency room.

Transient, emergency department, and weekend, on-call or coverage patients

Treating dentists should prescribe or dispense only minimal amounts of controlled substances until a patient's attending dentist can be contacted — particularly for patients with subjective pain complaints. Attending clinicians should be told of any prescriptions or refills authorized by covering colleagues.

Prescription drug fraud, forgery and diversion are common occurrences. Close attention to preventive measures will help reduce these problems.

Sample/Policy: prescription refills

Note: This is a sample policy only; we provide this sample for use as an idea springboard for offices developing or reviewing their own forms and policies.

Renewing prescriptions for patients on chronic medical therapy provides an opportunity to evaluate patient compliance with prescribed therapy, monitor therapeutic blood levels and assess the need for follow-up office visits.

Procedures

- We ask 24–48 hours' notice for prescription refills to be completed.
- After receiving a refill request from a patient or pharmacy, pull the patient's chart.
- Determine the date of the patient's last office visit. Patients on chronic medical therapy need to be evaluated by their healthcare provider on a yearly basis.
- All narcotics and benzodiazepines require dentist authorization.
- Note the last therapeutic blood level or laboratory screening for patients requesting refills of medications requiring the same screenings.
- Renew medications for six months if the patient is routinely coming to the office, blood levels are therapeutic, the patient is compliant with laboratory screening as required or there is no chart note indicating the need for other interim follow-up care.
- Renew a one-month supply of medication if the patient is lacking one of the above. Inform the patient and/or pharmacy that the patient needs to be evaluated by his or her healthcare provider before further refills will be authorized.
- Document the prescription refill on the medication flow sheet or in a progress note entry if indicated.
- Always consult the dentist if you have any questions regarding a refill request.

Sample drugs

When your office dispenses sample drugs to patients, you are acting as a pharmacist. Be sure that your office complies with all state statutes, federal laws and federal regulations.

Below is a list of suggestions you and your staff may want to follow when dispensing sample drugs to a patient:

- Ask the patient if he or she has any known drug allergies, and be sure to document this information in the patient's dental record.
- Give the patient written instructions on how to take the medication.
 - › Patients will not remember oral instructions on how to take medication.
 - › Place a copy of the instructions in the patient's dental record.
- Include the doctor's name on the written instructions.
- Include the office's phone number, in case of an allergic reaction.
- Include the patient's name on the written instructions.
- Include the date the samples were dispensed.
- Include the name and strength of the drug.
- Include the number of tablets you provided the patient.
- Include the dosage level and the time intervals the patient is to take the medication.
- Remember to document all of the above information in the patient's dental record at the time of the visit.

Sample/Drug form

Patient name _____ Date _____

Sample drug _____

Strength _____ Number of tablets _____

Instructions

Sample drug _____

Strength _____ Number of tablets _____

Instructions

Sample drug _____

Strength _____ Number of tablets _____

Instructions

Signature _____ Date _____

Doctor name _____ Office phone _____

Sample/Monthly medication purge sheet

Month	Medication & sample drugs purged	Completed by	Date
January			
February			
March			
April			
May			
June			
July			
August			
September			
October			
November			
December			

Crown and bridge replacement

Crown and bridge replacements are a common malpractice issue. These problems can be better avoided with good communication throughout the informed consent process, including talking with patients about their expectations. Patients should be told that crowns have a life-expectancy of about seven years. Your practice should not make guarantees but should have a consistent, predetermined replacement policy in place.

Sample/Policy: replacement crown

Note: This is a sample policy for demonstration purposes only and is not meant to advise you on how or what your replacement policy should be for your practice. Regardless of how you structure your replacement policy, just make sure you have a policy in place.

During years	Replaced at
1-2	No charge to patient
3-5	Patient charged 50% of crown fee
6-7	Patient charged 75% of crown fee
After 7	Patient charged full fee

An overview of the Health Insurance Portability and Accountability Act of 1996

A glance backward: How we got here

Many will recall the mid-1990s national debate about workers losing health insurance coverage as a result of losing or changing jobs. At about the same time, national and local media highlighted numerous instances where principles of medical confidentiality were clearly abused or ignored, causing real harm to the patients involved.

These and other factors prompted the passage of comprehensive federal legislation, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As part of this law, Congress gave itself a deadline to pass separate legislation setting forth national health-information privacy standards stipulating that failure to meet this date would hand over the task of creating detailed privacy standards to the U.S. Department of Health and Human Services. Congress did not act, so the Department of Health and Human Services was empowered to issue the privacy regulations, published in final form on Dec. 28, 2000.

The HIPAA Privacy Rule represents the federal government's attempt to protect the privacy of personal healthcare information by establishing, for the first time, a nationwide foundation of required practices and procedures to safeguard the confidentiality of healthcare information in this age of technology.

The Privacy Rule is only one component of the "administrative simplification regulations." Additional HIPAA regulations such as the Transaction and Code Set Rule, the proposed Identifier Rule and the proposed Security Rule will not be discussed here. We will focus only on the Privacy Rule.

The Privacy Rule became effective April 14, 2001, with healthcare providers and affected entities having to be in compliance by April 14, 2003. The task of compliance was not eased by the fact that the Privacy Rule replaced state law except where the state requirements were "more stringent" than the Privacy Rule. In many states, various statutes and regulations affecting the confidentiality of healthcare information have been in existence for many years.

This overview is intended to provide a broad understanding of the mechanics of the Privacy Rule.

Benefits of compliance with the privacy laws

- Improved protection of healthcare information (including your own) will promote patient trust and improve the quality of relationships between patients and providers.
- You will reduce your fears of endangering patient safety by unnecessarily restricting the flow of healthcare information needed for treatment.
- You will decrease the likelihood of patient privacy complaints and consequently increase patient satisfaction.
- You will learn a lot about how you conduct your business and will identify opportunities to eliminate unnecessary work in your day-to-day operations.
- You will avoid criminal prosecution and civil penalties.

Federal standards and state law

The Privacy Rule establishes a “floor” for medical privacy, meaning that existing state laws will remain in force to the extent that the state law is more stringent than the federal rule. In general, a law is deemed “more stringent” if it is more protective of privacy or provides patients with greater access to their own medical information than the federal rule. If the state law fails this test it is “preempted,” that is, replaced by the more patient-friendly federal rule. It is important for you to be aware of the privacy requirements in your state to determine whether federal or state regulations apply.

Because each state must conduct its own preemption analysis, any hope of a truly uniform national healthcare information system will not be achieved with the adoption of the Privacy Rule, because more stringent state-specific confidentiality laws will remain in effect. Many states have conducted a preemption analysis.

The Privacy Rule: Who is affected?

The Privacy Rule applies to healthcare providers, health plans and healthcare clearinghouses, all known and “covered entities” under the rule. Indirectly, the rule reaches beyond these categories to “business associates” of covered entities, an important concept we will address later.

Information subject to the rule

The Privacy Rule applies to essentially any information, whether oral, written or electronic, that is created by healthcare providers or other entities and that relates to the past, present or future physical or mental health or condition of an individual, the provision of healthcare to an individual, or billing and payments for the provision of healthcare to an individual.

If health information is not “individually identifiable” — meaning that there is no reasonable basis to believe that the information can be tied to the identity of a particular individual — it is excluded from the specific protections of the Privacy Rule. However, the rule sets forth a lengthy, technical set of criteria to help determine if healthcare information is individually identifiable.

Use and disclosure of “protected health information”: basic concepts

The Privacy Rule contains standards that control when and how various uses and disclosures of individual health information can occur. “Use” means the sharing, examining, analyzing or utilizing of information within the office or facility that maintains the information. “Disclosure” refers to the release of information in any manner to a person or entity outside the office or facility that maintains the information.

Health information subject to the Privacy Rule is called “protected health information,” or PHI, an acronym certain to be familiar to those involved in health-information management.

Use and disclosure of PHI: treatment, payment and healthcare operations

The Privacy Rule imposes different requirements for the use and disclosure of PHI for treatment, payment and healthcare operations, and the use and disclosure of PHI for other purposes.

“Healthcare operations” includes many of the activities necessary to operate your business and is defined, in part, as including quality-improvement activities, medical review, legal services, auditing functions, business planning and development, business management, and general administrative activities.

A healthcare provider (HCP) may use or disclose PHI, without patient permission, for certain commonsense purposes. These include use and disclosure for purposes of an HCP's own treatment, payment or healthcare operations as well as for the treatment and payment activities of another HCP. The Privacy Rule also permits disclosure to another provider for purposes of some of the healthcare operations of that provider, including quality improvement, peer review, credentialing and certain training activities. While the Privacy Rule does not require patient permission for these uses and disclosures, it does require most HCPs to make reasonable efforts to inform patients that such uses and disclosures may occur.

Use and disclosure of PHI: patient authorizations

If the HCP contemplates using PHI for any purposes other than treatment, payment or healthcare operations as described in the previous paragraph, or if the patient requests disclosure of PHI to outside persons or entities, then a signed patient authorization must, as a general rule, be obtained. The Privacy Rule contains detailed requirements concerning the content of a valid authorization. Among other requirements, the authorization must specify what information is to be disclosed and to whom. In addition, the authorization must contain an expiration date or event.

Reasonably familiar commonsense exceptions allow for use or disclosure of PHI to outside entities not involved in treatment, payment or healthcare operations in the absence of a properly executed authorization. Such exceptions include disclosures to avert serious threats to health and safety, disclosures to health oversight committees and public health agencies, and as otherwise required by law.

Minimum necessary

The Privacy Rule contains detailed requirements designed to ensure that a permitted use or disclosure of health information is limited to the minimum necessary information to accomplish the purpose of the use or disclosure. The most important exception to this minimum necessary requirement is for PHI disclosed or requested for treatment purposes. The most recent changes to the rule make it clear that two or more HCPs can discuss a patient's treatment without violating this or any other part of the Privacy Rule if they are inadvertently overheard.

Notice of privacy practices

A document required by the Privacy Rule is the Notice of Privacy Practices ("Notice"). The purpose of the Notice is, as the name suggests, to inform patients of their rights related to the use and disclosure of their healthcare information and set forth the HCP's legal duties pertinent to the maintenance of PHI. There are some exceptions to the duty to provide the Notice, including the exception for "indirect treatment providers," a term that generally refers to those who provide services based on the orders of the provider treating the patient and then give the results of those services to that provider.

The Notice must state examples of the types of disclosures the HCP is permitted to make for purposes of treatment, payment, and healthcare operations, in addition to a precise recitation of the HCP's legal duties. The patient must be advised of the right to complain directly to the Secretary of Health and Human Services if a violation is suspected.

Similar in concept and purpose to the notice of information practices, which may still be required under some states, the federal Notice is, by necessity, a multipage document. HCPs also have to make reasonable efforts to obtain a patient's signature acknowledgment of receipt of the HCP's Notice. One essential concept to remember is that HCPs and other covered entities are free to alter or amend many actual privacy practices, but only if this right is reserved in language appearing in the Notice and if the new practice is documented in an amended Notice.

The Notice must also inform patients of the right to access, correct or amend, and receive an accounting of disclosures of their records. The first two rights are similar to existing rights under most state laws. Certain disclosures of information are exempt from the accounting rule.

Disclosures to business associates

“Business associates” (BAs) are people other than members of the covered entity’s staff who perform or assist the covered entity with tasks that necessarily involve the disclosure of individually identifiable healthcare information. Examples of BAs include nonemployees who perform legal, actuarial, administrative, billing, accreditation and other similar functions on behalf of the covered entity. Though not directly subject to the Privacy Rule, BAs are indirectly impacted by way of the “business associate contract requirement.” Briefly, covered entities are required to enter into contracts with their BAs under which the BA must agree to “appropriately safeguard” any protected healthcare information received for purposes of performing the task at hand.

Administrative requirement

It will come as no surprise that the Privacy Rule imposes additional requirements concerning training, documentation, and the development of policies and procedures. While the regulations can seem overwhelming, the key is treating PHI reasonably and discreetly. Your policies and procedures will provide guidance in handling day-to-day privacy activities.

A Privacy Official, responsible for developing and implementing policies and procedures relating to the rule, must be appointed. HIPAA requires that all members of the workforce be trained and held accountable for compliance with privacy policies and procedures.

A written explanation or notice of your privacy practices and the privacy rights of patients must be provided to your patients during their first visit to your practice. A copy also should be available in your waiting area. You also must provide copies to anyone who requests the information. A reasonable attempt to obtain written acknowledgement of receipt of the privacy notice by patients should be made during their first visit for treatment and filed in their chart. Note: It is not necessary to obtain additional acknowledgement from patients during subsequent visits.

Staff members should understand your practice’s privacy policies and procedures and be regularly trained. Special attention should be taken to ensure that patients are not able to see computer screens, patient charts or other materials that have sensitive

patient information. All medical alert stickers with sensitive patient information should be placed on the inside of charts. Color-coded stickers used to identify medical alerts for staff use should be uniform and without writing.

Confidential information in electronic records should be subject to review by authorized staff only and safeguarded with passwords. Passwords should be complex and changed frequently. Electronic records should be data-encrypted to protect against fraud and identity theft.

Sample/Notice of privacy practices

This notice describes how medical information about you may be disclosed, and how you can get access to this information. Please review it carefully.

(Name of practice) respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and healthcare operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of use and disclosures of protected health information for treatment, payment and health operations

For treatment:

- Information obtained by a dentist or other member of our healthcare team will be recorded in your dental record and used to help decide what care may be right for you.
- We also can share information with others who provide you with care. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your dental care. Information provided to health plans may include your diagnoses, procedures performed or recommended care.

For healthcare operations:

- We use your dental records to assess quality and improve services.
- We may use and disclose dental records to review the qualifications and performance of our healthcare providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may contact you to raise funds.
- We may use and disclose your information to conduct or arrange for services including:
 - › Medical quality review by your health plan
 - › Accounting, legal, risk management and insurance services
 - › Audit functions, including fraud and abuse detection and compliance programs

Your health information rights

The health and billing records we create and store are the property of the practice. The protected health information in it, however, generally belongs to you.

You have a right to:

- Receive, read and ask questions about this notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request, but we will comply with any request granted.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information (Notice).
- Request that you be allowed to see and get a copy of your protected health information. You must make this request in writing, and we have a form available for this type of request.
- Have us review a denial of access to your health information – except in certain circumstances.
- Ask us to change your health information. You must give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your dental record and included with any release of your records.
- Receive a list of disclosures of your health information without charge once every 12 months. The list will not include disclosures to third-party payers.
- Ask that your health information be given to you by another means or at another location. Please sign, date and give us this request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during our business hours, please contact:

(name of designated staff member)

(phone number)

(address)

(email address)

Our responsibilities

We are required to:

- Keep your protected health information private
- Give you this notice
- Follow the terms of this notice

We have the right to change our practices regarding the protected health information we maintain.

If we make changes, we will update this notice. You may receive the most recent copy of this notice by calling and asking for it.

To ask for help or file a complaint

If you have questions, want more information or want to report a problem about the handling of your protected health information, please contact:

(name of designated staff member)

(phone number)

(address)

(email address)

If you believe your privacy rights have been violated, you can discuss your concerns with any staff member. You also can deliver a written complaint to (name of person) at our practice. You also can file a complaint with the U. S. Secretary of Health and Human Services.

We respect your right to file a complaint with us or the U.S. Secretary of Health and Human Services.

If you complain, we will not retaliate against you.

Other disclosures and uses of protected health information

Notification of family and others:

- Unless you object, we can release health information about you to a friend or family member who is involved in your dental care. We also can give information to someone who helps pay for your care. We can tell your family or friends about your condition and that you are in a hospital. In addition, we can disclose health information about you to assist in disaster relief efforts.

