

American Association of Dental Examiners

The Dental Patient Record

A Guideline Document published by
the American Association of Dental Examiners

And Report of the AADE Committee to Develop Guidelines on Recordkeeping

R. Mark Hinrichs, D.D.S. Chair
Mark L. Christensen, D.D.S., M.B.A.
Guy S. Shampaine, D.D.S.
Lili Reitz, Esq.

Consultants

Victor Sandoval, D.D.S., M.P.I.
Joan Dietrich, ADA

[June 12, 2009]

The Dental Patient Record

Introduction

This guideline document was developed to assist Dental Boards in their investigations of, response to and management of cases involving inappropriate or inadequate dental record keeping practices.

Dental Boards are responsible for protecting the health and safety of the public by setting standards for obtaining or maintaining licensure. This duty includes investigation of licensee record keeping practices that compromise the health, safety or well-being of patients.

Dental Boards recognize that different approaches to dental record keeping practices are common. This guideline therefore is necessarily general. However, basic requirements for the creation and maintenance of an effective dental patient record are universal. It is felt that having ready reference to the universal characteristics of the dental patient record will facilitate the work of regulatory agencies and help clarify record keeping issues for licensees.

This document is intended for use, with judgment, as a guide.

Contents

Introduction	2
The Dental Patient Record	4
General Patient Information.....	4
Medical History	4
Dental History	5
Oral and Physical Evaluation.....	5
Treatment Plan	7
Informed Consent	8
Progress Notes	9
Patient Referral	11
Legibility	11
Dating	11
Regulatory Requirements	12
Termination of the Doctor-Patient Relationship	12
Release or Transfer of Dental Patient Records or Information	14
Maintenance of Dental Patient Records.....	15
Appendix – Sample Disciplinary Order	16

The Dental Patient Record

The dental patient record is essential for the delivery of comprehensive care that will ensure optimum oral health for the patient. The dental patient record provides a history of care delivered to the patient, the results of examinations and diagnostic tests, imaging studies, a plan for addressing conditions that warrant treatment and other pertinent information that assists those who provide care to the patient. It is also a legal record that documents professional care provided to the patient.

These guidelines discuss the components of the dental patient record. Items discussed are not necessarily all required for every dental patient record; the inclusion and detail of some components are left to the clinical judgment of the attending dentist.

General Patient Information

General patient information is a component of every dental patient record. General information includes the patient's:

- Name
- Age (birth date)
- Gender
- Address
- Contact Information
- Emergency Contact Information

Medical History

The patient's medical history, in appropriate detail, is a mandatory component of every dental patient record. Evaluation of the patient's medical history and information is essential in determining the appropriateness, delivery and type of dental care for the patient. The patient's medical history typically includes:

- Review of systems
- Past medical history, including prior surgeries and resident hospitalizations
- List of physicians, including the patient's primary care and specialty physicians
- Current prescription and non-prescription medications the patient is taking

- A record of any medical consultations and the results of those consultations
- Any medical or psychological conditions that may affect the delivery of care or the expected outcome of therapeutic intervention
- Any additional medical information provided by the patient

Dental History

The dental patient record should include relevant dental history as documented or reported by the patient. The dental history recorded by a general dentist may be broader in scope than the dental history recorded by a specialist. The dental history should contain the patient's:

- Chief complaint or reason for seeking care, and desired outcome or treatment goal
- History of past dental treatment
- Home care practices
- Relevant dietary habits
- Other practices or habits that may affect the delivery or outcome of treatment

Oral and Physical Evaluation

Complete oral assessment involves the objective evaluation of intra-oral and extra-oral hard and soft tissues, anatomic abnormalities, missing teeth, previous restorations, appliances or prostheses the patient is wearing or using, any disease present, and any symptom or functional problem that needs to be addressed. These objective findings, evaluated in conjunction with the patient's medical and dental histories, provide the foundation for optimal preventive or therapeutic intervention.

