Appointment Record Examples

Disclaimer:

Here are a few examples of the way I like to write my notes. They're definitely *not* perfect. If your pts have been to the school before, I'd recommend reviewing their EDR and reading previous appointment records. As you read more of them, you'll get a sense of what is important to include and what isn't. Be as specific as possible, especially when it comes to discussions w pts regarding treatment decisions and informed consent. Think about what another student or dentist, who has never seen your pt before, would need to know about the appt today. Have fun in clinic and good luck!

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1. DPR (Diagnosis)

Covid screen neg. Pt arrived on time for DPR appt. IC obtained. Med hx & dent hx updated. Caries risk assessment partially performed (will complete IO components next appt).

CC: "lower molar implants"

HPC: Pt is referred to school for implants of 36 and 46. 36 has been missing for 2y, but 46 has been missing for over 5y.

Referring dentist sent bitewings, but it was recommended by Dr. _____ to update radiographs to better assess bone level and suitability for implants.

Radiographs acquired: 4 vertical BW (1 retake) and 1 pan. Perio odontogram updated with PD, BOP, GM-CEJ, and plaque score for mx and buccal md - due to time limitations, will complete remainder of md charting at next appt.

Next appt: complete perio odontogram, update charting odontogram, complete CRA, EO/IO exam, complete preliminary assessment form, Tx plan, Dx impressions and facebow if time permits.

Sterilization: all pass
04002 Sep 27 2020 - exam cassette
... etc.

2. OD (Tx Planning)

Covid screen neg. Pt arrived 10min early for Tx planning appt. IC obtained. Med & dent hx updated.

Completed perio charting from last appt with PD, BOP, GM-CEJ, and plaque score. _____ (RDH) confirmed findings. Completed charting odontogram, caries risk assessment, preliminary assessment form (see for details of implants referral), and IO/EO exam.

Patient was presented with the following Tx options, of which the benefits, risks, and costs were discussed:
- implants and crowns 36, 46 (as outlined in referral)
- implants and crowns 37, 36, 46
- implants 37, 36 without replacing 46
- bridge: 47-x-45 and implant 36
- md cast RPD to replace 37, 36, and 46
- no Tx

Pt decided to move forward with implants and crowns for 36 and 46 for now, and then depending on the outcome of the prosth consult and feasability of bone grafting in the region of 46, he may decide on a third implant for 37 as well, either in addition to 36 and 46, or in addition to 36 but without 46.

Explained to pt that there may be a wait before treatment can commence due to 3rd year students finishing up cases in progress from graduating 4th years. Pt understood. Pt signed the Tx plan in Salud.

Pt is still seeing his dentist in private practice for all care other than the implants, so he will have his pre-op scaling done there.

Next appt: prosth consult for implants, preliminary impressions, and facebow

Sterilization: all pass
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... etc.

3. OCA Recall (A)

Pt arrived 10 mins late for OCA recall appt. IC obtained. Med hx updated. Caries risk assessment completed.

CC: "flipper feels loose"

Clasps of flipper were tightened with ortho pliers until pt was satisfied with adjustment.

Updated perio charting with PD, BOP, GM-CEJ, and plaque score. Generalized heavy plaque noted with associated heavy calculus formation. Pt remarked that gums were quite sensitive during probing.
Perio recall form completed.

Radiographs acquired: 2 PAs: 32, 42

Dr. _____ assessed for caries: 32ML, 42M, 23B and 22B
Composite restorations for these surfaces added to Tx plan.

Proceeded with debridement. To manage sensitivity, Oraqix was applied to sulci on a per sextant basis. Calculus deposits were noted in association with deep probing depths in the posteriors.

_____ (RDH) confirmed findings from perio charting.

OHI given and use of end tuft brush explained to pt. Pt dismissed in good spirits.

Pt placed on operative waitlist.

Next appt: operative with assigned student

Next recall: 3mo

Sterilization: all pass
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... etc.

4. OCA Recall (B)

Pt arrived on time for OCA recall. IC obtained. Med and Dent Hx updated. Caries risk assessment updated.

Perio odontogram updated with PD, BOP, GM-CEJ, and plaque score. Generalized plaque noted. _____ (RDH) confirmed findings.

Proceeded with debridement.