You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

We may use and disclose your protected health information without your authorization as follows:

- With medical researchers — if the research has been approved and has policies to protect the privacy of your health information. We also can share information with medical researchers preparing to conduct a research project.
- To funeral directors or coroners consistent with applicable law to allow them to carry out their duties.
- To organ procurement organizations (tissue donation and transplant) or persons who obtain, store or transplant organs.
- To the Food and Drug Administration (FDA) relating to problems with food, supplements and products.
- To comply with Workers' Compensation Laws — if you make a workers' compensation claim.
- For public health and safety purposes as allowed or required by the law.
 - › To prevent or reduce a serious, immediate threat to the health or safety of a person or the public
 - › To public health or legal authorities
 - » To protect public health and safety
 - » To prevent or control disease, injury or disability
 - » To report vital statistics such as births or deaths
- To report suspected abuse or neglect to public authorities.
- To correctional institutions if you are in jail or prison, as necessary for your health and the health and safety of others.
- For law enforcement purposes such as when we receive a subpoena, court order of other legal process or you are the victim of a crime.
- For health and safety oversight activities. For example, we can share health information with the Department of Health.
- For disaster relief purposes. For example, we can share health information with disaster relief agencies to assist in notification of your condition to family or others.
- For work-related conditions that could affect employee health. For example, an employer may ask us to assess health risks on a job site.
- To the military authorities of U. S. and foreign military personnel. For example, the law might require us to provide information necessary to a military mission.
- In the course of judicial or administrative proceedings at your request, or as directed by a subpoena or court order.
- For specialized government functions. For example, we can share information for national security purposes.

Other uses and disclosures of protected health information

- Uses and disclosures not in this notice will be made only as allowed or required by law or with your written authorization.

Website

We have a website that provides information about us. For your benefit, this notice is posted on the website at this address: (insert here)

Effective date (insert effective date of the notice here)

Sample/Notice of privacy practices acknowledgement

We keep a record of the healthcare services we provide you. You can ask to see and copy that record. You also can ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You can see your record or get more information about it by contacting **(name of privacy officer)**.

Our Notice of Privacy Practices describes in more detail how your health information can be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

_____ Date _____
Patient/legally authorized representative

_____ Relationship _____
Printed name if signed on behalf of the patient

Notations, if any, by staff:

This form will be retained in your dental record.

Last update _____

Sample/Letter denying request to access PHI

Dear (patient name),

We received your request to access your health information record. We reviewed your request.

Unfortunately, we cannot honor your request because:

- We do not maintain this information. Contact (name and address of the healthcare provider who does maintain the information).
- This health information is not available because of federal and state laws.
- The record no longer exists or cannot be found.

You can contact (name or title of internal contact person) at (telephone number and address), if you:

- Have questions
- Want more information
- Want to report a problem about the handling of your information

(Include the section below ONLY if the reason for denial is reviewable as described in Procedures 3 (c) (viii – x) and 5 (c).)

You have the right to have this decision reviewed by another licensed healthcare professional.

If you would like to make this request:

1. Sign here _____, and select one of the following:

- Please have the following licensed healthcare professional review the decision
(his or her name and specialty) _____
- Please find a licensed healthcare professional to review the decision. This would be someone not involved in the original decision.

2. Return this form to us.

If you believe your privacy rights have been violated, you may contact (name or title of person) at our office by calling (insert telephone number). We respect your right to file a complaint with us or the Secretary of Health and Human Services.

Sincerely,

(Insert dentist or practice name)

Sample/Request to correct or amend health information

Request for (name of practice or healthcare facility) to correct or amend health information

Patient name _____ Date of birth _____

Previous name _____

Mailing address _____

I request a change to my records.

Please explain what the information in your record should say to be more accurate or complete. If you need additional space, please include a separate page. **Date of entry in record** _____

_____ Date _____

Patient/legally authorized representative

_____ Relationship _____

Printed name if signed on behalf of the patient

We will review your request and respond within 10 days of receiving your request. A copy will be added to your record.

We will send changes to:

- Anyone you identify
- Anyone who received the information in the past and who needs to know about the change

To be completed by the practice or healthcare facility Date received _____

Correction/amendment has been:

- Accepted
- Denied
- The review of this request for correction/amendment has been delayed. Your request will be processed by (date) _____ (not later than 21 days after the request).

If denied, check reason for denial:

- The existing health information is accurate and complete.
- This request does not pertain to the patient's medical and financial records.
- Because of federal and state laws, this health information is not available.
- This health information was not created by this organization.
- This record no longer exists or cannot be found.
- The record is not maintained by this organization.

_____ Date _____

Name of reviewing department or person

Last update _____

Sample/Letter denying request to correct/amend PHI

Dear (patient name),

We received your request to correct/amend your health information record. We reviewed your request. Unfortunately, we cannot honor your request because:

- The existing health information is accurate and complete.
- Because of federal and state laws, this health information is not available.
- The record no longer exists or cannot be found.
- Your request does not pertain to your medical and financial records.
- This health information was not created by this organization.
- The record is not maintained by this organization.

You can contact (name or title of internal contact person) at (telephone number and address), if you:

- Have questions
- Want more information
- Want to report a problem about the handling of your information
- Want to write a brief statement of disagreement to be added to your medical record.

This is your right. It can include:

- › The reason(s) you believe the health information should be corrected or amended
- › Why you disagree with any decision to deny your request

If you do not submit a statement of disagreement, you can request that in future disclosures, we include a copy of:

- Your original request to amend or correct the health information
- This letter

If you would like to make this request:

1. Sign here _____, and
2. Return this form to us.

If you believe your privacy rights have been violated, you may contact (name or title of person) at our office by calling (insert telephone number). We respect your right to file a complaint with us or the Secretary of Health and Human Services.

Sincerely,

(Insert dentist or practice name)

Sample/Complaint/grievance resolution letter

(Date)

(Address)

(Patient name)

Dear (insert name):

I am writing to respond to the concerns that you documented in your letter dated (insert date). You expressed concerns regarding the (handling/use/disclosure) of (insert patient name)'s protected health information. We respect your right to file a concern. We are very sorry that you are upset.

(Option 1 – if a complaint is made by the patient or the patient's legally authorized representative.)

Based on your concerns, we completed an investigation on (insert date). We (insert steps taken to investigate the complaint – interviewed staff, reviewed our policies, etc.). We found that (insert brief summary of the facts of the investigation).

(Option 2 – if a complaint is made by someone other than a patient or the patient's legally authorized representative, and patient permission has not been granted to authorize disclosure.)

Based on your concerns, we completed an investigation on (insert date). We (insert steps taken to investigate the complaint – contacted the patient, interviewed staff, reviewed policies, etc.). Because of privacy and security laws, we cannot tell you any details of our investigation or findings. However, we would be happy to give you information if the patient permits us to do so.

Thank you for bringing your concerns to our attention. We try hard to protect all of the health information that we handle. You have given us an opportunity to review our practices and to make improvements.

If you have additional questions, please contact (insert name) at (insert number).

Sincerely,

(Privacy officer or designee)

Sample/Accounting log for protected health information (PHI) disclosures

Note: In accordance with s. 164.258 (4)(i), track potential PHI disclosures for research purposes on a separate research accounting log.

Patient name _____ DOB/medical record number _____

Date of request	Brief description of PHI released	To whom disclosed (name and address)	Purpose of disclosure	Date of disclosure	Information released by (name of staff)

Last update _____

Sample/Employee confidentiality

Employee confidentiality statement

All patient protected health information (PHI) (which includes patient medical and financial information), employee records, financial and operating data of the practice, and any other information of a private or sensitive nature is considered confidential. Confidential information should not be read or discussed by any employee unless pertaining to his or her specific job requirements. Examples of inappropriate disclosures include:

- Employees discussing or revealing PHI or other confidential information to friends or family members
- Employees discussing or revealing PHI or other confidential information to other employees without a legitimate need to know
- The disclosure of a patient's presence in the office, hospital or other medical facility, without the patient's consent, to an unauthorized party without a legitimate need to know and that may indicate the nature of the illness and jeopardize confidentiality

The unauthorized disclosure of PHI or other confidential information by employees can subject each individual employee and the practice to civil and criminal liability. Disclosure of PHI or other confidential information to unauthorized persons, or unauthorized access to, or misuse, theft, destruction, alteration or sabotage of such information, is grounds for immediate disciplinary action up to and including termination.

Employee confidentiality agreement

I hereby acknowledge, by my signature below, that I understand that the PHI, other confidential records and data to which I have knowledge and access in the course of my employment with (insert name of practice) is to be kept confidential and that this confidentiality is a condition of my employment. This information shall not be disclosed to anyone under any circumstances, except to the extent necessary to fulfill my job requirements. I understand that my duty to maintain confidentiality continues even after I am no longer employed.

I am familiar with the guidelines in place at (name of practice) pertaining to the use and disclosure of patient PHI or other confidential information. Approval should first be obtained before any disclosure of PHI or other confidential information not addressed in the guidelines and policies and procedures of (insert name of practice) is made. I also understand that the unauthorized disclosure of patient PHI and other confidential or proprietary information of (name of practice) are grounds for disciplinary action, up to and including immediate dismissal.

Employee signature Date _____

Printed name of employee

Supervisor

Sample/Signature log

A copy of this log shall be maintained in the practice administrative files. The log should be updated to reflect the current signature and initials of each individual making entries into patient records.

Dentist/employee		Initials	Employed dates
Full name/title			from _____ to _____
Signature			
Full name/title			from _____ to _____
Signature			
Full name/title			from _____ to _____
Signature			
Full name/title			from _____ to _____
Signature			
Full name/title			from _____ to _____
Signature			
Full name/title			from _____ to _____
Signature			

Sample/Patient information update

Patient name _____ Today's date _____

1. Has your name changed since your last visit here? Yes No

If yes, what was your previous name? _____

What name do you use for health insurance if different than above? _____

2. If you have a new or different address since your initial visit, please indicate below.

3. Has your marital status changed? Yes No

4. Has your phone number changed? Yes No

If yes, new phone number _____

5. Has your employment changed? Yes No

If yes, new employer name, address and phone

6. Please note any changes in your health since your last visit.

Illness

Accident

Allergies

Medications, including OTCs or herbal remedies

Other

Signature _____ Date _____

Sample/Medical history update

Patient name _____ Today's date _____

Date of birth _____ Sex _____ Wt. _____ Ht. _____ Age _____

Occupation _____ Ethnicity _____

Are you presently in good health? Yes No

If no, please explain _____

Past serious illnesses? Yes No

If yes, please explain _____

Are you being treated for any illnesses? Yes No

If yes, please explain _____

List all medications you take including OTCs and herbal remedies.

Allergies to medications? Yes No

If yes, please list _____

Date of last physical exam _____

Is there a chance you are pregnant? Yes No

Have you ever had a blood transfusion? Yes No

List all surgeries in the past.

Any reaction to anesthesia? Yes No

Do you use tobacco products? Yes No

If yes, how much and for how long? _____

Do you drink alcoholic beverages? Yes No

If yes, how much and for how long? _____

Have you seen other doctors for the problem that brings you here today? Yes No

If yes, please describe _____

Do you have a past history of (check all that apply):

- Headaches
- Glaucoma
- High blood pressure
- Bleeding disorders
- Heart problems
- Lung problems
- Hearing problems
- Ulcers
- Snoring
- Mouth-breathing
- Reproductive disorders
- Psychiatric problems
- Street drug use
- Emotional problems
- Frequent infections
- Bad scarring
- Thyroid problems
- Circulatory problems

Family history of (check all that apply):

- Cancer
- Diabetes
- Heart disease
- Anesthetic problems
- Asthma

Comments

Sample/Facsimile notice

Date _____

To _____

Fax _____

Phone _____

Pages _____

From _____

Comments

The information contained in this facsimile transmission is privileged and confidential. It is intended for the use of the individual or entity named above.

If you are not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited.

If you have received this fax in error, please notify us immediately by telephone and destroy the document.

Self-assessment for record documentation

We encourage you to conduct regular chart audits on a monthly basis to check for charting deficiencies. Randomly select 10–15 patient records and do a written review of organization, quality of documentation, consistency and content. Have more than one staff member participate. Once deficiencies are identified and corrected, disseminate the information among the rest of the staff so they can be alerted to similar issues in other patient records. For this to be successful, chart audits should be done on a routine basis.

Discussing optimal ways to increase and maintain high standards of documentation should be encouraged during staff meetings and throughout the workday. The emphasis of a team approach on detailed, consistent, thorough documentation cannot be overemphasized. Thorough charting not only promotes excellent risk management and reduces liability exposures but also strengthens optimal relationships with your patients.

Survey/Self-assessment survey for office practice

The Risk Management Department has developed a self-assessment survey to help you identify possible areas of malpractice exposure. It can be used to evaluate your practice environment from clinical, practice management and patient-relations standpoints. This review can be valuable to all members of the dental care team by increasing awareness of risk management issues.

We suggest that the dentist and all members of clinical, administrative and support staff fill out the survey to monitor the operations of the practice from several points of view. Each member of the dental team can contribute to and learn from the risk management process. Learning and implementing sound risk management practices is a team effort that cannot be accomplished by dentists and staff acting in isolation. We also recommend that a practice periodically repeat this survey as part of an ongoing quality assurance program.

The survey is designed to address areas of risk common to all specialties but does not address clinical judgment or technical expertise. Some questions may not apply to your area of practice and should be answered as “N/A”. Whenever the “no” box is checked, the adjacent number should be circled. The total of the circled numbers is your malpractice risk score. There are 210 points possible on the survey. A cumulative score of 0 to 15 is a very low malpractice risk exposure; 16 to 30 is a low risk exposure; 31 to 45 is a medium risk exposure; 46 to 60 is a high risk exposure; and 61 or over indicates significant malpractice risk exposure.

This self-assessment does not consider any unique patient or practice demographics that may increase or decrease your malpractice exposure. Your scoring also can depend on and should be interpreted in light of the resources available in your local dental community. Significant variations in score between dentists and staff reviewing the same practice should be investigated.

Circle the number when the “no” box is checked.

I. Facilities review	N/A	Yes	No	Score
1. The reception area has stable furniture and open foot-traffic areas.				1
2. Patients cannot trip over equipment in the office.				1
3. Unstable patients are given staff assistance.				2
4. New dental equipment is checked out or calibrated prior to use.				2
5. Malfunctioning equipment is removed from service and tested before reuse.				2
6. A schedule of preventive maintenance and calibration of dental equipment is maintained.				2
7. All staff personnel are trained in the proper use and care of dental equipment.				2
8. Infection control procedures are in effect throughout the office.				3
Subtotal score				

Circle the number when the “no” box is checked.

II. Dentist-patient rapport	N/A	Yes	No	Score
1. The office communicates with patients in a friendly and courteous way.				3
2. Patients perceive us as approachable, sympathetic and understanding.				2
3. Patients’ questions are answered to their satisfaction.				3
4. Dental care is explained in language that patients can understand.				3
5. Dental, medical and financial information about patients cannot be overheard or read by other patients.				2
6. The dentist always discusses the treatment plan with the patient.				1
7. Staff members refer all patient complaints about dental care to the dentist immediately.				2
8. Patients with substantive complaints are invited to discuss their concerns in person rather than by telephone.				3
9. Angry or frustrated patients are not ignored.				3
Subtotal score				
III. Telecommunications	N/A	Yes	No	Score
1. There are sufficient telephone lines into the office.				1
2. The staff obtains patient permission before placing him or her on hold.				1
3. Patients are not on hold for more than two minutes.				1
4. Staff members are trained in telephone triage and are authorized to interrupt the dentist when necessary.				3
5. The staff has been instructed not to diagnose or recommend treatment by telephone without the dentist’s approval or prior protocol.				3
6. All substantive clinically related phone conversations with patients are documented in their charts.				3
7. The staff has been instructed to refer all medication refills to the dentist’s attention.				3
8. Patients in the reception area usually cannot hear front-desk telephone conversations.				1
Subtotal score				

Circle the number when the “no” box is checked.

