

Fundamentals of Dental Recordkeeping Checklist

Use this checklist to ensure your dental records meet RCDSO's [Dental Recordkeeping Guidelines](#) for accuracy, completeness, legibility, security, and continuity of care.

Details on documentation required for each step are reviewed in the RCDSO's course [Fundamentals of Dental Recordkeeping](#).

Accurate and comprehensive dental recordkeeping is a foundational component of quality patient care and professional accountability.

General Information

- Full legal name, date of birth, address, contact and demographic details.
- Emergency contact.
- Name of the person or agency responsible for payment.
- Insurance information, if applicable.

Confidentiality & Privacy

- Follow confidentiality and privacy requirements.
- Secure storage of digital and paper records in accordance with PHIPA.
- Store clinical and financial records separately.

Additional Information Referral Record Management

- Records must be retained in their original format.
- Records can be destroyed only when retention period has passed.
- Preserve patient confidentiality.
- Align with PHIPA requirements.
- Routine backups and restoration checks.
- Restrict access to authorized staff only.

Transfer or Change of Practice Ownership

- Ensure appropriate patient notification.
- Maintain continuity and access during practice changes.



1. Case History



2. Clinical Exam



3. Diagnosis & Treatment Plan



4. Consent to Treatment



5. Progress Notes



6. Referral Documentation

1. Case History

1a Medical History

- Complete before initiating treatment, update at each recall and before invasive procedures.
- Systemic conditions, allergies, medications, surgeries, and hospitalizations.

1b Dental History

- Previous dental treatments, complications, habits (e.g. tobacco and alcohol use), and oral hygiene patterns.
- Last dental visit and recommended recall intervals.

2. Clinical Examination

- Vital signs.
- Extra-oral and intra-oral findings.
- Periodontal assessment.
- Number of radiographs, labeled and dated, and clinical rationale.

3. Diagnosis & Treatment Plan

- Record diagnosis and options based on clinical and radiographic findings.
- Detailed treatment plan, including services to be provided, estimated timeline and number of visits for complex treatment.
- Document recall exams and rationale.
- Medical/dental histories.
- Postoperative follow-ups and compliance issues.

4. Consent to Treatment

- Consent for referral.
- Verbal and written consent.
- Nature and purpose of treatment.
- Discussion of risks, benefits, alternatives, relevant fees, and no treatment consequences.
- Document whether consent was given or refused and by whom.

5. Progress Notes

- Date entries for each visit, provider signature/initials.
- Any medications prescribed, dispensed or administered and the dosage of each.
- Post-treatment instructions and /or advice.

6. Referrals & Communication

- Referral letters sent and received (including clear instructions on the nature and scope of referrals and any relevant materials and/or information).
- Communications with other providers and summaries of patient discussions.