Radiographs acquired: 2PAs (22, 26) and 4 posterior BW. PA of 22 was taken to ensure it is still sound because it is supporting the denture. PA of 26 was taken due to previous discussions with the patient about potentially doing RCT on this tooth.

Pt noted that a tooth on his denture fractured, but he would not like to have it replaced at this time.

Dr. _____ assessed for caries: 14D, 26M+D (two separate lesions on D), 36D, 31M

Tx planned: 14DO composite, 26M + DO composite, 36 MOD amalgam, 31 MI composite

Pt placed on operative waitlist.

Next appt: operative with assigned student

Next recall: 6mo

Sterilization: all pass

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... etc.

5. Portfolio Recall

Covid screen neg. Pt arrived on time for portfolio recall appt. IC obtained. Med hx updated.

Discussed with pt that the school would prefer pts not take antibiotic prophylaxis due to pts requiring more appointments than in private practice, so antibiotic resistance is a concern. Pt agreed that we could send a letter to his orthopedic surgeon (Dr. _____ at _____ Hospital) to inquire if antibiotic prophylaxis is still necessary.

His temporary crown on 37 fell off last week, but he will be seen for final impressions in 2 days and a new temporary will be made.

Perio charting updated with PD, BOP, GM-CEJ, and plaque score. _____ (RDH) verified findings.

Proceeded with debridement. Generalized light caluculus formation with localized moderate calculus noted on maxillary and mandibular anteriors.

OHI given.

Next appt: pt will return in two days for final impression for 37 crown

Sterilization: all pass
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... etc.

6. Peds Recall

Pt arrived on time for recall appt. IC obtained from parent. Med hx reviewed and updated with parent. Caries risk assessment completed with parent. Estimated cost of treatment today given to parent: ~$60.

Updated odontogram. EO: WNL. IO: No caries identified clinically. Mild gingival edema on the facial of lower incisors. Deep fissures on 37 & 47 - previous sealants appear to have fallen out.

Completed oral exam 1 and ortho exam 1 forms.

Angle Class: 1 (bilateral)
Midline: Mand shift 3mm R
Overjet: 3mm
Overbite: 2mm (20%)
Crossbite: None

Radiographs not required today.

Discussed fissure sealants with parent and child, including benefits, risks, and fees. Parent agreed to have them completed today. Fissure sealants placed on 37 & 47 using Fuji Triage GI (white). Light cured 30s.

Proceeded with debridement. OHI given. 5% fluoride varnish applied and pt instructed not to eat or drink for at least 30 minutes.

Pt dismissed.

Frankl behaviour: ++

Next appt: recall 6mo

Sterilization: all pass
04002 Sep 27 2020 - exam kit
... etc.

7. Operative

Covid screen neg. Pt arrived on time for operative appt. IC obtained. Med hx updated.

It was decided to restore 16DOL and 17MO today.

TA. LA: 1 carp 2% lidocaine 1:100,000 epi via buccal infiltration.

Rubber dam isolation. Removed DOL portion of existing defective 16MODL composite and existing defective 17MO with HS. It was deicded to leave MO portion of 16 resto intact as it was still in good condition. Removed caries with SS.

Placed retentive pin (yellow) in DL area of 16. Placed Tofflemire matrix and wedge for restoration of 16. Etched with 35% phosphoric acid 15s and rinsed. Peak Universal bond applied, air dried, and cured 20s. Filtek Supreme composite shade A3 applied and each increment cured 20s.

Placed Garrison matrix to restore 17. Procedure above repeated for restoration of 17.

Occlusion checked. Restorations finished with diamond burs and rubber cups.

Pt recommended to have crown placed on 16 due to little remaining tooth structure. Pt understood and accepted this recommendation.

Sterilization: all pass
04002 Sep 27 2020 - operative cassette
... etc.

8. Prosth (1. Crown Prep)

Covid screen neg. Pt arrived on time for 37 crown prep appt. IC obtained. Med hx updated.

TA. LA: 1.5 carp 2% lidocaine 1:100,000 epi via IANB and long buccal. FG prep completed on 37 with HS. Mesial margin made subgingival due to restoration located near gingival margin. MB cavosurface margin of existing restoration was identified as decayed. Removed caries with spoon excavator and SS. Etched with 35% phosphoric acid 15s and rinsed. Peak Universal bond applied, air dried, and cured 20s. Restored with Filtek Supreme composite shade A2 and cured 20s. Preparation margins were successfully maintained on natural tooth structure.