IV. Patient load	N/A	Yes	No	Score
1. On average, the schedule allows patients to obtain an appointment in less than four weeks.				2
2. Emergent patients are able to be seen as necessary.				1
3. Patients with an appointment usually spend less than 30 minutes in the reception area and operatory combined before being seen.				2
4. Patients in the reception area are notified if appointments are running behind schedule.				2
5. The staff documents missed or cancelled appointments in the patient’s chart.				3
Subtotal score				
V. Patient accounts	N/A	Yes	No	Score
1. Treatment charges are discussed with patients prior to undertaking a treatment plan.				1
2. Payment options are discussed with patients prior to beginning treatment.				1
3. The dentist is informed of all patient complaints regarding billing disputes.				1
4. There is an adequate time period between initial billing and initiation of aggressive collection efforts.				2
5. The dentist reviews the patient’s chart before referring the account to a collection agency.				3
6. The collection agency is not allowed to sue the patient without the dentist’s express permission.				2
Subtotal score				
VI. Dental records	N/A	Yes	No	Score
1. A dental/medical history form is completed by all new patients and established patients not seen after a lengthy period.				3
2. All handwriting in the chart is legible.				3
3. All handwritten chart entries are signed using the first and last initial or full name of the author.				2
4. A progress note is written each time a patient has an office visit.				2
5. All entries in the dental records are in chronological order.				2
6. Dental records are organized so that a specific document can easily be found.				3
7. All chart entries document positive and negative findings that are essential to diagnosis and patient care.				2

(Dental records section continues on next page.)

Circle the number when the “no” box is checked.

VI. Dental records (continued)	N/A	Yes	No	Score
8. The chart is appropriately documented when verbal or written instructions are given to patients.				2
9. Written reference materials are provided to patients for common conditions.				2
10. The chart is documented when a patient is noncompliant with the treatment plan.				2
11. Dental complications or unusual occurrences are documented in the patient’s chart.				2
12. Patient comments, negative or positive, are documented in quotes when warranted.				3
13. Inappropriate statements and derogatory personal remarks are not made in patient charts.				3
14. All diagnostic study reports, consults and other reports are reviewed and initialed by the dentist prior to filing in the chart.				3
15. The dental record indicates a description of the exam and clearly identifies what was examined.				2
16. The chart consistently includes history, exam, diagnosis, treatment, prescriptions and “what’s next.”				3
17. Corrections in the dental record are made by lining out the error, writing in the correct information, and dating and signing the change.				3
18. The electronic record system includes data encryption and a redundant backup system.				3
19. When making a correction to the electronic records, an addendum is entered on the progress notes with the date and the staff member’s name.				3
20. After receiving a request for dental records or notice of a claim or suit, no alterations or additions are made to the patient’s chart.				3
21. When appropriate, written authorizations are required before releasing any patient charts.				2
22. Only copies of the original records are provided in response to a records request.				3
23. When discarding dental records, we use a crosscut shredder or an offsite contractor and keep a log.				2
Subtotal score				

Circle the number when the “no” box is checked.

VII. Pharmaceuticals	N/A	Yes	No	Score
1. Patient allergies/drug sensitivities are always obtained and posted consistently and conspicuously inside the patient’s chart.				3
2. Patients are carefully informed about potential adverse drug reactions and side effects and are instructed to report them.				3
3. Medication orders are clear, specific and legible to avoid confusion over drug names or dosages.				3
4. All medications administered in the office, as well as all medication samples, prescriptions and refills, are documented in the patient’s chart.				3
5. Nitrous oxide documentation always includes the reason for administering, PARQ, time of sedation, orientation at discharge, rate of gases delivered and percentage of nitrous administered.				3
6. The dentist is informed of any prescriptions or refills authorized by covering colleagues.				2
7. Drugs are not prescribed by telephone unless the dentist is sufficiently familiar with the patient’s dental, medical and medication history.				2
8. Appropriate security is used for all controlled substances in the office.				2
9. Prescription pads are kept secure and cannot be accessed by patients.				3
10. Any unlabeled bottles, vials or pre-filled syringes are immediately discarded.				2
11. Solutions and mixtures are kept in different-sized and labeled containers.				2
Subtotal score				
VIII. Emergency procedures	N/A	Yes	No	Score
1. The dentist and staff are periodically recertified in basic life support.				3
2. The office has the minimum emergency equipment of oxygen, oral airway, oxygen masks, bag resuscitator, diphenhydramine and epinephrine.				3
3. The emergency kit is inspected and resupplied at least semiannually.				2
4. The office calls the local emergency medical service when indicated for acute office emergencies.				1
5. Each staff member has specific responsibilities assigned in the event of an emergency.				1
Subtotal score				

Circle the number when the “no” box is checked.

IX. Miscellaneous clinical and practice management issues	N/A	Yes	No	Score
1. The licenses and references of office staff are verified and checked before hiring.				2
2. Office staff members make a good impression on patients.				2
3. Each staff member is instructed not to perform tasks beyond the scope of his or her license, training or qualifications.				2
4. A procedure has been established for informing patients of diagnostic study results.				3
5. A fail-safe follow-up system exists in the event that a patient is referred out for diagnostic studies.				3
6. A patient reminder system for periodic exams or routine follow-ups is in place.				2
7. Informed consent is obtained specifically by the dentist, during which the patient is advised of the procedure, alternatives and risks and given an opportunity to ask questions about the proposed treatment plan or procedure.				3
8. The ideal treatment plan is always discussed with the patient, regardless of his or her insurance coverage.				3
9. After the patient’s signature is obtained, the signed informed consent form is placed in the patient’s chart.				3
10. A specific informed consent form is used for frequently performed procedures.				3
11. Informed consent discussions are documented in the progress notes.				3
Subtotal score				
X. Claim management	N/A	Yes	No	Score
1. The professional liability insurance company is notified immediately upon receipt of a Summons and Complaint.				3
2. The dentist reviews all records requests from an attorney and notifies our insurance company of potential malpractice claims.				3
3. Claims are not discussed with anyone other than the insurance company representative or attorney.				3
4. Personal notes or copies of correspondence from the insurance company or attorney are not placed in the patient’s chart.				3
Subtotal score				
Total score				

Results	Total score
Very low malpractice risk exposure	0-15
Low malpractice risk exposure	16-30
Medium malpractice risk exposure	31-45
High malpractice risk exposure	46-60
Very high malpractice risk exposure	61+



After reading *Practice management*, please proceed to:

Exam/Module 3
before moving on to the next chapter.

Note: You cannot move forward without completing and passing the exam. If you exit the program before completion, you will not be able to enter a previous chapter.

Exam/Module 3:

Practice management

1. It is important to you and your patients that dental staff document the exchange of certain information conveyed over the telephone. Which of the following types of information should always be documented?
 - a) Significant patient anxiety
 - b) Change to or ordering of medications
 - c) Significant medical advice
 - d) All significant changes in health status
 - e) All of the above
 - f) B and C only
2. When responding to a request from a Child Protective Services worker for information relating to a minor patient, which of the following needs to be obtained?
 - a) A signed authorization from the minor patient's parent(s)
 - b) A court order
 - c) A subpoena
 - d) None of the above
3. When releasing a sedated patient from your practice, your chart notes should reflect that:
 - a) The patient was conscious and coherent
 - b) The patient was assisted to the car by an escort, along with the name of the escort
 - c) The escort (name of escort) was properly instructed
 - d) A copy of the instructions was given to the escort and also filed in the chart
 - e) All of the above
4. Which of the following steps can dentists take to minimize the chance of being victimized by drug scams?
 - a) Only the dentist has refill prescriptive authority
 - b) Dentists should quickly respond to pharmacist's telephone inquiries
 - c) On call dentists should wait to prescribe controlled substances until the patient's attending dentist can be contacted
 - d) All of the above
5. Which of the following should not be done when dispensing sample drugs to a patient?
 - a) Ask the patient if he or she has any known allergies and document this information in the chart.
 - b) Give the patient written instructions on how to take the medication.
 - c) Include the doctor's home number in the event of an allergic reaction.
 - d) Include the doctor's name on the written instructions.
 - e) Include the date the samples were dispensed in the written instructions and in the patient's chart.
 - f) None of the above

6. With regard to privacy practices, patients have the right to:
- a) Ask you to restrict certain uses and disclosures of their protected health information (PHI)
 - b) Request to see and get a copy of their protected health information
 - c) Request a list of disclosures of their health information
 - d) All of the above
 - e) A & C
7. Examples of appropriate disclosures of PHI include which of the following?
- a) Employees discussing or revealing PHI or other confidential information to friends or family members
 - b) Employees discussing or revealing PHI or other confidential information to other employees without a legitimate need to know
 - c) The disclosure of a patient's presence in the office
 - d) None of the above

Managing your dental records

4

The dental record is key to good patient care and the successful defense against malpractice lawsuits. As dentistry has become more complex, patients, staff and dentists benefit from the complete, accurate, legible and contemporaneous documentation of dental care. Facilities, professional review organizations, accreditation bodies, third-party payers, governmental agencies, dental licensing boards and juries all use dental records to judge the quality of patient care.

Cases that appear defensible on clinical grounds become indefensible in court when inadequate records are introduced as evidence. Similarly, cases with the potential for severe damages have been won by presenting comprehensive and meticulously documented records. Good charting is one of the most important patient care and risk management skills a healthcare professional can develop.

We recommend that dictated entries to the dental record be transcribed and filed in the chart within 48 hours of the patient encounter. Because the average individual talks much faster than he or she writes, a dictated record is generally more comprehensive and can provide better documentation of patient encounters. While we recognize that many chart entries are not

amenable to dictation, dictation does eliminate a major impediment to patient care and malpractice defense: illegible handwriting. Lawsuits have been lost or settled for substantial amounts because a single chart entry was illegible or subject to several interpretations.

Chart entries should be dictated or written in blue or black ink, as soon as possible following the patient encounter. They should include the complete date (day, month and year) and a complete record of the encounter. Handwritten notes should be signed using either the first and last initials or the name and designation of the author. Each note should be filed in chronological order, and each page of the chart should include, at a minimum, the patient's full name (spelled correctly), date of birth and any medication alerts. Including an account number or dental record number will further help to identify the patient. The chart should document all general and limited examinations, as well as positive and negative findings relating to the patient's complaint or condition.

In addition to the previous recommendations, we have developed a list of important documentation guidelines to help dental professionals document defensively.

Consider the following when developing documentation guidelines for your practice:

- Document facts, impressions, clinical judgment and treatment objectively. Be specific and avoid general statements such as “Patient doing well.”
- Use commonly accepted and understood dental terms, abbreviations and acronyms. Chart so that any dental professional can read the dental record.
- Use a standard charting format, such as the PARQ format when documenting progress notes.
- Avoid using sticky notes and half-sheets of paper to document information in the dental record.
- Don’t write in the chart margins (juries wonder if extraneous remarks were added later).
- Avoid leaving spaces.
- Have an annual written health history and regular information update in the chart.
- Document the patient’s chief complaint (if any) for each visit.
- The dentist should chart last (after hygienist and assistant).
- Appointment schedule and chart dates must conform.
- Use the “six X” format.
- Include a suggested return date and information about referrals to other healthcare providers when documenting the progress notes. When referring a patient to a specialist, be as specific and as clear as possible in your chart notes. For example, write “7/20/11 – patient referred to periodontist, Dr. Johnson, for osseous crown lengthening of the distal of #32,” rather than simply “patient referred to periodontist.”
- Document in the chart when patients are notified regarding test results and consultant opinions. Include the date the patient was notified, the method of reporting (e.g., in person, by telephone or by letter), the information reported and the person reporting.
- Chart drug names, doses, routes and regimens meticulously.
- Correct errors in the chart by drawing a single line through the error and dating and signing the correction.
- Add omitted information by identifying the entry as an addendum or late entry, and date and sign the entry.
- Chart all clinical interventions, given advice and patient’s responses. When appropriate, chart patient’s quotes using quotation marks.
- Avoid using the dental record as a battleground to criticize other professionals. Respect the opinion of peers. Never blame an adverse occurrence on another dentist.
- Never, ever use humor in the dental record. What may seem funny at the time may not seem funny to a jury.
- Eliminate bias from the written description of a patient. Avoid words such as “lazy” or “sloppy.” A jury may infer that patient care was substandard because the dentist did not like the patient.
- Chart all potential contributing patient acts. A jury may not be sympathetic to a patient who does not comply with a dentist’s instructions.
- Do not make assumptions on behalf of the patient when charting. Document the source of the information and use quotes appropriately. For example, chart as follows: “Patient reports, ‘I’ve been under a lot of stress recently and have been grinding a lot,’” as opposed to: “Patient is under stress and has been grinding.” As another example, chart as follows: “Patient reports, ‘My previous doctor did a poor RCT,’” as opposed to: “The previous doctor did a poor RCT.”
- Chart positive as well as negative comments from your patients, such as “I’m very happy with the way my dentures feel.” This way, if the status changes, your chart will have created a credible history of the treatment rendered as well as the patient’s level of satisfaction.
- Be repetitive and consistent:
 - › 8/3/10 – Pt instructed to wear night guard every night.
 - › 9/12/10 – Pt instructed to wear night guard again.
 - › 10/4/10 – Pt again warned to wear night guard.
- Chart all cancellations and no-shows.
- Note whether an appointment is a regularly scheduled appointment or an emergent appointment. If an appointment has been rescheduled or cancelled, note by whom (patient or staff).
- Avoid gaps or omissions in the record. The old adage “If it isn’t in the record, it didn’t happen” still holds true today.

The Six X's

1. HX: History
2. EX: Exam
3. DX: Diagnosis
4. TX: Treatment
5. RX: Prescriptions and over-the-counter recommendations
6. NEXT: What happens next?

Charting 101

The patient record should always include the following:

- Patient's diagnosis
- Description of treatment or services rendered
- Date and description of treatment complications
- Date and description of all radiographs, study models and periodontal charting
- Health history

How much?

The dental record should provide sufficient information for another dentist to understand the treatment provided, planned next steps and why these choices were made. Another dentist also should be able to maintain continuity of the patient's care. Everyone in the practice should follow the dental charting and organization techniques mentioned above. Doing so will help improve the quality of patient care and reduce the practice's overall malpractice risk.

The most common charting omissions:

- Failure to document a definitive diagnosis
- Failure to document a dental nexus for a prescription or medications given
- Failure to document a health history update
- Failure to document a declined treatment or the patient's selection of a less desirable alternative

The most common charting mistakes:

- Not noting the PARQ conference
- Incomplete documentation of anesthesia
- Missing informed consent
- Failure to document the medications given or prescribed and their doses – including OTCs
- No mention of failed appointments or cancellations
- Not documenting the shortfalls in treatment

- › It's important to document follow-up efforts when there are treatment shortfalls.
- › The dentist should do the follow-up.

Remember: Your best defense is your chart notes

Why should my charting standards be higher than what I think is necessary?

Time and again our experience is that juries and state licensing boards find well-documented charts the most reliable and persuasive basis upon which to form their decisions. Contemporaneous chart notes are tangible and credible despite contrary testimony. In addition, high charting standards discourage malpractice suits because plaintiff attorneys are less likely to challenge consistent, well-documented records.

You have a state board complaint; what else exacerbates the issues?

An unhappy patient files a complaint with the state licensing board, or a colleague, not fully informed of the treatment you've provided a patient, encourages a complaint to the board. Incomplete or poor charting is guaranteed to exacerbate an already challenging situation. Here are some of the charting issues we've seen with state board defense claims that could have easily been avoided:

- Lack of documentation of the PARQ conference
- Lack of documentation of the diagnosis
- No treatment plan documented
- Lack of documentation of pulp testing, etc.
- Lack of documentation of dental nexus of Rx
- Issues with documentation, such as a separated file
- Lack of health history updates

Nitrous oxide-oxygen sedation documentation

It is not uncommon for patients to be nervous when they arrive at the dentist's office. Because so many practices offer nitrous oxide, it's unnecessary for most patients to have to struggle with anxiety. As with all medications administered to patients, careful charting is required, including stating the medical reason for the provision of nitrous oxide (e.g., "patient is anxious"). Additional charting for patients receiving nitrous oxide should include:

- The date of sedation
- PARQ conference
- Documentation of the patient's orientation

- at discharge
- Rate of total volume of gases delivered
 - › Example: 8 liters/minute
- Post-operative 100 percent oxygen flush
- Total time of sedation
- Percentage of nitrous oxide administered
 - › This step will require multiple entries from induction to the completed sedation.