Relevant findings should be thoroughly documented. The scope of the focused physical examination and of the dental examination is determined by the extent and type of treatment. For example, the administration of sedation and/or general anesthesia or the management of chronic pain would require a more in-depth focused medical physical examination and valuation than routine restorative dentistry. Any significant pathology or abnormal condition, if clinically significant, should be recorded. Oral cancer screening should be intentionally accomplished and the result documented.

Objective findings often include an appropriate radiographic survey, review of the survey and comment on significant findings. They may also include comment on the review of

diagnostic casts or diagnostic wax-up or digital imaging projection of the potential outcome of treatment.

The dental patient record may document or include:

- A focused medical physical evaluation that may include a record of blood pressure and pulse or heart rate at a systematic interval
- An extra-oral head and neck examination
- An intra-oral soft tissue and anatomic evaluation
- A dental examination, including the condition of the dentition:
 - Presence or absence of teeth
 - Developmental dental abnormalities
 - Attrition
 - Erosion
 - Fracture
 - Mobility
 - Restoration
 - Marginal integrity
 - Occlusion
 - Esthetic condition
 - Contour
 - Functional adequacy
 - Periodontal impact
- A functional evaluation
- An occlusal and/or orthodontic evaluation
- A prosthetic evaluation
- Any oral Disease
 - Dental disease
 - Dental caries
 - Diagnostic Tests
 - Percussion
 - Palpation
 - Thermal
 - Application of occlusal pressure
 - Periodontal disease
 - Gingival recession
 - Adequacy or absence of attached keratinized gingival tissue
 - Alveolar bone loss

- Furcation involvement
 - Periodontal pocketing
 - Other disease of the oral cavity
 - Oral Cancer, etc.
- Biopsy results
- Laboratory (test) findings
- Caries risk assessment
- Comment on evaluation of a diagnostic casts, diagnostic wax-up, or digital imaging projection of treatment outcome
- Assessment or evaluation of salivary adequacy
- Radiographic imaging
 - Patient identification, date and exposure
 - Image interpretation
- Comment on evaluation of a diagnostic casts, diagnostic wax-up, or digital imaging projection of treatment outcome

Integration of all the previously described information should result in development of an accurate differential diagnosis and dental diagnosis. These various diagnoses then provide the foundation for a logical plan of treatment that comprehensively addresses identified problems as well as expressed patient concerns.

Treatment Plan

The resulting treatment plan should have clear treatment objectives, and should lay out a logical and efficient plan or sequence of treatment designed to achieve those objectives. A well designed treatment plan supports the delivery of appropriate care. In the absence of an adequate plan, even well executed treatment is liable to yield less than optimal results. The treatment plan, supported by the complete and thorough assessment of the patient's condition, needs and desires, is an integral part of the dental patient record.

The treatment plan is used in a variety of ways. It is referenced by staff for scheduling appointments and for making patient payment arrangements. It is referenced by providers as they provide treatment, and also relative to new developments as treatment progresses. It is used as a tool to communicate with patients, not only before, but during and following complex treatment. And the treatment plan is part of the dental patient record that is reviewed by third parties in connection with legal or regulatory proceedings that involve the patient. Providers of oral health care have a professional, moral and ethical responsibility to

inform patients about their current oral conditions and treatment options for those conditions. The treatment plan documents, in part, performance of this duty.

The treatment plan consists, basically, of a sequenced list of planned treatment. The sequence may be modified for various reasons, but in most instances contemporary treatment planning generally reflects the following sequence:

- Patient's chief complaint or reason for seeking care
- Medical/systemic care
- Emergency care
- Non-emergency disease control
- Definitive care
 - Direct restoration
 - Indirect restoration
 - Prosthesis provision
- Maintenance care

In some instances treatment may be broken down to the level of treatment per appointment or may be divided into phases. The plan may include waiting times for healing or gates where re-evaluation is to occur before beginning subsequent phases of treatment.

