Dental Professional Liability | Pre-treatment Issues

Medical History

Please Note

A number of sample risk management forms and letters are available electronically in association with this manual, including written informed consent templates, patient termination letters, records release authorization forms and others. Dentist's Advantage-insured dentists may access these sample documents on the Dentist's Advantage website.

Each PDF sample permits customization: copy and paste the sample text from the PDF template document to a text editing file (MS Word, Apple Pages, etc.); edit text and add your dental practice information where appropriate; save the file to create a blank form for ongoing use. If necessary, customize the text of the form template for specific patient needs. You may wish to include components from various sources if the templates provided do not meet the needs of your practice.

While a number of form templates are available, documents are not available for every dental procedure. We encourage you to create consent forms for those dental procedures you perform frequently. You may wish to use the sample consent forms as an outline and review the manual section on informed consent. Consider consulting your attorney to ensure that your forms comply with state informed consent statutes.

Risk management content and resources are provided for illustrative purposes only. The information is intended to provide only a general overview of the matters discussed and is not intended to establish any standards of care.

Medical History

An accurate, thorough, and current medical history represents an essential tool in providing quality dental care. It also protects both the patient and you from unnecessary risks. Failure to obtain, update, and investigate the patient's medical history have all been alleged in professional liability claims asserted against dentists.

The primary purpose of a written medical history is to inform you of the patient's past and current physical status, reducing the likelihood of injury. By taking and regularly updating the patient's medical history, you can prevent drug interactions, identify oral manifestations of systemic diseases or pharmacotherapy, and better manage patients with such medical conditions as heart disease, high blood pressure, cancer, and diabetes. Evidence of a dentist's lack of diligence in asking for and distributing vital medical information would strongly support a patient's claim of professional negligence.

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New Patient Medical Histories

- Have each patient complete a thorough, written medical history at the initial visit.
  - Consider using forms that require a specific "yes" or "no" response from the patient.
  - Ask about allergy to latex, drugs, and nickel, as well as any other allergies.
  - Document all prescription drugs, over-the-counter drugs, dietary and herbal supplements, and non-prescribed drug and alcohol use.
- Have access to a current drug reference manual and use it frequently or contact a pharmacist, if needed. Review for possible ramifications with dental procedures and possible drug interactions, if dispensing or prescribing. Electronic drug reference manuals represent an excellent supplement to or replacement for a hard copy manual. Electronic drug resources are typically updated regularly or continuously to provide the latest information available.
- Before beginning treatment, orally review the medical history with the patient using everyday language the patient can understand. An oral review is essential, since many patients do not fully understand medical and/or dental terminology.
- Visually assess the patient, noting physical and/or psychological problems that may not be evident from the written history.
  - Check and record the blood pressure. This is especially important for patients with a history of hypertension or other cardiovascular conditions. Recording initial blood pressure and pulse for dental patients over 12 years of age is *required* to meet the standard of care in Texas (Rule 108.7(2)(B)). Make sure to investigate and comply with any similar requirements in your state.
- When the entire medical history interview is complete, the form should be physically or electronically signed by both the dentist and the patient. *Throughout this section, note that recommendations for signature, initials or other validation refers to use of acceptable validation methods for paper and/or electronic records.*
- Important health history information should be displayed in a prominent location *inside* the dental record, allowing all providers and staff to be aware of drug interactions, allergies, infectious diseases and other potential complications.
- *Never* place medical alert information on the outside of a patient chart, as this may be construed as a violation of patient confidentiality. Caution must also be exercised with such information if displayed on a computer screen.

Updating the Medical History

Good dentistry depends upon always having the most current information about your patients' health and checking their medical history before beginning treatment.

- The following steps should, therefore, be taken at *each and every visit*:
  - Review the written medical history.
  - Check the patient's current medications, remedies and dietary supplements.
  - Ask your patient, "Have you had any changes in your medical history since your last visit?"
  - Document the patient's response, especially affirmative responses and changes in medication and supplement regimens.
- At least annually, ask patients to review their most recent medical history questionnaire and note in writing on the form or in the electronic record any changes that have occurred since it was originally completed.
  - Have the patient initial and date the changes, if any, then re-sign and date the form near the patient's original signature.
  - After the patient has reviewed the form, review it orally with the patient, then sign and date it yourself. When the form becomes crowded with notations, the patient should be asked to complete a new questionnaire.
- Any changes revealed on the questionnaire also should be documented in the progress notes section of the patient record. In addition, visually assess the patient, noting physical and/or psychological problems that may not be evident from the written history.
  - Document the updated information in the progress notes section of the patient record, specifying any changes noted on the questionnaire. A typical record entry might read "MHR: now taking Inderal 180 mg daily, up from 100 mg. Remainder neg."
  - Consult your current drug reference manual and/or a pharmacist to check current medications for possible ramifications with dental procedures and possible drug interactions.
- At recall visits, when the patient has *not* completed or revised a medical history questionnaire, ask the following questions:

  Since your last dental visit,
  - Have you seen a physician or other healthcare professional for any treatment or consultation?
  - Have you suffered any illness or injury?
  - Have you stopped, started or changed any prescription or over-the-counter medication or remedy or dietary supplement?

Proper documentation is essential after *every* inquiry, even if there are no changes. Entries such as "Reviewed MH, pt. reports no changes" or "MHR neg" indicate that the health history was reviewed and found unchanged since the last visit.

The importance of compiling complete, accurate health history information cannot be overstated. Failing to obtain and distribute vital data endangers patients and increases the liability risk for you and your staff. Remember that even a small oversight may cause significant patient injury.

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For more information call Dentist's Advantage at 888-778-3981, or navigate to the Dentist's Advantage website Risk Management section.

In addition to this publication, CNA and Dentist's Advantage have produced additional risk control resources on topics relevant to dental professionals, including: newsletters; articles; forms; letters; and claim scenarios.

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