- reliability of your backup.
- › Keep a signed backup log showing who did backup and when.

Your electronic system should also include a fraud prevention program. With the rising rate of employee embezzlement claims, make sure you avail yourself to daily financial reports that are not available to staff.

Electronic record systems

Electronic record systems have been available for years, but with the ease of use and improvements in technology, many dentists either have or will soon switch from paper charts to a completely computerized system.

Electronic systems come with their own challenges that require their own unique solutions. For example, when drawing a diagram for a patient or obtaining the patient’s signature on important documents such as consent forms, it’s important to include the paper image in the electronic record. Scanning the image for the electronic record and retaining the original in a master file is the most common solution.

Remember that the data on the hard drive is the original, and it is conceivable that a plaintiff attorney, alleging that electronic records were altered, could subpoena the hard drive for examination. Never, ever adulterate records; it is almost always detectable in different locations on the storage media. If a correction needs to be made to a patient’s record, enter the correction as an addendum on the progress note with the date and the staff member’s name who made the change.

Some additional safeguards include:

- Practice data encryption to protect from identity theft and breach of data.
- Have staff members type their name at the end of each entry.
- Require the dentist to review staff members’ entries and sign off by typing his or her own name.
 - › Have a redundant backup system to eliminate potential catastrophic losses (such as fire, burglary, flood, etc.).
 - › Back up daily.
 - › Have two sources of backup.
 - › Take your backup disk off site.
 - › Do an occasional audit to confirm

Discarding dental records

To avoid identity theft and a breach of patient confidentiality, it is extremely important to destroy dental records in a prudent manner. Dental offices can either hire an off-site shredding company to properly discard records, or use an in-office shredder and destroy the records themselves.

When discarding your dental records on-site, use a crosscut shredder and keep a log with:

- The name of the chart
- The name of the employee shredding
- The date the chart was shredded

When using an off-site contractor, keep the receipts from the shredding service and keep a log of the charts that were shredded.

Dental abbreviations

A.....	Assessment
Ab	Antibiotics
Abr.....	Abrasion
Abs.....	Abscess
Abut	Abutment
ACNR	All caries not removed
ACR.....	Acrylic resin or all caries removed
Adj	Adjust
Alg	Alginate
Alv	Alveolar
Alvy.....	Alveolectomy
Am or Amal.....	Amalgam
Anes	Anesthesia or anesthetic
Ant.....	Anterior
ANUG.....	Acute necrotizing ulcerative gingivitis
Apico.....	Apicoectomy
Appl.....	Appliance
Appt.....	Appointment
AW.....	Arch wire

B.....	Base	H & C.....	Hot and cold
B or Bu or Buc	Buccal	HC.....	Home care
BA.....	Broken appointment	HH.....	Health history
BI.....	Bleeding index	HQR.....	Health questionnaire reviewed
Bk.....	Bracket	Hx.....	History
BP.....	Blood pressure	Imp.....	Impression or impacted
BU.....	Build up	Inc or I.....	Incisal
BW.....	Bite wing	Ins.....	Insurance
BWX.....	Bite wing X-ray	JRR.....	Jaw relation record
Canc.....	Cancelled	L or Li or Ling.....	Lingual
CaOH.....	Calcium hydroxide	L.....	Left
Car.....	Caries	LI.....	Lingual incisal
CC.....	Chief complaint	M or Mes.....	Mesial
CD.....	Complete dentures	Man or Mand.....	Mandibular
CMCP.....	Camphorated paramono-chlorophenol	Max.....	Maxillary
Comp & U, Y, G, DY, etc.....	Composite	MI.....	Mesial incisal
Cont.....	Continue	ML.....	Mesial lingual
Cop.....	Copalite or copal varnish	MO.....	Mesial occlusal
Cr.....	Crown	MOD.....	Mesial occlusal distal
CSN.....	Cancelled short notice	MOF.....	Mesial occlusal facial
Cur.....	Curettage	MOL.....	Mesial occlusal lingual
D or Dist.....	Distal	NP.....	New patient
DA.....	Dental assistant	NSF.....	No significant findings
D/D.....	Full upper and lower denture	O.....	Objective
Dent or Dtr.....	Denture	O or OCC.....	Occlusal
DL.....	Distal lingual	OB.....	Occlusal buccal
DO.....	Distal occlusal	OCSE.....	Oral cancer screening examination
DOB.....	Distal occlusal buccal	OD.....	Oral diagnosis
DOL.....	Distal occlusal lingual	OHC.....	Oral health counseling
Dr.....	Doctor	OL.....	Occlusal lingual
Drn.....	Drain	Ortho.....	Orthodontics
Endo.....	Endodontics	Op.....	Operative
Epi.....	Epinephrine	OS.....	Oral surgery
EPT.....	Electric pulp test	P.....	Plan
Equil.....	Equilibrate(ation)	PA.....	Public assistance or periapical xray
Eug.....	Eugenol	Pano.....	Panalipse or panorex X-ray
Ex.....	Exam	PARQ.....	Procedure, alternative, risks, questions
Ext.....	Extraction	PCOR.....	Pericoronitis
F or Fac.....	Facial	PD.....	Preventive dentistry
F/F.....	Full upper and lower denture	Perio.....	Periodontitis, periodontal
FGC.....	Full gold crown	PFM.....	Porcelain fused to metal crown
F-, Fl.....	Fluoride	Porc.....	Porcelain
FMX.....	Full mouth X-rays	Post.....	Posterior
FPD.....	Fixed partial denture (bridge)		
Fx.....	Fracture		
GP.....	Gutta percha		

POT.....	Post operative treatment
P/P	Upper and lower partial
Pro or Prophy	Prophylaxis
Pros.....	Prosthodontics
Prep	Preparation
Press	Pressure
Pt.....	Patient
R.....	Right
RCF.....	Root canal filling
RCT or Endo.....	Root canal
RD	Rubber dam
Rest.....	Restoration
Rev	Review
RHH	Review health history
RP & C.....	Root plane and curettage
RPD	Removable partial denture
RTC.....	Return to clinic
RX	Prescription
S	Subjective
Scl.....	Scaled, scaling
Sens	Sensitive or sensitivity
SOAP.....	Subjective, objective, assessment, plan
SSC	Stainless steel crown
STC.....	Soft tissue conditioner
Su.....	Suture
Surg.....	Surgical, surgery
TA.....	Tooth ache
TB.....	Tooth brush
Temp.....	Temporary
Th	Tooth
Thirds or 3rds	Wisdom teeth
TMJ	Temporalmandibular joint
Top	Topical
Tx.....	Treatment
w/.....	With
WNL.....	Within normal limits
w/o.....	Without
Xylo or Xyl	Xylocaine or w/epi
ZOE.....	Zinc oxide or eugenol
Roman numerals	
I, II, III, IV and V	tooth mobility
I through 10	periodontal pocket measurement (depth)



After reading *Managing your dental records*, please proceed to:

Exam/Module 4 before moving on to the next chapter.

Note: You cannot move forward without completing and passing the exam. If you exit the program before completion, you will not be able to enter a previous chapter.

Exam/Module 4:

Managing your dental records

1. Good charting is one of the most important patient care and risk management skills a healthcare professional can develop. Which of the following does not conform to good charting guidelines?
 - a) Document facts, impressions, clinical judgments and treatment objectively. Be specific and avoid general statements such as “patient doing well.”
 - b) The dentist should chart last (after the hygienist and assistant).
 - c) Add omitted information by identifying the entry as an addendum or late entry, and date and sign the entry.
 - d) Chart all potential contributing patient acts.
 - e) None of the above
2. Care providers should document positive as well as negative comments from patients, using quotes when appropriate.
 - a) True
 - b) False
3. When referring a patient to a specialist, be as specific and clear as possible. Chart notes should include:
 - a) Date patient referred
 - b) Type of specialist and his or her name
 - c) Reason for referral
 - d) All of the above
4. The dental record should provide sufficient information for another dentist to understand the treatment provided, planned next steps and why those choices were made. Another dentist also should be able to maintain continuity of the patient’s care.
 - a) True
 - b) False
5. Charting for patients receiving nitrous oxide should, in part, include:
 - a) PARQ conference with the patient
 - b) Patient’s orientation at discharge
 - c) Reason for administering nitrous oxide
 - d) Total time sedated
 - e) A, B, D
 - f) A,B,C,D

6. Many practices have switched or will switch to electronic records. Which safeguards should be implemented?
- a) Practice data encryption
 - b) Back up once a year
 - c) Store backup data away from the office
 - d) After making changes to the record, hit “save”
 - e) Require staff members to type their name at the end of each entry
 - f) All of the above
 - g) A, B, C, E
 - h) A, C, E

Malpractice issues

5

Sometimes a lawsuit doesn't get started in a lawyer's office. It often gets started in another dentist's office.

Standard of care

Standard of care is defined as what a reasonably prudent dentist would have done under similar circumstances.

A general dentist is held to a specialist's standard of care when:

- A procedure is attempted and the available or known evidence suggests that it should have only been performed by a specialist.
- The dentist insists on completing a procedure when complications arise that are best handled by a specialist.
- The dentist continues a procedure when circumstances would allow the work to be stopped without serious complications to the patient rather than referring the patient to a specialist to complete.

Colleagues as a source of state licensing board complaints

How many times have you had a patient in your practice who simply wouldn't follow your treatment plan? Or didn't keep their appointment? Or wanted to piece-meal their treatment? Or left and went to another practitioner without a word to your office? Did you wonder what the subsequent treating dentist thought of your work?

Unfortunately, some dentists are critical of prior work without knowing the full circumstances surrounding the treatment, and they encourage patients to file a complaint with their state licensing board.

Some better options would be to:

- Call the other dentist to discuss concerns.
- Call your malpractice carrier to discuss concerns.

Frequent findings by state licensing boards:

- The diagnosis is obvious from the films but not explained in the chart. For example, "irreversible pulpitis" needs to be stated if that is the reason for the RCT.
- There is no documentation of the health history having been updated.
- The dental nexus of the Rx is not documented.

- The CE was actually insufficient when the doctor renewed his or her license.
- The CE required for the level of anesthesia permit held is missing.
- The treatment plan is missing.
- Perio probing is not documented.
- The diagnosis of perio condition is not documented.
- There is no evidence of a discussion with the patient.
- The chart does not contain justification for nitrous (e.g., patient anxious).

Do you really want to be a plaintiff's expert?

Many doctors don't realize that if they give their opinion about care rendered by a previous provider, it can inadvertently place them in a position as a plaintiff's expert witness. Here are a few scenarios that can put you in that situation:

- You report something to your state's licensing board.
- You tell a patient that his or her prior dentist made a mistake.
- You tell a patient that he or she needs retreatment, and you aren't extremely clear that you are not being critical of the prior dentist who did the work.
- You agree to talk to a patient's attorney and don't make it very clear, in writing, that you have no intention, EVER, of testifying.
- You prepare a letter for your patient explaining the problem and are not clear that you are not being critical of the prior dentist's work.
- You put something in your chart that is negative about past treatment done by others.

Why do the above situations place you in a vulnerable position as a potential plaintiff's expert witness? Because each of these situations is discoverable by a plaintiff's attorney, and if he or she becomes aware of any or all of the above, he or she can solicit you as an expert witness.

If you do want to be a plaintiff's expert, consider the following:

- Do you really know all the facts?
- Have you talked to the prior dentist to find out if you understand the decisions he or she made and the reasons for those decisions?

- Do you know what warnings were given to the patient?
- Do you know whether the patient tried to dictate poor treatment choices?
- Have you seen the prior dentist's chart notes?
- Do you know whether the prior dentist has been provided the opportunity to fix the problem?
- Your way is not the only way.
- Perfection is not required to meet the standard of care.
- You may be asked if this has ever happened to you:
 - › Have you ever perforated a root while doing a root canal?
 - › Have you ever had a short fill on a root canal?
 - › Have you ever unknowingly left an open margin?
 - › Have you ever missed an infection?
 - › Have you ever missed a root fracture?
 - › Have you ever left a bone fragment in an extraction site?
 - › Have you ever done treatment you thought might not last on a patient?
 - › Have you ever failed to chart something significant?
 - › Have you ever had a patient who you told to return, fail to follow up?
- If it is something that could happen to you sometime in your career, even if it is not perfect, it is not negligence or a breach of the standard of care.

If you are sued

DO:

- As soon as you receive the Summons and Complaint, report it to your malpractice carrier by phone.
- Make copies of the papers and send the originals to your carrier.
- Write a summary of the treatment of the patient using the treatment record to refresh your memory. Include everything you can remember, even if it is not in the treatment notes.

- Make a copy of the records, including radiographs, chart pocket documents and the narrative that you wrote to your carrier. Lock the originals in a safe place. The originals will be provided to your defense attorney at a later date.
- Tell your staff about the suit and instruct them not to talk to anyone asking questions about the case without obtaining your permission.

DON'T:

- Tell the patient or his or her representative that you are insured.
- Agree to or offer a settlement.
- Agree to or offer to pay for a specialist's services.
- Alter your records.
- Lose your records.
- Discuss the case with anyone.
- Admit guilt or fault to anyone.
- Try and contact the patient's attorney.
- Continue to treat the patient.

Demands for payment

- Deal with patient complaints immediately and reduce the likelihood of any written demand.
- If you do receive a demand for payment, call your carrier immediately.

Statements of apology

In the ideal world, nothing would ever go wrong; there would be no bad outcomes. But despite our best efforts and delivering treatment within the standard of care, still sometimes the results are not what we expected or would have wished for our patient.

As previously discussed, if an adverse outcome has occurred, the best practice is to inform the patient as soon as possible of the complication and then create a plan to move forward. But what about apologizing or expressing regret?

If a statement of apology is made within 30 days of an incident, it is not admissible in a civil action. A statement of apology includes:

- A statement
- Affirmation
- Gesture or conduct expressing fault
- Apology, sympathy, commiseration, condolence, etc., that relates to pain, suffering, injury or death

Expressing your empathy and concern can actually strengthen the rapport and relationship you have with your patient and statistics repeatedly show that people are less likely to sue people they like or trust.



After reading *Malpractice issues*, please proceed to:

Exam/Module 5 before moving on to the next chapter.

Note: You cannot move forward without completing and passing the exam. If you exit the program before completion, you will not be able to enter a previous chapter.

Exam/Module 5:

Malpractice issues

1. When is a general dentist held to a specialist's standard of care?
 - a) When the general dentist attempts a procedure and the evidence suggests that it should only have been performed by a specialist
 - b) When the general dentist insists on completing a procedure after complications arise, even though he or she could have safely referred the patient to a specialist
 - c) A and B

2. Placing something in your patient's chart that is negative about past treatment done by others can inadvertently place you in the position of being a plaintiff's expert witness.
 - a) True
 - b) False

3. If you are sued, you should do the following:
 - a) Continue to treat the patient until the case is settled.
 - b) Offer to pay for a specialist's services.
 - c) Tell your staff and instruct everyone not to talk to anyone with questions about the case without obtaining your permission.
 - d) None of the above

4. A statement of apology is not admissible in a civil action if it is made within:
 - a) 15 days of the incident
 - b) 30 days of the incident
 - c) 60 days of the incident
 - d) 90 days of the incident

Final thoughts

6

Course and scope of practice

With the ever-increasing pressures to make sure practices are cost-effective and efficient, some doctors are considering ways to provide services for their patients that can generate additional revenue.