Treatment plans can vary depending on the unique situation the patient presents. However, the treatment plan should be based on solid clinical principles and the link between treatment planned and clinical findings should be transparent. The reason for some treatment is self-evident. For complex treatment, such as multi-phase or implant-prosthetic treatment, or when many alternative treatment possibilities exist, the rationale, thought process and patient discussion that supports and justifies planned treatment should be documented. Management of acute pain for reasons that are self evident does not require the same level of documentation that management of chronic pain does.

Informed Consent

The risks, benefits and goals of proposed treatment should be discussed with the patient and the patient's consent to proceed obtained before treatment begins. This discussion or its result is generally documented in the dental patient record. Whether this documentation consists of written forms accompanied by the patient's signature or consists of

documentation of an oral discussion depends on the prevailing standard of care and on the complexity and risk associated with the planned procedure.

Informed consent for any procedure that embodies significant risk should be explicitly documented in the dental patient record. Malpractice liability companies may have more stringent requirements, but dental procedures that embody significant risk or the possibility of an unfavorable outcome for the patient are generally understood to include:

- Surgical procedures, including oral surgery and surgical periodontal procedures
- Endodontic therapy
- Orthodontic therapy
- Select and complex restorative procedures, including select and complex removable and fixed prosthetic procedures

Treatment plans sometimes present more than one treatment option. If more than one option is offered, detail regarding discussion of the benefits and risks associated with each of the options offered should be documented.

The critical elements of informed consent or informed refusal are:

- Explanation of the diagnosis or condition being treated
- Description of the recommended treatment
- Presentation of alternatives to the recommended treatment, including no treatment
- Discussion of the risks and benefits of recommended treatment and alternative treatment
- Receipt of the patient's permission or refusal to proceed

Progress Notes

Progress notes are the contemporaneous documentation of treatment. Integral to the process of treating the patient is the determination that the treatment plan is still appropriate in light of the patient's condition, including the patient's oral and medical presentation.

Progress notes should include:

- Date

- Purpose or treatment planned for the appointment
- Subjective complaints or response from the patient to treatment, if any
- Drugs administered during treatment, including route of administration and dosing, including but not limited to:
 - Topically administered medications like fluoride, anesthetic or antibiotic solutions or gels
 - Orally administered medications like antibiotics or sedative agents
 - Inhalation agents like nitrous oxide and oxygen
 - Parenteral or IV administered agents including complex drug administration such as sedation and/or general anesthesia.
 - Sedation and/or general anesthesia requires specific record detail and documentation. Discussion of the specific requirements for these situations can be found in the ADA Guideline Documents for Anesthesia and Sedation as well as specialty guideline documents such as those of the American Association of Oral and Maxillofacial Surgeons.¹
- Patient current condition with respect to treatment and relevant treatment goals
- Treatment rendered and immediate outcome, including complications encountered, if any
- Post-operative instruction given to the patient
- Post-operative follow-up and outcome
- Prescriptions given to the patient
 - Drug prescribed
 - Dosing information
 - Refill designation, if any
- Patient conversations, including telephonic conversations
- Patient compliance with treatment recommendations, instructions and home care

If specialty care is required, the dental patient record should include copies of the referral for specialty consultation or treatment and include the outcomes of the consultation and/or treatment provided.

¹ When general anesthesia or sedation is administered there are specific additional requirements, including documentation of the availability of appropriate equipment and properly trained personnel. Also, most jurisdictions require that the office or facility where administration of general anesthesia or sedation will occur be inspected and certified by the state dental board or its designee prior to the administration of any anesthesia or sedation procedure. A complete discussion of these issues can be found in the *ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists, 2007*.