Provisional fabricated using putty matrix and Integrity provisional material. Finished and polished with acrylic finishing burs. Cemented with temp bond. Occlusion checked.

Next appt: final impression and collect lab fee

Sterilization: all pass
04002 Sep 27 2020 - operative cassette
... etc.

9. Prosth (2. Crown Final Impression)

Covid screen neg. Pt arrived 15min early for final impression appt (37 FGC). IC obtained. Med hx updated.

Pt's provisional fell off a few days ago, but he saved it and brought it with him to today's appt.

TA. LA: 2 carpules 2% lidocaine 1:100,000 epi via IANB.

Removed cement from temporary and cleaned the tooth prep with interproximal carver.

Size 000 cord packed into sulcus around 37, followed by size 1. Due to difficulties placing the second cord, size 1 was removed and size 0, soaked in hemodent, placed. Cord left in sulcus for 10min.
Tray adhesive applied to size medium stock tray. Pt instructed to hold cheek retractors. Teeth and mucosa dried with gauze and air. PVS putty material placed into medium stock tray. Light body PVS applied to dried 37 prep. Tray seated and material let set for 3min.

Additionally, two sectional impressions of 3rd quad taken, using same technique as above, due to difficulty capturing mesial margin.

Adjusted existing temporary with flowable composite at the distal margin where there was a small defect. Temporary cemented with Temp-Bond temporary cement. Occlusion adjusted.

Next appt: crown delivery, followed by 48h check

Sterilization: all pass
04002 Sep 27 2020 - operative cassette
... etc.

10. Prosth (3. Crown Cementation)

Covid screen neg. Pt arrived on time for cementation of 37 FGC. IC obtained. Med hx updated.

Prep cleaned with prophy paste and prophy cup. A thin (~1mm) slice of mesial amalgam from the prep was loose, so it was removed. It was decided to cement the crown without restoring the defect as the cement would fill it. Fuji CEM2 was applied to the intaglio surface of the crown, which was then placed on the prep. Held crown with finger pressure for 5min. Excess cement was removed after 1min. Flossed through contacts with knotted floss to remove excess cement interproximally. Occlusion adjusted and crown polished with gold polishing cups. Pt satisfied with tx rendered today.

Next appt: 48h check will be completed over the phone

Sterilization: all pass
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... etc.

11. Prosth (Reline 1)

Covid scree neg. Pt arrived on time for denture repair appt. IC obtained. Med & dent hx updated.

CC: Upper denture is loose and dislodges frequently unless denture adhesive is used. Also, canine denture teeth are chipped on both sides.

Assessed fit of CUD. The buccal flanges were slightly over-extended in the posterior region and lack of retention was significant. Preparing the denture for hard reline with functional impression is planned for today.

IO: 35 mobility 2, hopeless prognosis given bone loss and mobility.
35 exo added to Tx plan.

Flanges were trimmed 1mm with acrylic burs, ensuring adequate clearance for frenal attachments, followed by trimming of the intaglio surface 1mm.

Lynal was applied to the denture and an impression was taken using border molding movements. Voids and defficiencies were filled with a second Lynal mix and seated once more for 5 min in bite. Increased retention was verified by placing the lined denture intraorally once more.

Denture teeth 13 and 23 were adjusted using acrylic burs and soflex disks. Patient was satisfied with the appearance after adjustment.
Instructions were given verbally regarding how to take care of relined denture, such as storing it on the teeth surface at night and avoiding brushing the inside of the denture.

Next appt: Pt will return in 2 days so that the case can be submitted to the lab for a hard reline.

Sterilization: all pass
04002 Sep 27 2020 - operative cassette
... etc.

12. Prosth (Reline 2)

Covid screen neg. Pt arrived on time for continuation of denture repair appt. IC obtained. Med hx updated.

CC: Denture feels loose since the appt 2 days ago after liner was placed. It dislodges

sometimes when talking or eating.

Upon clinical examination, it was noted that retention is adequate. However, the flanges are overextended, which is likely the reason for the denture dislodging during function.