Doctors should always consider whether the services they want to provide fall within the course and scope of practice of their dental license. Your state board determines the definition of scope of practice by the dental practice act.

There has been significant interest in providing patients with facial injections of botulinum toxin and other cosmetic injections. Even though a doctor has attended the prerequisite courses and may even be able to obtain professional liability coverage for the exposure, it does not mean the practice falls within the scope of a dentist's license. Doctors are well advised to check with their state dental board before offering these services. A professional liability policy will not provide protection to dentists practicing outside the course and scope of their licensure.

Sleep apnea is a disease that affects millions of people and some dentists have decided to specialize in this area. Sleep apnea appliances are becoming more commonplace in treating this problem. Special

consideration should be made to work in concert with a patient's physician rather than diagnose a patient on your own. Severe health consequences are associated with untreated sleep apnea. Once a patient has been diagnosed by his or her physician and referred to you for treatment, every effort should be made to refer the patient back to the physician to be certain the apnea has been properly addressed. Check with your state's dental board to determine its definition of scope of practice.

Only prescribe or dispense medications related to a dental condition, whether for patients or when treating a family member. Medications prescribed for any other condition are not considered within the practice of dentistry.

If you're considering ways to expand your practice and are contemplating areas that may be new to dentistry, check with your state board, your state dental association and other trusted organizations to make certain your idea falls within your state's definition of scope of practice.

Did you know?

It is generally not permitted to write off the dental insurance co-pay or deductible. However, you can under some circumstances — for example, if you have made an effort to collect payment. If you are

writing off all or some of the fee, you must refund the proportionate share to the dental insurance company as well.

Records and practice transitions

If you sell your practice, make sure that your sales contract specifically gives you access to the dental records.

This can be a confusing time for patients as you transition your practice from one owner to the next. Let patients know who has their records and give them a timeframe to respond to the change – for example: “If we don’t hear from you in 60 days, we will turn your records over to Dr. Buyer.”

Self-inflicted wounds

- Keeping no record of care to staff members or family

Dentists often provide complimentary care to staff and family members, but some fail to keep adequate records of the care provided. This typically can get doctors into trouble if a staff member is terminated or if a family member becomes estranged through divorce and bad feelings surface. Suddenly all that goodwill care can become suspect, and without adequate charting, providing a good defense can be extremely difficult. As you would with any patient, thoroughly document all care you provide for your staff members, friends or family members. Their chart should include:

- › A medical history
- › Diagnosis and diagnostic testing
- › Documentation of PARQ dialogue
- › Documentation that prescriptions are dentally necessary
- › Address of staff or family member

NOTE: It’s also important not to bill “insurance only” when providing care to staff members or family.

- Not keeping accurate track of continuing education accomplishments, including Basic Life Support/CPR and medical emergency training
- Not confirming the certifications (or lack thereof) of your staff
- Not knowing what anesthesia permit you need for your practice
- Changing the dental record after you gave it out

Final thoughts

- Sign all of your own entries.
- Review and initial all staff treatment entries.
- Correct errors properly and promptly.
- Remember to initial and date any changes.
- Unprofessional comments are taboo.
- Avoid giving your professional opinion outside of the office – because you will have no documentation of the conversation.
- Never give out your original records to the patient.
 - › BOD will request original records.
 - › If you are sued, give your attorney the patient’s chart.
- Always chart patient cancellations.
- Chart who is responsible for rescheduling appointments.
- Chart all no-shows.
 - › Proof that the patient was uncooperative could greatly aid the defense.
- Chart your informed consent conference.
 - › If possible, have a witness to the conference.
- Have the patient sign a written informed consent form.
- Keep copies of brochures or handouts used in the conference.
- Draw pictures in the progress notes and keep any diagrams or drawings used.
- Keep all of the old treatment plans.
- Don’t treat a patient of the opposite sex alone.
- Confirm each patient’s name before treating him or her. For example, say, “Hi, Sally. How are you today?”
- Know your limitations and know when to refer.



After reading *Final thoughts*, please proceed to:

Exam/Module 6
before moving on to the next chapter.

Note: You cannot move forward without completing and passing the exam. If you exit the program before completion, you will not be able to enter a previous chapter.

Exam/Module 6: Final thoughts

1. Doctors should always consider whether the services they would like to provide fall within the course and scope of practice of their dental license. The dental practice act is determined by:
 - a) Your state dental association
 - b) Your state board of dentistry
 - c) Your state insurance department
 - d) None of the above

2. When providing complimentary care to staff and family members, it is permissible to bill “insurance only.”
 - a) True
 - b) False

This ends the online risk management module.

Forms

7

The following forms are available for use to DBIC insureds.

- Patient information
- Appliance release and payment agreement
- Bleaching teeth outside the dental office
- Informed consent for composite fillings
- Informed consent for crown and bridge prosthetics
- Consent for amalgam replacement
- Informed consent for cosmetic treatment(including bleaching, whitening, bonding and veneer)
- Consent for CT scan
- Consent for dental implants
- Dental history and consent for treatment
- Consent for dental procedure
- Kinship caregiver's informed consent declaration for minors
- Consent for oral sedation/anesthesia
- Consent for oral surgery
- Consent for oral surgical treatment in patients who have received oral bisphosphonate drugs
- Consent to perform periodontal cleaning
- Informed consent for periodontal root planing and scaling
- Informed consent for pulpotomy (permanent teeth)
- Informed consent for sealants
- Informed consent and permission form
- Informed consent statement for periodontal disease
- Informed consent for occlusal equilibration
- Informed consent for nitrous oxide sedation
- Informed refusal of recommended treatment

Patient information

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, please don't hesitate to ask.

Patient name _____ Today's date _____

Social Security No. _____ Date of birth _____ Age _____ Sex _____

Driver's license No. _____ State _____

Home address _____

Phone _____ Cell phone _____

Billing address (*if different from above*) _____

Employer/occupation _____ Business phone _____

Spouse's name _____ Spouse's phone _____

Emergency phone (*other than spouse*) _____

Primary dental insurance _____ Group No. _____

Secondary dental insurance _____ Group No. _____

Subscriber's name _____

Subscriber's Social Security No. _____ Date of birth _____ Age _____ Sex _____

Name of your medical doctor _____

Date of last visit to medical doctor _____

Name of previous dentist _____

Date of last visit to dentist _____

Referred to us by _____

Dental health history

- Are you apprehensive about dental treatment? Yes No
- Have you had problems with previous dental treatment? Yes No
- Do you gag easily? Yes No
- Do you wear dentures? Yes No
- Does food catch between your teeth? Yes No
- Do you have difficulty chewing your food? Yes No
- Do you chew on only one side of your mouth? Yes No
- Do you avoid brushing any part of your mouth because of pain? Yes No
- Do your gums bleed easily? Yes No
- Do your gums bleed when you floss? Yes No
- Do your gums feel swollen or tender? Yes No
- Have you ever noticed slow-healing sores in or around your mouth? Yes No
- Are your teeth sensitive? Yes No
- Do you feel twinges of pain when your teeth come in contact with:
- Hot foods or liquids? Yes No
- Cold foods or liquids? Yes No
- Sour foods? Yes No
- Sweets? Yes No
- Do you take fluoride supplements? Yes No
- Are you dissatisfied with the appearance of your teeth? Yes No
- Do you prefer to save your teeth? Yes No
- Do you want complete dental care? Yes No
- How often do you brush? _____
- How often do you floss? _____
- Does your jaw make noise so that it bothers you? Yes No
- or others? Yes No
- Do you clench or grind your jaws frequently? Yes No
- Do your jaws ever feel tired? Yes No
- Does your jaw get stuck so that you can't open freely? Yes No
- Does it hurt when you chew or open wide to take a bite? Yes No
- Do you have earaches or pain in front of the ears? Yes No
- Do you have jaw symptoms or headaches upon awaking in the morning? Yes No
- Does jaw pain or discomfort affect your appetite, sleep, daily routine
or other activities? Yes No
- Do you find jaw pain or discomfort extremely frustrating or depressing? Yes No
- Do you take medications or pills for pain or discomfort (pain relievers,
muscle relaxants, antidepressants)? Yes No
- Do you have a temporomandibular (jaw) disorder (TMD)? Yes No
- Do you have pain in the face, cheeks, jaws, joints, throat, or temples? Yes No
- Are you unable to open your mouth as far as you want? Yes No
- Are you aware of an uncomfortable bite? Yes No
- Have you had a blow to the jaw (trauma)? Yes No
- Are you a habitual gum chewer or pipe smoker? Yes No

Medical health history

Do you have or have you had any of the following?
(check all that apply)

- Heart problems
- Chest pain
- Shortness of breath
- Blood pressure problem
- Heart murmur
- Heart valve problem
- Taking heart medication
- Rheumatic fever
- Pacemaker
- Artificial heart valve
- Blood problems
- Easy bruising
- Frequent nosebleed/Abnormal bleeding
- Blood disease
- Anemia
- Ever require a blood transfusion?
- Allergy problems
- Hay fever
- Sinus problems
- Skin rashes
- Taking allergy medication
- Asthma
- Intestinal problems
- Ulcers
- Weight gain or loss
- Special diet
- Constipation/diarrhea
- Kidney or bladder problems
- Fainting spells, seizures or epilepsy
- Stroke(s)
- Frequent or severe headaches
- Thyroid problems
- Persistent cough or swollen glands
- Premedications required by physician
- Cancer/tumor
- Diabetes
- Urinate more than six times a day
- Thirsty or mouth is dry much of the time
- Family history of diabetes
- Tuberculosis or other respiratory disease

- Do you drink alcohol?
 > If so, how much? _____
- Hepatitis, jaundice or liver trouble
- Herpes or other STD
- HIV positive/AIDS
- Glaucoma
- Do you wear contact lenses?
- Head injury
- Epilepsy or other neurologic disease
- History of alcohol or drug abuse

During the past 12 months, have you taken any of the following?

- Antibiotics or sulfa drugs
- Anticoagulants (e.g., Coumadin)
- High blood pressure medicine
- Tranquilizers
- Insulin, Orinase or similar drug
- Aspirin
- Digitalis or drugs for heart trouble
- Nitroglycerin
- Cortisone (steroids)
- Natural remedies
- Nonprescription drug/supplements
- Other _____

Are you allergic, or have you reacted adversely, to any of the following?

- Local anesthetics (“Novocain”)
- Penicillin or other antibiotics
- Sulfa drugs
- Barbiturates, sedatives or sleeping pills
- Aspirin, acetaminophen or ibuprofen
- Codeine, Demerol or other narcotics
- Metals
- Latex or rubber dam
- Other _____

Women

- Are you taking contraceptives or other hormones?
- Are you pregnant?
- If so, expected delivery date _____
- Are you nursing?
- Have you reached menopause?
- If so, do you have any symptoms?

_____ Date _____
Patient signature/legally authorized representative

_____ Relationship _____
Printed name if signed on behalf of the patient

_____ Date _____
Dentist signature

Appliance release and payment agreement

Patient name _____ Date _____

The dental or orthodontic appliance being made for you is a temporary appliance intended to maintain proper tooth space or to provide better aesthetics or both.

I understand that if the appliance is not used as instructed by Dr. _____, the intended outcome may not be achieved. I further understand that without periodic examinations, problems may occur to the teeth to which the appliance attaches. For example, a band may become loose, which may cause tooth decay or other problems if left unattended.

I agree not to hold Dr. _____ responsible for any problems or additional treatment cost arising from such problems or concerns regarding the appliance or its use, and I further acknowledge that Dr. _____ is not responsible for matters arising from my lack of notification.

I agree to pay \$_____ for the initial appointment, at which time impressions will be taken for the appliance. I agree to pay the balance, less any amount for which there is insurance coverage, when the appliance is delivered. I also agree that after impressions have been taken for the appliance, I will be fully responsible for the total cost of the appliance, even if I choose not to have the appliance placed.

I have read and fully understand the terms of this appliance release and payment agreement.

Patient signature/legally authorized representative Date _____

Printed name if signed on behalf of the patient Relationship _____

Bleaching teeth outside the dental office

Hydrogen peroxide has been used for many years to bleach teeth. In recent years, in-home use of hydrogen peroxide by patients, through the use of dentist-provided trays, has increased. Although the results of this procedure are not significantly different from the traditional in-office technique, a few potentially reversible negative effects are described below. Also, as with other forms of tooth bleaching, it may be necessary to upgrade bleach applications in future years.

Patient instructions (*nighttime use only*)

1. At bedtime, brush and floss teeth; rinse mouth well.
2. Place two to three drops of bleaching gel into each space in the tray for every tooth to be lightened.
3. Insert tray into mouth over teeth, expectorate excess gel and wear loaded tray during sleep every night.
4. Rinse tray each morning and clean teeth as usual. Fluoride containing toothpaste and mouth rinse can be used if desired.
5. Discontinue bleach if tooth sensitivity, gum irritation or any other negative event occurs. Notify your dentist of the problem immediately.

The average time for optimum color change to occur using the nighttime bleaching technique is six weeks, although effects may be noticed in as few as two weeks. Observation appointments with your dentist are required every seven to 10 days to check the progress of the bleaching.

Additional patient instructions

In addition to using the bleaching trays each night, you can expedite the tooth whitening process by applying the solution in your trays to your teeth for additional two-hour periods daily. Total bleaching time per day, including the seven or eight hours during sleep, should not exceed 18–20 hours. Most patients find that one to three total periods per day (including night) is ideal.

I have read and fully understand the above directions and cautions.

_____ Date _____
Patient signature/legally authorized representative

_____ Relationship _____
Printed name if signed on behalf of the patient

Informed consent for composite fillings

I understand that the treatment of my dentition involving the placement of composite resin fillings, which may be more aesthetic in appearance than some of the conventional materials that have been traditionally used, such as silver amalgam or gold, may entail certain risks. There is the possibility of failure to achieve the desired or expected results. I agree to assume those risks that may occur, even if care and diligence is exercised by my treating dentist in rendering this treatment. These risks include possible unsuccessful results and/or failure of the filling associated with, but not limited to, the following:

1. Sensitivity of teeth

Often after preparation of teeth for the placement of any restoration, the prepared teeth may exhibit sensitivity. The sensitivity can be mild or severe. The sensitivity can last only for a short period of time or last for much longer periods of time. If such sensitivity is persistent or lasts for an extended period of time, I will notify the dentist because this can be a sign of more serious problems.

2. Risk of fracture

Inherent in the placement or replacement of any restoration, is the possibility of the creation of small fracture lines in the tooth structure. Sometimes these fractures are not apparent at the time of removal of the tooth structure and/or the previous fillings and placement or replacement, but they can appear at a later time.

3. Necessity for root canal therapy

When fillings are placed or replaced, the preparation of the teeth often requires the removal of tooth structures adequate to ensure that the diseased or otherwise compromised tooth structure provides sound tooth structure for placement of the restoration. At times, this may lead to exposure or trauma to underlying pulp tissue. Should the pulp not heal, which often is exhibited by extreme sensitivity or possible abscess, root canal treatment or extraction may be required.

4. Injury to the nerves

There is a possibility of injury to the nerves of the lips, jaws, teeth, tongue or other oral or facial tissues from any dental treatment, particularly those involving the administration of local anesthetics. The resulting numbness that can occur is usually temporary but, in rare instances, it could be permanent.

5. Aesthetics or appearance

When a composite filling is placed, effort will be made to closely approximate the appearance of natural tooth color. However, because many factors affect the shades of teeth, it may not be possible to exactly match the tooth coloration. Also, the shade of the composite fillings can change over time because of a variety of factors including mouth fluids, foods, smoking, etc. The dentist has no control over these factors.

6. Breakage, dislodgement or bond failure

Because of extreme masticatory (chewing) pressures or other traumatic forces, it is possible for composite resin fillings or aesthetic restorations bonded with composite resins to be dislodged or fractured. The resin-enamel bond can fail, resulting in leakage and recurrent decay. The dentist has no control over these factors.