Patient Referral

Referral of the patient for specialty care or to another provider for any diagnostic service, consultation or treatment should be documented in the dental patient record. This documentation should include:

- Date
- Reason for referral
- Name of the provider to whom the patient is referred, if available
- Outcome, if known, including treatment provided by or outcome of any consultation with the provider to whom the patient is referred

Legibility

Each dental patient record entry, including the date of the entry, should be made in some permanent medium. If handwritten, entries should be in ink that cannot be erased or easily altered. An error should be simply crossed out or lined through and a correction then entered into the record. Digital recording should be fixed and unalterable after a certain point in time, like the close of the day, and should create or be accompanied by an electronic audit trail. However recorded, the dental patient record should be legible and readily decipherable. And all entries in the record should be initialed by the clinician or author. Comments should be confined to necessary information about the patient's treatment. No financial information should be kept in the dental record.

Dating

All entries in the dental patient record should be dated. This includes not only clinical notes and progress notes, but the patient's medical and dental history, physical and oral evaluation, treatment plan, informed consent and any patient communication including telephonic conversations. It is useful to have general information dated too, since patient address and contact information is likely to change. Laboratory tests as well as referral to another provider should be dated, and also the outcome, when known. The latter are sometimes evidenced by a letter or some form of electronic documentation containing an embedded date. Appending this documentation to the dental patient record facilitates accurate record keeping. Similarly, termination of the doctor-patient relationship is an action that is dated and often accompanied by additional documentation that can be appended to the dental patient record. And the transfer or release of information in the record or the inactivation of the dental patient record should be dated.

Regulatory Requirements

The dental patient record must also comply with all applicable regulatory requirements, such as Health Insurance Portability and Accountability Act (HIPAA) regulations, and regulatory requirements imposed by the state with respect to informed consent, patient abuse issues, etc. Applicable regulations often require that patients be informed of their rights and that the dentist's compliance with these regulations be documented.

Termination of the Doctor-Patient Relationship

The doctor-patient relationship—a central focus of any dental practice—is essentially a legal contract that is established as soon as money or something of value is exchanged. Once established certain obligations accompany the doctor-relationship until it is appropriately terminated. The extent of these obligations varies, depending on circumstances, but always generally relates to the dentist's obligation to professionally care for the patient. Once the doctor-patient relationship is established, failure to make every reasonable effort to care for the patient could lead to charges of patient abandonment. Therefore, properly terminating the doctor-patient relationship is important, and documenting termination of the relationship in the dental patient record is essential.

Reasons for terminating the doctor-patient relationship include, but are not limited to:

- The patient moves or changes dentists
- The dentist retires, moves or leaves the area
- The dentist dies or becomes disabled and unable to practice
- The dentist sells the practice
- The dentist terminates the doctor-patient relationship because the patient:
 - Fails to pay for services
 - Fails to keep appointments
 - Is noncompliant with respect to treatment instruction or recommendations

When the patient terminates the relationship the dental patient record should include:

- Date
- The patient's decision to seek no further professional service from the dentist

- Documentation or evidence that the patient has been informed regarding any planned and uncompleted treatment and the dentist's recommendation regarding unfinished treatment
- Documentation of the offer to release relevant clinic records to the patient's next dentist, with appropriate authorization²

When the dentist terminates the relationship it is advisable to complete any treatment underway and stabilize the patient's condition, if possible. The dental patient record for dentist-initiated termination of the doctor-patient relationship should include:

- Date
- Decision to terminate the doctor-patient relationship with the patient
- Reason(s) for terminating the relationship
- Documentation or evidence that the patient has been informed of the decision and has been given a specified and adequate period³ of time to engage another dentist
- Documentation that the dentist will remain available to care for the patient should any emergency dental need arise during the specified transition period.⁴
- Documentation of the dentist's recommendation regarding any planned and uncompleted treatment.
- Documentation of the offer to release relevant clinic records to the patient's next dentist, with appropriate authorization

The dentist can terminate the relationship for almost any reason⁵ and is not required to inform the patient of the reason for refusing to provide further care, but in most instances may wish to do so, particularly if the reason is noncompliance or if there are significant ramifications that may result from the patient's behavior. Whether or not the patient is

² Appropriate authorization typically consists of a formal document that authorizes release of patient information. This document, which is signed by the patient or legal guardian of the patient, is dated and names the patient and the dentist designated to receive the information. A copy of the document should be placed in the dental patient record. If verbal authorization is given, details including the date, time, and persons involved should be documented in the dental patient record.