Received functional impression (Lynal) in complete maxillary denture from pt.

Labwork: Will box impression and pour cast without separating and complete laboratory prescription prior to submitting to lab for hard reline.

Next appt: Pt will return in approxmately 1 week to receive relined denture. Will adjust overextended flanges at this time.

Sterilization: all pass
04002 Sep 27 2020 - operative cassette
... etc.

13. Prosth (Reline 3)

COVID screen neg. Pt arrived on time for reline delivery appt. IC obtained. Med & dent hx updated.

CUD was marked with PIP and seated. It was noted that the right flange was too long, resulting in the denture becoming dislodged during function

Adjusted the flanges with acrylic burs. Polished with rubber points.

Pt content with adjustments & will return should additional adjustments need to be made.

Will present her case to OS for extraction of 35.

Next appt: 35 exo

Sterilization: all pass
04002 Sep 27 2020 - operative cassette
... etc.

14. Perio-1 Case Presentation

COVID screen neg. Pt arrived early for Perio-1 case presentation appt. IC obtained. Med hx updated.

Case presented to Dr. _____. Perio odontogram updated with PD, BOP, GM-CEJ, and plaque score.

Dx: Localized Stage III Grade B Periodontitis. Debridement of maxillary arch completed and checked by Dr. _____.

Pt dismissed.

Next appt: Debride mandibular arch.

Sterilization: all pass
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... etc.

15. Perio-1 Re-Eval

COVID screen neg. Pt arrived on time for Perio 1 Re-eval appt. IC obtained. Med hx updated.

Reviewed by Dr. _____. Sx phase not considered due to PD generally < 6mm (please see Perio Re-Eval form in Salud for details). Lingual anteriors and posterior interproximal areas debrided due to calculus formation since last debridement appt.

Recall interval: 3 months

Next appt: extractions of hopeless teeth: 25, 27, 45

Sterilization: all pass
04002 Sep 27 2020 - perio cassette
... etc.

16. Urgent Care

Pt arrived on time for UC appt. IC obtained. Med hx updated.

CC: Pain on upper right.
HPC: Sharp "stabbing" pain to hot and cold, sensitive to biting, does not wake her up at night, started one week ago, no hx of trauma to the area, pt sometimes feels "pressure" in right cheekbone

EO: Pt feels some pressure on the right cheek when cheek is palpated.

IO: Large 5-surface composite restoration on 15, root caries near the DB margin of the restoration.

Tests performed:

Percussion:
13 -
14 -
15 +

Cold:
13 + WNL
14 + WNL on lingual; - when performed on the buccal
15 -
25 -

EPT:
15 + on lingual, very rapid response, non-lingering; - on buccal

Probing:
B, from MB: 311
L, from DL: 113

Radiographs acquired: 1 PA of 15
No periapical pathology detected, however there is a cloudiness in the sinus. Large pin-retained composite restoration on 15.

Tx rendered: None today

Explained to pt that the pressure in her right cheek, as well as the sensitivity to biting and percussion, is likely related to her sinus. There is a cavity on the distal of the tooth, which is likely the cause of temperature sensitivity. Root canal therapy is deemed unnecessary at this time based on clinical findings and symptoms; however, elective RCT might be considered as part of pt's comprehensive tx plan going forward. Pt encouraged to follow up with physician regarding tx for sinus.

Next appt:
Pt will return for comprehensive exam with assigned student, who will incorporate treatment of 15 into the treatment plan for the rest of her dentition.

Sterilization: all pass
04002 Sep 27 2020 - operative cassette
... etc.

17. Screening (A)

Pt arrived on time for screening appt. IC for screening obtained. Med hx udpated.

CC: Would like cleanings.

IO: No caries detected. Small gingival defect where a supernumerary tooth was extracted just palatal to 16. Pt reports no dental pain in general or pain in the region of his extraction (occurred at hospital 2-3 weeks ago).

Completed screening form and preliminary assessment form.

Dr. _____ assessed pt suitability for the student clinic. Pt deemed unsuitable due to lack of educational value (existing restorations in good condition and no caries detected clinically).

Pt dismissed with phone number for Fanshawe Hygiene.