7. New technology and health issues

Composite resin technology continues to advance, but some materials yield disappointing results over time and some fillings may have to be replaced by better, improved materials. Some patients believe that having metal fillings replaced with composite fillings will improve their general health. This notion has not been proven scientifically and there are no promises or guarantees that the removal of silver fillings and the subsequent replacement with composite fillings will improve, alleviate or prevent any current or future health conditions.

Informed consent

I understand that it is my responsibility to notify this office should any undue or unexpected problems occur or if I experience any problems relating to the treatment rendered or the services performed. I have been given the opportunity to ask any questions regarding the nature and purpose of composite fillings and have received answers to my satisfaction. I voluntarily assume any and all possible risks, including the risk of substantial harm, if any, that may be associated with any phase of this treatment in hopes of obtaining the desired outcome. By signing this document, I authorize Dr. _____ and/or his/her associates to render any services deemed necessary or advisable in the treatment of my dental condition, including the prescribing and administration of any medically necessary anesthetic agents and/or medications.

_____ Date _____
Patient signature

Printed name

_____ Date _____
Witness signature

Informed consent for crown and bridge prosthetics

I have been advised of and understand that treatment of dental conditions requiring **crowns** and/or **fixed bridgework** involves certain risks and possible unsuccessful results, including the possibility of failure. Even when care and diligence is exercised in the treatment of conditions requiring crowns and bridgework and fabrication of the same, there are no promises or guarantees of anticipated results or the length of time the crown and/or fixed bridgework will last. I agree to assume the risks associated with crowns and/or fixed bridgework, which include but are not limited to the following:

1. **Reduction of tooth structure**

To replace decayed or otherwise traumatized teeth, it is necessary to modify the existing tooth or teeth so that crowns (caps) and/or bridges may be placed upon them. Tooth preparation will be done as conservatively as practical.

2. **Numbness following use of anesthesia**

In preparation of teeth for crowns or bridges, anesthetics are usually needed. As a result of the injection or use of anesthesia, at times there may be swelling, jaw muscle tenderness or even a resultant numbness of the tongue, lips, teeth, jaws and/or facial tissues that is usually temporary; in rare instances, such numbness may be permanent.

3. **Sensitivity of teeth**

Often, after the preparation of teeth for the reception of either crowns or bridges, the teeth may exhibit mild to severe sensitivity. This sensitivity may last only for a short period of time or for a much longer period. If it is persistent, notify us so that we can determine the cause of the sensitivity and seek to treat that condition.

4. **Crown or bridge abutment teeth may require root canal treatment**

After being crowned, teeth may develop a condition known as pulpitis or pulpal degeneration. The tooth or teeth may have been traumatized from an accident, deep decay, extensive preparation for the crown or bridge, or from other causes. It may be necessary to do root canal treatments on the affected teeth. If teeth remain sensitive for long periods of time following crowning, root canal treatment may be necessary. Infrequently, the tooth or teeth may abscess or otherwise not heal, which may require root canal treatment, root surgery or possibly extraction.

5. **Breakage**

Crowns and bridges may chip or break. Many factors can contribute to this situation, including chewing excessively hard materials, change in biting forces, traumatic blows to the mouth, etc. Undetectable cracks may develop in crowns from these causes, but the crowns/bridges themselves may not actually break until sometime later. Breakage or chipping because of defective materials or construction is somewhat uncommon. If it does occur, it usually occurs soon after placement.

6. **Uncomfortable or strange feeling**

Crowns and bridges are artificial and, therefore, feel different from natural teeth. Most patients become accustomed to this feeling over time. In limited situations, muscle soreness or tenderness of the temporomandibular joint (TMJ) — jaw joint — may persist for indeterminable periods of time following placement of the prosthesis.

7. Aesthetics or appearance

Patients will be given the opportunity to observe the appearance of crowns or bridges in place prior to final cementation. While satisfactory, this fact is usually acknowledged by an entry into the patient’s chart initialed by the patient.

8. Longevity of crowns and bridges

Many variables determine how long crowns and bridges can be expected to last. Among these are some of the factors mentioned in the preceding paragraphs, including the general health of the patient, oral hygiene, regular dental checkups and diet. As a result, no guarantees can be made or assumed to be made regarding the longevity of the crowns or bridges.

It is a patient’s responsibility to seek attention from the dentist should any undue or unexpected problems occur. The patient must diligently follow any and all instructions, including the scheduling of and attendance at all appointments. Failure to keep the cementation appointment can result in ultimate failure of the crown/bridge to fit properly and an additional fee may be assessed.

Informed consent

I have been given the opportunity to ask any questions regarding the nature and purpose of crowns and/or bridge treatment and have received answers to my satisfaction. I voluntarily assume any and all risks including those listed above and including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. By signing this document, I am freely giving my consent to allow and authorize Dr. _____ and/or his/ her associates to render any treatment necessary and/or advisable to my dental conditions, including the prescribing and administering of any medications and/or anesthetics deemed necessary to my treatment.

Tooth No(s). _____

_____ Date _____
Patient signature/legally authorized representative

_____ Relationship _____
Printed name if signed on behalf of the patient

_____ Date _____
Witness signature

Consent for amalgam replacement

1. I hereby authorize Dr. _____ and/or other dentists or assistants as may be selected by him/her to treat my condition(s). The procedure(s) necessary to treat the condition(s) have been explained to me, and I understand the nature of the procedure as follows:

- 2. I have been informed of my current dental diagnosis and of possible alternative methods of treatment (if any).
- 3. I further understand that this is an elective procedure and that other forms of treatment or no treatment at all are additional choices that I have, and I have discussed the known risks of these other forms of treatment with my dentist(s).
- 4. I understand that replacement of dental amalgam in a nonallergic patient does not indicate that the doctor is of the opinion that amalgam is a health hazard.
- 5. The doctor has explained to me that there are certain inherent and potential risks in ANY treatment plan or procedure. We do not expect these to occur, but there is that possibility. In this specific instance such risks include but are not limited to the following:
 - Nerve inflammation leading to hot and cold sensitivity
 - The need for endodontic therapy (root canal treatment)
 - Cracked cusps
 - A shorter length of serviceability of the restoration with the need for more frequent replacement in cases where the previous restorations (fillings) are very large, the use of cast or full coverage crowns or bonded porcelain are often recommended.
- 6. It has been explained to me that during the course of the procedure(s), unforeseen conditions may be revealed that may necessitate an extension of the original procedure(s) or different procedure(s) than those set forth in paragraph 1 above. I, therefore, authorize and request that the people described in paragraph 1 above perform such procedures as are medically necessary and desirable in the exercise of their professional judgment. The authority granted under this paragraph 6 shall extend to the treatment of all conditions that require treatment and are not known at the time the original procedure is commenced.
- 7. I consent to the administration of anesthesia, including local, intravenous and/or general anesthesia in connection with the procedure(s) referred to above, by any of the persons described in paragraph 1, and to the use of such anesthetics as may be advisable with the exception of _____ to which I said I was allergic. I recognize that there are always risks to life and health associated with anesthesia and such risks have been fully explained to me.
- 8. Medications, drugs, anesthetics and prescriptions may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs; thus I have been advised not to operate any vehicle, automobile, or hazardous devices or to work, while taking such medications and/or drugs, or until fully recovered from the effects of the same. I understand and agree not to operate any vehicle or hazardous device until I have recovered from the effects of the anesthetic medication and drugs that I may have been given in the office for my care.

9. It has been explained to me, and I understand, that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted.
10. I agree to cooperate completely with the recommendations of the doctor while I am under his/her care, realizing the lack of same could result in a less than optimum outcome and that failure to follow the doctor's suggestions and directions could even be life threatening.
11. I have been given ample opportunity to ask questions, and any questions I have asked have been answered in a satisfying manner.
12. I certify that I read and write English and fully understand this consent. **Please ask the doctor if you have any questions concerning this consent form before signing it.**

_____ Date _____
Patient signature

Printed name

_____ Date _____
Dentist signature

_____ Date _____
Witness signature

Informed consent for cosmetic treatment

(including bleaching, whitening, bonding and veneer)

I, _____, understand that treatment of my dentition for which I desire cosmetic dental procedures to be performed may entail certain risks and possible unsuccessful results, with even the possibility of failure to achieve the results that may be desired or expected. Even though care and diligence is exercised in the treatment, there are neither guarantees of anticipated or desired results nor any assurance of the longevity of the treatment. I agree to assume those risks, possible unsuccessful results and/or failure associated with but not limited to the following:

1. Reduction or roughening of tooth structure

In preparing the teeth for the reception of cosmetic veneers, it may be necessary to slightly reduce or roughen the surface of the tooth to which the veneer(s) may be bonded. This preparation will be done as conservatively as possible. If the veneer covering breaks or comes off, the uncovered tooth may become more susceptible to decay.

2. Sensitivity of teeth

Even though in the majority of the cases (whitening, bleaching, bonding and veneering teeth) there is usually no appreciable sensitivity, this type of treatment may cause teeth to become sensitive. Should sensitivity occur and persist for any length of time, please contact this office for an examination.

3. Chipping, breaking or loosening of the veneer

No matter how well the veneer is placed, this could occur. Many factors may contribute to this happening, including chewing of excessively hard materials, changes in occlusal (biting) forces, traumatic blows to the mouth, breakdown of the bonding agents and other conditions over which the doctor has no control.

4. Sensitive or allergic reactions of soft tissues to whitening, bleaching or bonding agents

This is an unusual occurrence. The gums or soft tissues of the mouth, which may be exposed to the various agents used in these procedures, may exhibit an allergic response. Also, gum tissues may in some cases exhibit signs of inflammation. Should this occur, please contact this office to be examined.

5. Aesthetics/appearance

Every effort possible will be made to match and coordinate both the form and shade of veneers and/or bonding agents to be cosmetically pleasing to the patient. However, there are some differences that may exist between the natural dentition and the artificial materials of the veneers and bonding agents, making it impossible to have the exact shade and/or form to perfectly match your natural dentition.

6. Longevity

It is impossible to identify any specific criteria on the length of time that veneers and bonding should last or for the lightened appearance of whitened or bleached teeth to maintain the lightened shades. These time periods may vary depending on many conditions existing from patient to patient as well as each patient's individual habits or circumstances.

It is the patient's responsibility to inform the doctor and seek attention from him/her should any undue or unexpected problems occur or if the patient is dissatisfied. Also, all instructions must be diligently followed, including scheduling and attending all appointments.

Informed consent

I have been given the opportunity to ask any and all questions regarding the nature and purpose of cosmetic dental treatment and have received all answers to my satisfaction. I voluntarily assume any and all possible risks, including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning the results. The fee(s) for these services have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. _____ and/or his/her associates to render any treatment deemed necessary, desirable and/or advisable to me, including the administration and/or prescribing of any anesthetics and/or medications.

Tooth No(s). _____

Patient signature/legally authorized representative Date _____

Printed name if signed on behalf of the patient Relationship _____

Witness signature Date _____

Consent for CT scan

A CT scan — also called “computerized tomography” — is an X-ray technique that produces images of your body that visualize internal structures in cross section, rather than the overlapping images typically produced by conventional X-ray exams.

A conventional X-ray of your mouth limits your dentist to a 2-D visualization. Diagnosis and treatment planning can require a more complete understanding of a complex 3-D anatomy. CT examinations provide a wealth of 3-D information, which can be used when planning for dental implants, surgical extractions, maxillofacial surgery and advanced dental restorative procedures. One benefit of CT scans is the greater chance for diagnosing conditions such as vertical root fractures, which can be missed a significant percentage of the time on conventional films and which can result in the patient avoiding unnecessary additional treatment. To summarize, the CT scan enhances your dentist’s ability to see what he/she needs to see before treatment is started.

CT scans are NOT recommended for pregnant women because of danger to the fetus. (Initial below as appropriate).

- _____ I am pregnant.
- _____ I am not pregnant.
- _____ I am unsure whether I am pregnant.

Risks

CT scans, like conventional X-rays, expose you to radiation. The amount of radiation you will be exposed to by the CT scan used by this office is approximately the equivalent to the exposure you would get from _____ days in the sun. An alternative to CT scans is conventional X-rays.

While parts of your anatomy beyond your mouth and jaw may be evident from the scan, your dentist is not qualified to diagnose conditions that may be present in those areas, nor will your dentist be looking for any abnormal conditions other than those normally diagnosed by a dentist involving the area of the mouth and jaw. Therefore, the mere fact that other structures may be evident on the scan does not mean that they are being examined by a professional to determine whether they are normal. Your dentist is not a physician or a specialist qualified to make those determinations. Our office can email our scan to your physician for a small administrative fee, if you ask us to do so.

Do not sign this form unless you have read it, understand it and agree with what it says.

I, _____, being 18 years or older, certify that I have read the above in the presence of _____ and that I understand the procedure to be used and its benefits, risks and alternatives. I acknowledge that I have had a full opportunity to discuss this matter with Dr. _____ and have had my questions answered. I give my consent to have Dr. _____ and his/her staff as he/she may designate, perform a CT scan.

Patient signature/legally authorized representative

Date _____

Printed name if signed on behalf of the patient

Relationship _____

Consent for dental implants

Patient name _____ Date of birth _____

You have the right and the obligation to make decisions regarding your healthcare. Your dentist can provide you with the necessary information and advice, but as a member of the healthcare team, you must participate in the decision-making process. This form will acknowledge your consent to treatment recommended by your dentist.

1. I request and authorize Dr. _____ or his/her associates or assistants to perform the surgical placement of dental implants upon me. This procedure has been recommended to me by my dentist as an option to replace my natural teeth.

Dental implants are metal anchors put inside the jawbone underneath the gum line. Small posts are attached to the implants and artificial teeth or dentures are fastened to the posts.

Most patients need two surgical procedures to install the implants. The first procedure involves drilling small holes into the jawbone and placing the anchors. A temporary denture may be worn for a few months while the anchors bond with the jawbone and the gums and bone heal. The second procedure will uncover the implants to allow for attachment of the posts. After the posts are in place, the replacement teeth, in the form of fixed or removable bridgework or a denture, are fastened to the posts. Depending on the condition of the mouth, bone grafting or guided tissue regeneration also might be necessary to install the anchors and posts.

The potential benefits of this procedure include the replacement of missing natural teeth or supporting dentures.

2. I have chosen to undergo this procedure after considering the alternative forms of treatment for my condition, which include no treatment at all, complete or partial dentures, or fixed or removable bridges. Each of these alternative forms of treatment has its own potential benefits, risks and complications.
3. I consent to the administration of anesthesia or other medications before, during or after the procedure by qualified personnel. I understand that all anesthetics or sedation medications involve the very rare potential of risks or complications such as damage to vital organs including the brain, heart, lungs, liver and kidneys; paralysis; cardiac arrest; and/or death from both known and unknown causes.
4. I understand that there are potential risks, complications and side effects associated with any dental procedure. Although it is impossible to list every potential risk, complication and side effect, I have been informed of some of the possible risks, complications and side effects of dental implant surgery. These could include but may not be limited to the following:
 - Postoperative discomfort and swelling
 - Bleeding
 - Postoperative infection
 - Injury or damage to adjacent teeth or roots of the teeth
 - Injury or damage to nerves in the lower jaw, causing temporary or permanent numbness and tingling of the chin, lips, cheek, gums or tongue
 - Restricted ability to open the mouth because of swelling and muscle soreness or stress on the joints in the jaw – temporomandibular joint (TMJ) syndrome

- Fracture of the jaw
- Bone loss of the jaw
- Penetration into the sinus cavity
- Mechanical failure of the anchor, posts or attached teeth
- Failure to implant itself
- Allergic or adverse reaction to any medications

Most of these risks, complications and side effects are not serious or do not happen frequently. Although these risks, complications and side effects occur only very rarely, they do sometimes occur and cannot be predicted or prevented by the dentist performing the procedure. Although most procedures have good results, I acknowledge that no guarantee has been made to me about the results of this procedure or the occurrence of any risks, complications or side effects.