³ In terms of length, adequacy of the transition period depends on alternative dentist availability or the difficulty the patient may encounter locating another dentist in the area. In general a transition period of something between 10 days and one month would be deemed reasonable and adequate for most locations.

⁴ Informing the patient of the decision to terminate the relationship is usually accomplished by means of a letter sent by certified mail, return receipt requested. A copy of the letter and the receipt is then filed in the dental patient record. If the patient refuses the certified letter, the dentist can place the letter (unopened) in the record and send another copy to the patient by regular mail.

⁵ The dentist may not terminate the doctor-patient relationship for an illegal reason. For example, the dentist may not terminate the relationship by refusing to see a patient merely because they have AIDS (because this would violate the American Disabilities Act (ADA)).

explicitly informed of the reasons for withdrawal, the reasons should be clearly captured in the dental patient record.

Death, disability, or arrest and imprisonment are catastrophes that create a special subset of the foregoing because the dentist is not available to provide emergency care during the transition period. Other elements, however, remain intact. Patients are entitled to notification that the dentist's services will no longer be available and to information regarding provisional arrangements made to assist them if a dental emergency should arise before they are able to find or have their dental patient record transferred to another dentist. Again, a copy of this notice should become part of the dental patient record.

Sale of a dental practice creates a slightly different scenario. Under certain conditions, a practice's dental patient records may be transferred, as a whole, to a purchaser who then owns the records together with accompanying obligations to protect and maintain them for all patients except those patients who opt out of the transfer or respond that they would like to have a copy of their dental patient record sent to a different dentist. Alternatively, the records are copied and a copy of each record is potentially transferred to the buyer. Regardless, patients need to be informed of the transition, be given an opportunity to opt out of the transfer or request that their records be sent elsewhere, and be given a reasonable time to make this decision and respond. Notice of sale or practice transition is usually in the form of a letter that is mailed to patients. A copy of this letter should be placed in the dental patient record of every patient affected by the transition, and a signed release form should be found in the dental patient record for every patient whose records are forwarded to some other party. In the latter instance, the dental patient record should contain notation that, on a certain date, a copy of the record was sent to the designated recipient.

Release or Transfer of Dental Patient Records or Information

The release or transfer of dental patient records or information contained in the records requires appropriate authorization. The required authorization typically consists of a formal document that authorizes release of patient information. The document, which is signed by the patient or legal guardian of the patient, is dated and names the patient and the dentist designated to receive the information. A copy of the document, together with dated notation that a copy of the record was sent to the designated recipient, should be placed in the dental patient record.

Original records, generally, need not be released because they can be copied, printed or information otherwise transferred without disturbing the original record. In some instances where, in connection with sale or transfer of an entire practice for example, original physical records are transferred, it may be advisable for the dentist or the dentist's estate to retain a list of the patients whose records have been transferred in case a question regarding the location of a record or some reason to access information in a record arises.

Maintenance of Dental Patient Records

Reasonable and prudent precautions should be taken to protect and preserve dental patient records. Physical records should be stored in such a way as to afford reasonable protection from fire or water damage. For long-term storage alternative methods such as microfilming, warehousing, or transferring records to a computer database should be considered.

Ideally records should be maintained indefinitely. However, some states allow dentists to discard inactive dental patient records after a certain number of years.⁶ Each jurisdiction has specific requirements regarding the maintenance of dental patient records. There is usually a different requirement for the retention of records of children; these records must be kept for a certain period after the child reaches the age of majority. The dentist should be thoroughly familiar with state requirements relative to the maintenance, release and transfer of records. The dental office should have a records retention policy that all staff understand and follow when working with patient records.