Sterilization: all pass
04002 Sep 27 2020 - exam cassette
... etc.

18. Screening (B)

Pt arrived on time for screening appt. IC for screening obtained. Med hx updated.

CC: Pain on the top and bottom left when chewing, some fillings fell out, broken teeth, would like a cleaning.

IO: a few fractured teeth, several caries, a few missing restorations

Completed screening form and preliminary assessment form.

Dr. _____ assessed pt's suitability for the student clinic. Pt deemed suitable due to number of caries with restorative potential as well as potential for RCT and extractions.

Explained next steps (assignment to student in the fall, DPR/OD process) to pt. Pt works full-time but is confident she will be able to manage availability during the week with appropriate notice.

Pt signed remainder of consent forms and was dismissed with the UC phone number in case she has any emergencies before the fall term.

Sterilization: all pass
04002 Sep 27 2020 - exam cassette
... etc.

19. Endo + Post Placement (1. Cleaning & Shaping)

Pt arrived on time for endo appt re tooth 44. Covid screen neg. Med hx updated. IC obtained. Pt reports that pain associated with 44 has subsided since starting antibiotics prescribed by his physician and he is feeling well today. Discussion regarding risks and benefits of RCT, including explanation of the necessity to clean bacteria out of the canal to allow for healing, as well as the possibility of RCT failure, future fracture of the root, and possible decay under the crown. Pt understood, accepted Tx, and signed RCT IC.

TA. LA: 1 carp 2% lidocaine 1:100,000 epi via mental nerve block, then 1.5 carps throughout procedure to maintain anesthesia (2.5 carps total). Following caries excavation using SS round bur and spoon excavator, a tofflemire matrix was placed, 44 was built up with Fuji 2 LC GI shade A2 and cured 20s. Rubber dam isolation (clamp 2).

Canal accessed. Exploratory radiograph taken (est WL: 17mm to cavosurface margin). Cleaning and shaping completed using K files and wave gold small, first to coronal 2/3rd, then procedure repeated to WL, measured by apex locator (20mm).

CaOH placed in the canal. Cotton pellet placed over canal and sealed w Fuji 2 LC GI (shade A2) and cured 20s. Occlusion adjusted.

Pt instructed to finish course of antibiotics, continue taking analgesics as necessary, and call if any issues arise.

Next appt: pt will return next week for obturation.

Sterilization: all pass
04002 Sep 27 2020 - endo cassette
... etc.

20. Endo + Post Placement (2. Obturation)

Pt arrived on time for endo appt re tooth 44. IC obtained. Med hx updated.

TA. LA: 1 carp 2% lidocaine 1:100,000 epi via mental nerve block, then intrapulpal injections every 10min to maintain anesthesia.

CaOH removed from canal via copious irrigation with NaOCl and endo activator, followed by IRI (5 cycles).

Since occlusion was adjusted prior to dismissing the pt last appt, which may have compromised the reference point, WL was verified via apex locator and new WL radiograph.

WL: 20mm

Gauge: 30
Vortexed to 35
MAF: 35

Size 35 cone fit short of the apex, however the canal is patent w 15k file, so vortexed once again, starting from 25 and proceding through 30 and 35. Final cone fit within 1mm of apex (acceptable).

Cone fit radiograph taken.

Final irrigation protocol: NaOCl, EDTA

Downpack radiograph taken.

44 was restored with cotton pellet and Fuji 2 GI shade A2.

Next appt: post placement

Sterilization: all pass
04002 Sep 27 2020 - endo cassette
... etc.

21. Endo + Post Placement (3. Post Placement)

Covid screen neg. Pt arrived on time for endo appt today re tooth 44. IC obtained. Med hx updated.

TA. LA: 0.25 carp 2% lido (1:100,000 epi) via buccal infiltration.

Access re-opened and cotton pellet removed. Post drill (size 1) used along with the universal drill to reach 1mm to the GP. There was some difficulty reaching 16 mm (WL minus 4mm of GP downpack) due to unknown circumstances, but the space was deemed acceptable by Dr. _____. The size 1 post was etched with 35% phosphoric acid and rinsed, and then bonded w Peak Universal, as was the post space. However, this resulted in a poor fit with the post not seating all the way. The adhesive was

removed with the post drill, however the post still would not seat. A size 0 post was tried in, which had a better fit. The post space and post were etched, rinsed and repared with Scotchbond, which then and light cured 20s. This post fit to the correct length. Cosmecore core build-up material was placed in the canal, the post seated fully, then light cured 20s. Post trimmed w diamond bur and closed w Cosmecore. Occlusion adjusted to slight hypoocclusion.