These potential risks and complications could result in the need to repeat the procedures; remove the implants; or undergo additional dental, medical or surgical treatment or procedures, hospitalization or blood transfusions. Very rarely, the potential risks and complications could result in permanent disability or death. I recognize that during the course of treatment, unforeseeable conditions may require additional treatment or procedures. I request and authorize my dentist and other qualified medical personnel to perform such treatment as required.

5. I certify that I have read or had read to me the contents of this form. I have read or had read to me and will follow any patient instructions related to this procedure. I understand the potential risks, complications and side effects involved with any dental treatment or procedure and have decided to proceed with this procedure after considering the possibility of both known and unknown risks, complications, side effects and alternatives to the procedure. I declare that I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

_____ Date _____
Patient signature/legally authorized representative

_____ Relationship _____
Printed name if signed on behalf of the patient

Dental history and consent for treatment

Reason for seeking dental care at this time _____

Former dentist _____ City/state _____

Date of last dental visit _____

Reason? _____ Date of last X-rays _____

How often do you: Brush _____ times per _____ Floss _____ times per _____

How do you feel about dental treatment?

- Relaxed
- A little uneasy
- Tense
- Anxious
- Very anxious

Do you have or have you ever had any of the following? Please mark boxes and comment.

- Aching or sensitive teeth _____
- Broken filling _____
- Areas of food traps _____
- Unfavorable dental experience _____
- Sensitive or bleeding gums _____
- Loose teeth _____
- Difficulty opening wide _____
- Growths or lesions in your mouth _____
- Broken or missing teeth _____
- Bad breath _____
- Clicking or popping jaw _____
- Cold sores _____
- Grinding or clenching _____
- Swollen glands _____
- Jaw pain or tiredness _____
- Dry mouth _____
- Swelling or lumps in mouth _____
- Gum infection _____
- Orthodontic treatment _____
- Other _____

If you could change your smile, what would you change?

- Remove unsightly fillings
- Straighten teeth
- Change shape of teeth
- Close gaps in teeth
- Replace missing teeth
- Whitening
- Make teeth same color
- Other _____

Consent

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employ any such assistance as he/she deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others who may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

_____ Date _____
Patient signature/legally authorized representative

_____ Relationship _____
Printed name if signed on behalf of the patient

Primary insurance

Insured's name _____

Insurance company _____

Address _____

Union or local number _____

Group _____

Employer _____

Social Security number _____

Secondary insurance

Insured's name _____

Insurance company _____

Address _____

Union or local number _____

Group _____

Employer _____

Social Security number _____

Insurance agreement

I certify that the above insurance information is correct and in force. I am aware that it is my responsibility to read and understand my own dental insurance policy, including benefits, limitations and exclusions. I understand that filing of insurance claims is my responsibility and may be provided as a service to me and that any agreement for dental coverage is between my insurance company and me. I understand that an estimated portion is due at the time of service and is estimated according to expected coverage, which may not be disclosed nor guaranteed, by my insurance company. I understand that my portion may be more if my insurance company does not pay the anticipated amount. I also understand that services are rendered independent of insurance reimbursement.

_____ Date _____
Patient signature/legally authorized representative

Consent for dental procedure

Dentists, hygienists or staff have explained to me the following procedure, or treatment to be undertaken:

I am aware that alternative treatments/procedures may be available, as well as the option not to proceed with the recommended treatment/procedure. I also understand that there are inherent risks to this recommended treatment/procedure as well as to any alternative treatment/procedure, as well as postponing or declining this recommended treatment/procedure. Those risks may include but are not limited to:

In addition, my dentist or his/her staff has offered me a more detailed explanation of this recommended treatment/procedure — if I so desired. I am fully satisfied with the description and information given, and all of my questions/concerns have been satisfactorily answered.

I acknowledge that no guarantee or warranty has been made to me about the results of any of the above recommended choices. Therefore, I freely give my consent to this above recommended treatment/procedure.

_____ Date _____
Patient signature/legally authorized representative

_____ Relationship _____
Printed name if signed on behalf of the patient

Kinship caregiver's informed consent declaration for minors

Individuals authorized to provide informed consent to healthcare on behalf of a child under the age of 18 must be a member of one of the following classes of people in the following order of priority:

1. A guardian or legal custodian appointed by the court
2. A person authorized by the court to consent to medical care for a child in out-of-home placement pursuant to the dependency and termination of parental rights statutes
3. A parent of the minor patient
4. A person to whom the minor's parent has given a signed authorization to make healthcare decisions for the minor patient
5. A competent adult presenting himself or herself to be a relative responsible for the healthcare of such minor patient or competent adult who has signed and dated a declaration under penalty of perjury stating that he or she is a relative who is responsible for the healthcare of the minor patient

The following declaration applies to a person in category 5 listed above.

I (print name) _____ am a relative of
(print name of minor patient) _____
and am responsible for his/her healthcare. I declare under penalty of perjury that the foregoing is true and correct.

Signed at (place) _____ on (date) _____.

Signature Date _____

Printed name Relationship _____

This declaration is effective for no more than six months from the date on which it is signed.

Consent for oral sedation/anesthesia

Patient name _____ Date _____

Procedure _____

I have requested an oral sedative: Valium, Halcion, Ativan, (other) _____ with a dosage of _____ to help relieve anxiety and/or apprehension. I understand the sedative may cause dizziness, drowsiness, time constriction, motor incoordination and fatigue. I understand that I must have an adult transport me to the office and home afterward. I understand that I will be under the influence of the sedative for 8 to 10 hours and agree to stay at home under the supervision of an adult and will not attempt to drive, supervise or care for children, or perform anything that requires coordination or personal judgment. I understand that I can NOT have any alcohol, tranquilizers or other sedatives on the day of the treatment – either before or after treatment.

Anesthesia includes:

Local anesthesia: Novocain, Lidocaine, etc., to block pain pathways in a localized area

Local intravenous sedation or general anesthesia: alters your awareness of the procedure by producing sedative/amnesic effects or sleep

I understand there are risks involved with both anesthesia and oral sedation that can include but are not limited to:

- Nausea and vomiting
- Temporary partial numbness to face or tongue
- Unexpected allergic reaction
- Pain, swelling, bruising or inflammation to the area of injection
- Prolonged disorientation, confusion or drowsiness after treatment
- Respiratory or cardiovascular responses that can lead to stroke, heart attack or death

I also understand and agree that prior to any anesthesia, I will not ingest any fluids or solids by mouth for six (6) hours prior to the dental procedure as this could be life-threatening.

I understand that I must have an adult transport me to the office and home afterward. I understand that I will be under the influence of the sedative for 8 to 10 hours and agree to stay at home under the supervision of an adult and will not attempt to drive, supervise or care for children, or perform anything that requires coordination or personal judgment.

I also agree that I have provided a complete and truthful medical history that includes all medications, drug use, pregnancy, etc.

We invite your questions concerning this or related procedures and their risks. By signing below you acknowledge that you have read this document, understand the information presented, understand that you could see a specialist but are choosing care from the treating dentist, and have had all your questions answered satisfactorily.

Additional comments _____

_____ Date _____
Patient signature

Printed name

_____ Date _____
Doctor signature

_____ Date _____
Witness signature

Consent for oral surgery

Patient name _____ Date _____

I hereby authorize Dr. _____ and any associates to perform the following procedure _____.

The doctor has explained to me the proposed treatment and the anticipated results of such treatment. I understand this is an elective procedure and that there are other forms of treatment available, including the option of no treatment.

The doctor has explained to me that there are certain potential risks in this treatment plan or procedure. These include:

1. Injury to a nerve resulting in numbness or tingling of the chin, lip, cheek, gums and/or tongue on the operated side; this can persist for several weeks, months or, in rare instances, permanently
2. Postoperative infection requiring additional treatment
3. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery
4. Restricted mouth opening for several days or weeks, with possible dislocation of the temporomandibular (jaw) joint
5. Injury to adjacent teeth or fillings
6. In rare circumstances, cardiac arrest or breakage of the jaw
7. Postoperative discomfort, swelling and bleeding that may necessitate several days of recuperation
8. A small piece of root left in the jaw when removal would require extensive surgery
9. Stretching of the corners of the mouth with resultant cracking and bruising
10. _____

Unforeseen conditions may arise during the procedure that require a different procedure than set forth above. I therefore authorize the doctor and any associates to perform such procedures when, in their professional judgment, they are deemed necessary.

I understand that medications, drugs, anesthetics and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I also understand that I should not consume alcohol or other drugs at the same time because they can increase these effects. I have been advised not to work and not operate any vehicle, automobile or hazardous devices while taking such medications and until fully recovered from their effects.

It has been explained to me and I understand that a perfect result is not guaranteed or warranted.

Please don't hesitate to ask the doctor or staff if you have any questions.

Patient signature/legally authorized representative Date _____

Printed name if signed on behalf of the patient Relationship _____

Doctor signature Date _____

Consent for oral surgical treatment in patients who have received oral bisphosphonate drugs

Patient name _____ Date _____

Please initial each paragraph after reading. If you have any questions, please ask your doctor **before** initialing.

Having been treated previously with oral bisphosphonate drugs, you should know that there is a very small but real risk of future complications associated with dental treatment. This risk is currently estimated to be less than 2/10 of 1 percent up to 4 percent. Bisphosphonate drugs appear to adversely affect the health of jaw bones, thereby reducing or eliminating the jaw bone's ordinarily excellent healing capacity. This risk is increased after surgery, especially with extraction, implant placement or other "invasive" procedures that might cause even mild trauma to the bone. Spontaneous exposure of the jaw bone (osteonecrosis) can result. This is a smoldering, long-term, destructive process in the jaw bone that is often very difficult or impossible to eliminate.

Your medical/dental history is very important. We must know the medications and drugs that you have received or taken or are currently receiving or taking. An accurate medical history, including names of physicians, is important.

The decision to discontinue oral bisphosphonate drug therapy before dental treatment should be made by you in consultation with your medical doctor.

1. ___ If a complication occurs, antibiotic therapy may be used to help control infection. For some patients, such therapy may cause allergic responses or have undesirable side effects such as gastric discomfort, diarrhea, colitis, etc.
2. ___ Despite all precautions, there may be delayed healing, osteonecrosis, loss of bone and soft tissues, pathologic fracture of the jaw, oral cutaneous fistula (open draining wound), or other significant complications.
3. ___ If osteonecrosis should occur, treatment may be prolonged and difficult, involving ongoing intensive therapy, including hospitalization, long-term antibiotics and debridement to remove nonvital bone. Reconstructive surgery may be required, including bone grafting, metal plates and screws, and/or skin flaps and grafts.
4. ___ Even if there are no immediate complications from the proposed dental treatment, the area is always subject to spontaneous breakdown and infection because of the condition of the bone. Even minimal trauma from a toothbrush, chewing hard food or denture sores may trigger a complication.
5. ___ Long-term post-operative monitoring may be required, and cooperation in keeping scheduled appointments is important. Regular and frequent dental check-ups with your dentist are important to monitor and attempt to prevent breakdown in your oral health.

6. ___ I have read the above paragraphs and understand the possible risks of undergoing my planned treatment. I understand and agree to the following treatment plan. _____

7. ___ I understand the importance of my health history and affirm that I have given any and all information that may impact my care. I understand that failure to give true health information may adversely affect my care and lead to unwanted complications.
8. ___ I realize that, despite all precautions taken to avoid complications, there can be no guarantee as to the result of the proposed treatment.

Consent

I certify that I speak, read and write English and have read and fully understand this consent for surgery, have had my questions answered, and that all blanks were filled in prior to my initials or signature.

_____ Date _____
Patient signature

Printed name

_____ Date _____
Doctor signature

_____ Date _____
Witness signature

Consent to perform periodontal cleaning

I, _____, have been informed that I have periodontal disease, and the progression of this disease has been explained to me. As a result, I fully understand the following regarding periodontal disease:

1. This disease has resulted in the loss of bone that normally supports the teeth.
2. To help prevent further loss of bone around my teeth, I must prevent buildup of live bacteria called “bacterial plaque” on a daily basis, and it is my responsibility to schedule regular dental checkups and cleanings after treatment for periodontal disease is complete.
3. The proposed treatment plan is intended to arrest the effects of periodontal disease and has been explained to me. I understand that further treatment may be needed, if additional problems develop.
4. As a result of periodontal root planing and curettage:
 - a) The gums will be more receded where cleaned, and portions of the roots will be exposed post cleaning.
 - b) The exposed roots will be more sensitive to hot, cold and/or sweets. This problem usually corrects itself in about six months. Occasionally, further treatment may be needed. On rare occasions, this condition persists despite treatment.
 - c) The exposed roots, being more porous, will stain more easily than the crowns of teeth.
 - d) Food will collect more easily between teeth after meals.
 - e) The teeth may be looser immediately after cleaning. This occasionally persists indefinitely on isolated teeth where more bone loss has taken place. Normally, the teeth will eventually be about as loose as they were pre-operatively.
 - f) If significant bone loss has occurred around upper front teeth, speech may be slurred postoperatively. In severe cases, an appliance may be needed to replace missing gum tissue around the front teeth for aesthetics and to correct this speech problem.
5. Failure to follow these recommended actions will most likely result in continued bone loss with probable periodontal abscesses and eventual tooth loss.
6. After an appropriate healing period, the status of periodontal disease will be re-evaluated. At that time, referral to a periodontist for periodontal surgery may be indicated.

I am aware that the practice of dentistry is an inexact science, and I acknowledge that no guarantees regarding the outcome of the periodontal cleaning have been made to me. The risks involved in the administration of anesthetics, sedative agents and the surgery itself have been fully explained to me, and I do give my free voluntary informed consent to the same.

Patient signature Date _____

Printed name

Dentist signature Date _____

Informed consent for periodontal root planing and scaling

I understand that periodontal procedures (treatment involving the gum tissues and other tissues supporting the teeth) include risks and possible unsuccessful results from such treatment. Even when the utmost care and diligence is exercised in the treatment of periodontal disease and associated conditions through scaling and root planing, risks and results associated with treatment include but are not limited to the following:

1. Response to treatment

Because of the variables within each patient's physiological makeup, it is impossible to determine whether or not the healing process, in which tissue response is a vital element, will achieve the results desired by Dr. _____ and the patient. Should the desired results not be attained, extractions may be required.

2. Postoperative patient responsibility for care

With the types of treatment required in correcting periodontal problems, it is mandatory that the patient exercise extreme diligence in performing the home care required after treatment, as instructed by the treating dentist. Without the necessary follow-up care, the probability of unsatisfactory results is greatly increased.

3. Pain, soreness and sensitivity

There may be temporary or permanent postoperative discomfort, related to hot and cold stimuli, contact with teeth, and sweet and sour foods, and the gums also may be sore immediately following treatment.

4. Bleeding during or after treatment

Laceration or tearing of the gums may occur and might require suturing. The gums may bleed as well, during or after treatment.

5. Recession of the gums after treatment

After healing occurs, there may be gum recession that exposes the margin or edge of crowns or fillings, increases sensitivity of teeth, and creates aesthetic or cosmetic changes in the front teeth, resulting in longer tooth appearance and wider inter-proximal spaces. These wider inter-proximal spaces are more likely to trap food.

6. Broken curettes, scalers or other instruments

If an instrument breaks off during scaling or root planing, it may be necessary to retrieve the broken instrument surgically.

7. Post-treatment infection

Post-treatment infection also can result from calculus being lodged in the tissue, which also can require surgical intervention.

8. Increased mobility (looseness) of the teeth during the healing period

Some patients experience increased mobility of teeth during the healing period. This is usually a temporary condition.

9. Noise and water spray

Ultrasonic instrumentation is noisy and the water used may cause cold sensitivity during treatment on nonanesthetized teeth not being treated.