⁶ Some states allow discarding of inactive dental patient records after a period of seven years. The justification for this interval probably relates to an applicable statute of limitations that, in many instances, precludes a complainant from bringing suit for malpractice after this period of time.

Appendix – Sample Disciplinary Order

IN THE MATTER OF * BEFORE THE STATE BOARD
RESPONDENT DDS * OF DENTAL EXAMINERS
License Number 0000000-0000 * Case Number D-423

* * * * *

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Pursuant to the Dental Practice Act of the State and Rules and Regulations of the State Board of Dental Examiners (the “Board”) hereby renders the following decision and order.

BACKGROUND

The Board, pursuant to its statutory authority investigated a patient complaint lodged against Respondent DDS (“Respondent”). Protection of the public health is the primary function of the Board. In furtherance of that objective, the Board may take a range of disciplinary actions—including imposition of a fine, reprimand, suspension, or revocation of a license—against a dentist found to have violated the Dental Practice Act or the governing Rules and Regulations of the Board.

On or about January 23, 2009 the Board charged Respondent alleging violations of the Dental Practice Act of the State. The Board also alleged that Respondent violated the following Code of Ethics provision: American Dental Association Principles of Ethics and Code of Professional Conduct (ADA Code of Professional Conduct).

Pursuant to the State’s Administrative Procedure Act, Rules and Regulations, a hearing on the merits took place on a certain date and month before a full quorum of the Board. The Assistant Attorney General represented the State and private counsel represented Respondent.

ALLEGATIONS OF FACT

1. The Board initiated an investigation of Respondent's practice after having learned of a law suit filed by Patient A (the "Patient") alleging negligence.

2. On or about a certain Date 1, Patient, experiencing pain and swelling in the right rear of his mouth, sought treatment from Respondent. No contemporaneous records of this visit exist.

3. Patient returned on Date 2, approximately two months later, with severe pain in the same area. Respondent, taking no radiographs, performed the first stage of root canal therapy on tooth #29 for which he prescribed no antibiotics. Once again Respondent failed to document, among other things, that he performed diagnostic tests, the basis upon which he performed the root canal procedure, and the use and concentration of anesthetics, and the site of administration of anesthetics.

4. Two days later, on Date 3, Patient returned with severe pain and swelling in the area where the root canal had been initiated. Respondent took no radiographs, but prescribed penicillin. He made no record of the visit nor did he record the basis for the prescription of penicillin.

5. A little more than a week later on Date 4 Patient's physician prescribed clindamycin, an antibiotic, for Patient's infection.

6. On Date 5 following receipt and use of the clindamycin prescribed by the physician, Patient's wife telephoned Respondent and described Patient's continued pain and swelling. Respondent offered to see Patient the next day; however, Patient was unable to see Respondent because he was admitted to Wellbody Regional Hospital where he required an emergency tracheotomy and drainage of a submandibular abscess. Respondent did not document the telephone call in Patient's treatment record.

EXHIBITS

State's Exhibits 1 through 14 were admitted into evidence. Respondent's Motion to Exclude to State's Exhibit number 12 was denied.

Respondent's Exhibits A through F and H were admitted into evidence. Exhibits G and I were excluded.

FINDINGS OF FACT

The Board finds the following by a preponderance of the evidence:

1. At all times relevant, Respondent was licensed to practice dentistry in the State;
2. No contemporaneous records, nor radiographs, exist for Patient's office visits on the specific dates of Date 1, Date 2, Date 3, Date 4, or for the telephone call on Date 5;
3. Respondent prepared non-contemporaneous notes of the aforementioned office visits from billing records;
4. On Date 1, without having taken a radiograph to support his conclusion, Respondent concluded that the Patient's complaint of pain and swelling in the right rear of his mouth indicated need for root canal therapy;
5. On Date 2, Patient again complained of pain and swelling in the right rear of his mouth. Respondent removed nerve tissue from the tooth without first taking a radiograph;
6. On Date 3, Respondent took no radiographs when Patient again complained of pain and swelling in the same area. He prescribed antibiotic medication at that time;
7. On Date 4, Patient's physician prescribed clindamycin for the infection.
8. On Date 5, Patient's wife telephoned Respondent reporting that Patient was complaining of continued pain and swelling. Respondent scheduled an appointment to see Patient the next day;
9. On Date 5, Patient was taken by ambulance to Wellbody Regional Hospital where he underwent an emergency tracheotomy and incision and drainage of an abscess. (State's Exhibit #9).

OPINION

The Board carefully considered and reviewed the entire record which supports charges that the Respondent's treatment of Patient was incompetent. Respondent could produce no contemporaneous of Patient's treatment for Date 1, Date 2, Date 3, Date 4 or of the telephone call on Date 5. What he did produce were non-contemporaneous notes created from patient billing records.

Dr. Goodrecord, the State's expert, concluded that Respondent's treatment of Patient for the period of Date 1 through Date 5 was incompetent and unprofessional. The Board agrees with Dr. Goodrecord's conclusion.

At the time of the office visit on Date 1 Respondent provided no radiograph in support of the need for root canal therapy on tooth #29. On Date 2, Respondent removed nerve tissue from the subject tooth without first having taken a radiograph and he failed to prescribe antibiotics.

Respondent took no radiograph when Patient presented with pain and swelling on Date 3, and when, on Date 5, Patient's wife reported that Patient was complaining of continued pain and swelling, Respondent, unable to see him that day, ought to have advised that he go to an emergency room.

The Board gives little weight to the Testimony of Dr. Weaselout, Respondent's expert. Dr. Weaselout, acknowledging that Respondent's notes were inadequate, took no issue with his treatment of Patient. Regarding the office visit on Date 1, Dr. Weaselout testified that he could only assume Respondent's treatment plan met the standard of care. He would not, however, offer an expert opinion to that effect. Supporting Respondent's treatment of the Patient on Date 2, Dr. Weaselout acknowledged that he incorrectly assumed facts not in evidence.

CONCLUSIONS OF LAW

Based on the foregoing, the Board finds as a matter of law that Respondent violated the Dental Practice Act of the State, Rules and Regulations of the State Board of Dental Examiners and Section 1B of the ADA Code of Professional Conduct.

ORDER

Based on the foregoing, it is this specific day of a certain year, by a majority of the full authorized membership of the Board:

ORDERED that Respondent's license to practice dentistry in the State is hereby REPRIMANDED; and it is further

ORDERED that Respondent be placed on PROBATION for a period of TWO (2) years which shall commence from the date this Order is executed by the Board, subject to the following terms and conditions:

ORDERED that Respondent shall retain, at his expense, a Board approved mentor/practice reviewer in endodontics and general dentistry who will conduct random chart audits and to whom the Respondent shall provide a copy of this Final Order. The mentor/practice reviewer shall meet with Respondent FOUR (4) times over the first year of probation to review patient charts and to discuss cases, treatment planning and treatment. Respondent shall be responsible for ensuring that the mentor/practice reviewer submits written reports to the Board on his or her observations, findings and recommendations. The mentor/practice reviewer may consult with the Board and its agents regarding his or her findings. Respondent shall abide by all written recommendations of the mentor/practice reviewer; and it is further

ORDERED that Respondent may not petition the Board for termination of probation prior to ONE (1) year from the effective date of this Order; and it is further

ORDERED that Respondent shall practice in accordance with the laws and regulations governing the practice of dentistry in the State; and it is further

ORDERED that Respondent's failure to fully comply with the terms and conditions of this Consent Order shall be deemed a violation of probation and of the Consent Order and Respondent may be subject to additional charges by the Board; and it is further

ORDERED that this document is a public record, pursuant to State Code Annotated, Article and Section specified.

Date of the Order