Final radiograph showed a slight gap between the post and the GP, approximately 0.3mm. However, this should not present a problem as the canal is otherwise well sealed and has been adequately debrided.

Perio-1 measurements were obtained. Once pt's Perio-1 and other restorative work are complete, will begin process for crown on 44.

Note: Pt reports his consultation at the hospital for 12 exo is scheduled for May 10th.

Pt dismissed in good spirits.

Next appt: Perio-1 case presentation.

Sterilization: all pass
04002 Sep 27 2020 - endo cassette
... etc.

22. OS

CC: Bottom left fractured tooth

HPC: Initially fractured 2y ago, filling fell out about 1mo ago. Painful on chewing + when food gets caught - provoked pain only, the area becomes "inflamed" when eating.

Med Hx (conditions/meds/allergies)
DM 2: insulin, metformin, gliclazide
HTN: bisoprolol
Coronary artery diease: ASA (81mg)
BPH: alfuzosin
Hypercholesterolemia: rosuvistatin, ezetimibe
GERD: lanzoprazole
Hx of iron deficiency anemia
No known allergies.

Sx hx: elective double coronary bypass surgery 2010; pt notes no pre-med required.
Colon cancer surgery June 2020.

Exam/Radiographic findings/Diagnosis/Tx Plan
Exam (vitals/extraoral/intraoral):
BP: 130/72
HR: 58
EO: WNL
IO: fracture and severe decay on tooth 37 MOBL, no swellings identified.

Radiographic findings: fracture and severe decay on MO of 37, extending onto the root surface to the alveolar crest level and into the furcation. Am filling lost.

Diagnosis: gross caries of 37

Tx Plan: TA. LA: 1 carp 2% lidocaine 1:100,000 epi via IANB, 1/2 carp via long buccal. Employ envelope flap with distal release to gain access to roots. Section tooth buccolingually with surgical handpiece and remove buccal bone if necessary. Elevate roots out with 77R elevator. Curette socket. Use bone file to remove sharp edges of bone. Pinch alveolar ridge gingiva to compress socket and approximate tissues. Place gel foam in socket and secure with approx 4x simple interrupted sutures using 3-0 plain gut suture material. Achieve hemostasis with damp gauze and biting pressure.

Appointment Record
Pt arrived on time for exo apt. IC for examination was obtained and med hx updated.

Pt feeling pain on lower left (pt points to 37). Pt advised that exo will likely become surgical due to depth of caries. Pt advised that it is likely that the 36 FGC could dislodge or become damanged in the process of elevating due its to proximity to 37. Pt understood and accepted these risks. Post-op instructions and costs were reviewed with the patient and the patient understood. OS informed consent was signed by pt.

Pt also had a concern regarding teeth on the upper left (24, 25) which recently fractured and is concerned that roots are retained. On IO exam the retained roots are visible. He would like these extracted because they cause him discomfort. These teeth with be assessed at a future OS appt.

Radiographs acquired: a new PA of 37 was taken to show the extent of the caries subgingivally, as previous radiographs were from Nov 2020 and the patient has new condition of lost amalgam filling present today.

TA. LA 2% lidocaine 1:100,000 epi. 1 carpule via IANB. 1/2 carpule via long buccal. Employed envelope flap with distal release to gain access to roots. Sectioned tooth buccolingually with surgical handpiece and removed buccal bone. Elevated roots out with 77R elevator. Curetted socket. Used bone file to remove sharp edges of bone. Pinched alveolar ridge gingiva to approximate tissues. Placed gel foam in socket and sutures. Achieved hemostasis with damp gauze and biting pressure.

Pt given post-op instruction sheet and sent home with gauze and monojet syringe for

irrigating with salt water solution. Pt will manage post-op pain with Advil & Tylenol and will call should any concerns arise.

Next appt: 24, 25 exos

Sterilization: all pass
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... etc.