10. Post-treatment complications

Cracking or stretching of the lips or corners of the mouth during treatment is possible. There is the possibility that additional surgical treatment may be necessary after root planing.

11. Sequela of local drug delivery

If tetracycline fiber is used, there may be premature loss of the fibers necessitating a return visit to the dental office for replacement. There may be soreness or pain in the treated areas. The patient will be aware of the adhesive sealer, which often has a granular surface. The sealer has an opaque or milky appearance that may be visible. There will be a need for a postoperative visit to remove the fibers seven to 10 days after placement. There may be an adverse reaction to the antibiotic in the fiber, whether a pre-existing known allergy exists or not.

Informed consent

I have been given the opportunity to ask questions regarding the nature and purpose of periodontal treatment and have received answers to my satisfaction. I voluntarily assume any and all known possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No promises or guarantees have been made to me concerning my recovery and results of this treatment. The fee(s) for this service have been explained to me and are acceptable. By signing this form, I am freely giving my consent to allow and authorize Dr. _____ and/or his/her associates to render any treatment necessary or advisable for my dental conditions, including any and all anesthetics and/or medications.

_____ Date _____
Patient signature

Printed name

_____ Date _____
Witness signature

Informed consent for pulpotomy (permanent teeth)

A pulpotomy is an interim treatment done with the intention of temporarily preserving a vital tooth without removing all of the pulpal or nerve tissue. During a pulpotomy, tissue is generally removed from the pulp chamber but tissue contained in the root canals of the tooth remains. Complete removal of tissue from within the tooth is termed a pulpectomy.

I understand that a pulpotomy is performed as a temporary measure in all but the most unusual cases in the attempt to preserve the tooth for an undetermined period of time depending upon the circumstances for which the temporary preservation is required, and that this treatment may include inherent risks including but not limited to the following:

1. **Root canal treatment**

Even though it is anticipated that this treatment may extend the time in which a tooth will remain vital until further necessary procedures may be successfully performed at a more appropriate time, it may be necessary to perform complete root canal treatment (pulpectomy) if conditions should so dictate. Care should be taken not to unduly delay completion of the root canal process. Referral to an endodontic specialist may be necessary as determined by the attending dentist.

2. **Numbness**

There is the possibility of injury to the nerves of the face or tissues of the oral cavity during the administration of anesthetics or during the treatment procedures, which may cause a numbness of the lips, tongue, tissues of the mouth and/or facial tissues. This numbness is usually temporary but can be permanent.

3. **Fracture**

The crown portion of the tooth may be weakened because of the nature of the procedure and/or the tooth injury or disease that necessitated this procedure. As a result, the tooth may be more susceptible to fracture or breakage.

4. **Temporary crown**

Should the remaining tooth structure appear to be excessively fragile, it may be necessary to place a temporary crown on the tooth to preserve it.

5. **Extraction**

If the tooth does not heal, it fractures extensively or it is unacceptable for the performance of a complete root canal treatment, extraction of the tooth may be necessary.

6. **Pain**

In most cases, once the pulpectomy has been performed and the initial pain has subsided, the tooth is no longer painful. However, in some cases, severe pain or extreme sensitivity will persist. If so, it is the patient's responsibility to notify the dentist immediately.

I acknowledge that it is my responsibility to seek immediate attention should any undue problems occur after treatment. I shall diligently follow all preoperative and postoperative instructions given to me.

Informed consent

I have been given the opportunity to ask any questions regarding the nature and purpose of having a pulpotomy procedure performed and have received answers to my satisfaction. I voluntarily undergo this treatment in hopes of obtaining the desired results, which may or may not be achieved. I specifically acknowledge that no guarantees or promises have been made to me concerning my recovery or the results of the treatment provided to me. I acknowledge and accept any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment. The fee(s) for this service have been explained to me and are acceptable. By signing this form, I freely give my consent to allow and authorize Dr. _____ and/or his/her associates to render that treatment necessary or advisable with respect to my dental conditions, including the administration and/or prescribing of any and all anesthetics and/or medications.

_____ Date _____
Patient signature

Printed name

_____ Date _____
Witness signature

Informed consent for sealants

I understand that the treatment of teeth through the use of sealants is a preventative measure intended to facilitate the inhibition of dental caries (tooth decay or cavities) in the pits and fissures of the chewing surfaces of the teeth. Sealants are placed with the intention of preventing or delaying conventional restorative measures used in restoring teeth with fillings or crowns after the onset of dental caries. I agree to assume any risks that may be associated with the placement of sealants even though care and diligence will be exercised by Dr. _____ while rendering this treatment. In addition to possible unsuccessful results and failure of the sealant, the risks of the procedure include but are not limited to the following:

1. Preparation of the teeth

The teeth are prepared through use of an enamel etching technique. This etching is accomplished in one of two ways:

- a) Through the use of a special acid solution that etches the surface enamel in the area in which the sealant is to be placed to aid in its retention. The etching solution is somewhat caustic, and if the patient makes any unexpected movement during the application process, there is the possibility that a small amount of the solution will attach to the soft tissues of the mouth, which could cause some slight tissue burns. This seldom occurs, but it is a possibility. If the etching solution contacts the root surface, the tooth may develop some temporary sensitivity.
- b) Through the use of a technique called "air abrasion." Air abrasion also slightly etches the surface of the enamel in the area in which sealant is to be placed to aid in the retention of the sealant. Air abrasion involves the generation of a powdery dust, which, if inhaled, could cause some discomfort.

2. Loosening and/or dislodging of the sealant

There is the possibility of the sealant loosening or becoming dislodged over time. The length of time over which this may happen is indeterminable because of the many variables that can impact the life of the sealant including but not limited to the following:

- a) The forces of mastication (chewing). These forces differ from patient to patient. The forces may be much greater in one patient than in another. Also, the way teeth occlude (come together in chewing) may have an effect on the life of the sealants.
- b) The types of food or other substances that are put in the mouth and chewed. Very sticky food, including some types of gum, sticky candies such as caramels, some licorices, very hard substances, etc., can cause loosening or dislodgment of the sealant.
- c) Inadequate oral hygiene such as infrequent or improper brushing of the teeth also may allow leakage around and under the sealant causing it to loosen and allow decay to develop.

3. Entire tooth is not protected with sealants

Sealants are applied primarily to the pits and fissures that are in the chewing surfaces of the teeth. These pits and fissures are extremely susceptible to decay and can be protected through the application of sealants that flow into and seal those areas. However, sealants do not protect the areas between the teeth, so thorough brushing and the use of dental floss in these areas is necessary. Otherwise, decay could develop in those areas uncovered by the sealants.

I understand that it is my responsibility to notify this office should any unexpected problems occur or if any problems relating to the treatment rendered are experienced. Routine examinations by the dentist are recommended to allow ongoing assessment of the sealants placed.

Informed consent

I have been given the opportunity to ask questions regarding the nature and purpose of sealants and have received answers to my satisfaction. I voluntarily undergo this treatment in hopes of achieving the desired results from the treatment rendered, though no guarantees have been made regarding the outcome.

I hereby assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment. The fee(s) for these services have been explained to me, and I accept them as satisfactory. By signing this form, I am freely giving my consent to authorize

Dr. _____ and/or all associates involved in rendering services or treatment necessary to the existing dental condition, including the administration and/or prescribing of any anesthetic agents and/or medications.

_____ Date _____
Patient signature

Printed name

_____ Date _____
Witness signature

Informed consent and permission form

Before you give your permission for the removal of teeth, removal of impacted teeth (those that are “buried” or beneath the gums), other dental treatment, or the administration of certain anesthetics, you should understand that there are certain associated risks.

Common risks include but are not limited to:

1. Drug reactions and side effects
2. Damage to adjacent teeth or fillings
3. Postoperative infection
4. Postoperative bleeding that may require treatment
5. Possibility of a small fragment of root being left in the jaw and its removal, requiring extensive surgery
6. Delayed healing (dry socket) necessitating frequent postoperative care
7. Possible involvement of the sinus during removal of upper molars, which may require additional treatment or surgical repair at a later date
8. Possible involvement of the nerve during the removal of lower molars resulting in temporary or possible permanent tingling or numbness of the lower lip, chin or tongue on the operated side
9. Bruising and/or vein inflammation at the site of administration of intravenous medications, which may require further treatment
10. Other _____

I was given the option of different anesthetic techniques, and I consent for the following anesthetics to be used:

- _____ Local anesthesia
- _____ Local anesthesia with intravenous sedation
- _____ Local anesthesia with oral premedication
- _____ General anesthesia/hospital operating room

I hereby acknowledge that I have completely read the foregoing, have discussed any questions or concerns that I may have regarding my proposed surgery/dental treatment, and have been given satisfactory answers. I am aware that the practice of dentistry is an inexact science and that no guarantees can be provided and none have been made to me.

Patient signature Date _____

Printed name *Printed initial*

Witness signature Date _____

Informed consent statement for periodontal disease

This information is to ensure that you are aware of the existing periodontal disease (gum disease) and infection present in your mouth. It is to acknowledge that you have been informed of the existence of this disease and given a copy of the periodontal pocket charting. The consequence of nontreatment will likely result in a progression of this infection and, if it continues, eventual bone loss, loosening of teeth and the ultimate loss of teeth. This release also acknowledges that on this date, at least two options for treatment were offered to you:

1. A nonsurgical approach to periodontal disease in which you are an active co-participant
2. Referral to a periodontal specialist for a surgical approach to therapy or other treatment as deemed appropriate

I accept option 1, for which a fee of \$ _____ has been quoted, and I accept responsibility for the same.

_____ Date _____
Patient signature

I accept option 2 and prefer to be referred to a specialist for treatment.

_____ Date _____
Patient signature

Name of specialist to whom patient was referred _____

I decline both options 1 and 2, and I prefer to have only a basic cleaning of my teeth, knowing that cleaning by itself will not prevent advancement of my disease or correct the disease. I also understand that the consequences include possible loss of bone and teeth because of nontreatment of the disease.

_____ Date _____
Patient signature

Informed consent for occlusal equilibration

Patient name _____ Date _____

Dentist _____

Selective reshaping of the chewing surfaces of teeth with the intention to reposition the mandible and stress relieve the muscle in the head and neck suspension apparatus

_____ Occlusal equilibration

_____ Following preconditioning appliance therapy

I, the undersigned, have sought or have been referred to the above named dentist for occlusal equilibration, which I understand is a means of altering the chewing surfaces of some or all of my teeth, so that when my teeth come together, the temporomandibular joints (jaw joints) are in better anatomical position. I fully understand the importance of the history that I have given to the dentist, which together with the dentist's examination, indicated that the symptoms I have reported to the dentist may be improved.

I understand that the dentist does not guarantee any outcome as a result of changing the chewing surfaces of my teeth, and in fact, I have been informed by the dentist that there are possible complications that can occur despite the exercise of the dentist's skill and care. These complications include but are not limited to loss of a portion of tooth enamel; the possibility that a tooth or teeth may prove unsound and require restoration, including the replacement of existing restorations; the rebuilding of a tooth or teeth by removing additional amounts of tooth structure and replacing it with a crown, which may require additional cost; pain in the face and jaw; chewing difficulty; joint noise; and sensitive teeth.

I further understand that additional dental services may be required in the future such as additional equilibration and additional recommended dental care and treatment as set forth in the treatment plan presented by the dentist, if one has been discussed and agreed upon. I further understand that if extensive equilibration is required there may be some change in the appearance of the teeth and mouth and some increased sensitivity to temperature extremes. The dentist has explained to me that there are other approaches to occlusal equilibration, such as occlusal appliance therapy, orthodontics, reconstructive dentistry and orthognathic surgery. Although all these options have been discussed and offered to me, I have selected occlusal equilibration.

I fully consent to receiving occlusal equilibration from the dentist and to pay all reasonable and necessary charges related thereto, which have been previously and fully explained to me.

Patient signature/legally authorized representative

Date _____

Printed name if signed on behalf of the patient

Relationship _____

Dentist signature

Date _____

Informed consent for nitrous oxide sedation

Patient name _____ Date _____

Introduction

Nitrous oxide is a colorless, slightly sweet gas that is used during dental treatment for relaxation and anxiety relief. When inhaled, it can induce feelings of euphoria and sedation. It also can produce sensations of drowsiness, warmth and tingling in the hands, feet and/or about the mouth. In the dental setting, it will not induce unconsciousness. You will be able to swallow, talk and cough as needed.

Contraindications

Please let us know if you have any of the following medical conditions, because we may not be able to safely use nitrous oxide: congestive heart failure, chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, chronic asthma, bronchiectasis, pregnancy, hepatitis B or C, tuberculosis, macrocytic anemia, immune diseases, respiratory diseases, middle ear infections, or a history of substance abuse. Also, if you suffer from claustrophobia, you may choose not to use nitrous oxide.

Preoperative guidelines

Nitrous oxide is administered through a nasal mask. You must be able to breathe through the nose (blocked nasal passages, colds, etc., defeat the idea of using nitrous oxide for relaxation). Avoid eating at least four hours prior to the dental appointment. Avoid caffeinated products before coming in for treatment. Nitrous oxide can cause “stomach butterflies” (nausea), which may result in vomiting. On the day of your appointment do not take any antidepressants (unless your dentist is aware of them) or other sedatives unless prescribed by your dentist.

Instructions during nitrous oxide use

Your mask must remain firmly in place during the entire period. Do not breathe through your mouth. Breathe through the nose only. Notify the doctor if you are experiencing difficulty in breathing through your nose. No talking is allowed while nitrous oxide is being used. Talking blows nitrous oxide into the room, lessening the desired effect for you, and exposing the dental staff to the nitrous effects.

Postoperative guidelines

Recovery from nitrous oxide sedation is rapid. The gas will be flushed from your system with oxygen. If you feel dizzy after the sedation, remain seated, and the sensation should pass in a few minutes. Do not leave the office until your head feels clear, and you are able to function (i.e., walk and drive) safely.

Risks of nitrous oxide

You may feel nauseated, dizzy, drowsy or claustrophobic during and after sedation.

Alternatives to nitrous oxide

You may choose not to use nitrous oxide and complete your dental treatment without any treatment for anxiety. You may choose, if your dentist feels this is an option for you, to take an oral sedative or a pill that will relieve your anxiety. This consent is valid for a period of twelve (12) months. I may withdraw my consent at any time.

I understand the previous statements and have had my questions answered.

_____ Date _____
Patient signature/legally authorized representative

_____ Relationship _____
Printed name if signed on behalf of the patient

_____ Date _____
Dentist signature

_____ Date _____
Witness signature

Informed refusal of recommended treatment

Patient name _____ Date _____

You have the right and the obligation to make decisions regarding your healthcare. Your dentist can provide you with the necessary information and advice, but as a member of the healthcare team, you must participate in the decision-making process. This form will acknowledge your refusal of treatment recommended by your dentist.

Dr. _____ has recommended the following treatment to me _____

This treatment has been recommended to me for the purpose of _____

The possible benefits of proceeding with the recommended treatment include _____

The possible risks and complications of refusing the recommended treatment could include but are not limited to _____

These potential risks and complications could result in additional medical or dental treatment or procedures, tooth loss, hospitalization, blood transfusions, or, very rarely, permanent disability or death.

I have chosen to refuse this treatment after considering both the recommended and alternative forms of diagnosis and/or treatment for my condition. Each of these alternative forms of diagnosis or treatment has its own potential benefits, risks and complications.

I certify that I have read or had read to me the contents of this form. I understand the possible advantages of proceeding with the recommended treatment and the possible risks and consequences of refusing the recommended treatment. I have decided to refuse the treatment recommended by my dentist. I hereby release Dr. _____ and his/her employees, partners, agents or corporation from any liability for any and all injuries and damages I may sustain as a result of my refusing recommended dental treatment. I attest that I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

Patient signature/legally authorized representative Date _____

Printed name if signed on behalf of the patient Relationship _____

Dentist signature Date _____

Witness signature Date _____