Patient completion of treatment record keeping requirements:

1. Signatures:
   - On rad hx,--Rx for radiographs: student (date and sign), RDH instructor, dentist; for retakes, student; RDH
   - At completion of EIOE: student, RDH instructor
   - At completion of tx (bottom of EIOE form): student (date and sign) and instructor
   - On dental (hard tissue) charting: student (date and sign), instructor and dentist
   - On perio charting: student (date and sign), instructor and dentist (for rad pathology)
   - Perio charting is complete with AL numbers noted and gingival margin (green line) and mucogingival (blue dotted line) drawn
2. Med hx: Filled out completely with dentist's and physician's first and last name with full street address, city, state, zip
   - If recare series of appts, pt has written in recare space "no changes" in own handwriting and pt, student and instructor have signed, dated
3. Clearances: address answers to all questions asked
4. PFI: calculation noted in %, dated
5. Tobacco assessment filled out by pt; student notes on back showing intervention at least every recare visit
6. Caries risk dated: ADA form for first year: all risk factors noted, quantified w/a number; CDA for second year: note baseline or recall, all risk factors circled; risk assessment circled, visualize with "X" on balance
7. Referral of conditions:
   - Filled out completely with dentist's first and last name with full street address, city, state, zip
   - Filled out completely with pt's first and last name with full street address, city, state, zip
   - Filled out w/pt's name and date of exam
   - Services provided by student circled
   - If radiographs, type(s) listed circled yes if taken and whether or not printed and enclosed or will be sent digitally; if none taken, circled no; circle something whether or not being kept in pt chart for EFDA/dentist found
   - Dentist's signature; student's signature with date sent to dentist of record
8. Treatment plan:
   - Plan acceptance signed/dated
   - Care plan completed signed/dated
   - DCI column filled in for each appt
9. Treatment notes:
   - if diabetic client: notes state in client handwriting the day's blood sugar, what eaten today, what meds taken; if client requires premed, in client handwriting what was taken and when, the #milligrams
   - reflect perio and caries dx and dentist signature
   - reflect dentist approval of Rx items (injectable anesthesia, 5000ppm fluoride, CHX, Arestin)
   - reflect all medicaments used during appt, including names/ingredients and amounts in mg/ml of local anesthetic, topical anesthetic used
   - reflect all signatures of student and RDH instructor.
   - Reflects that ROC has been sent to dentist of record
   - Reflects ALL phone conversations with pt., attempts to make appts., cancellations, broken appts w/student signature
10. Tracking sheet

    Stage of Work: Pt complete date noted, date re-eval,, if applicable, complete noted

    Dates next to Physiotherapy aids used

    Dates and charges noted next to
    - Exam, radiographs, fluoride
    - 4910 for previous 4341 or pt w/bone loss, previous active periodontal disease
    - 4345 for calc 3, BLC 1
    - 4910 and 4342 (localize root planing) used together tooth numbers
    - Sealants completed with tooth numbers noted
11. All "like" forms stapled together with most recent on top