DigitalTCO

FREE CHECKLIST

The Malpractice-Proof Documentation Checklist

9 elements every clinical note must contain.
Check each one after every appointment.

Poor record-keeping is cited in 40% of unsuccessful malpractice defences. — Average payout: $128,000

1. **Chief complaint / Reason for visit** ☐
   In the patient's own words. Why are they here today? What prompted this visit? Document their words, not your interpretation.

2. **Clinical findings** ☐
   What you found on examination — hard tissue, soft tissue, periodontal, radiographic. Document normal findings too ("soft tissue NAD" proves you looked).

3. **Diagnosis / Assessment** ☐
   Your clinical interpretation of the findings. The bridge between what you found and what you decided to do. Without a documented diagnosis, treatment appears arbitrary.

4. **Treatment options presented** ☐
   Every realistic option you discussed, including no treatment. Each option with its rationale. This proves the patient made an informed choice, not a directed one.

5. **Risks, benefits & alternatives** ☐
   Document specifically which risks you discussed — not "risks explained." The material risks that would change a reasonable patient's decision if they knew about them.

6. **Informed consent** ☐
   What the patient agreed to and that they understood. Their questions or concerns. "Pt happy to proceed" does not constitute documented consent.

7. **Treatment delivered** ☐
   Enough detail that another dentist could understand exactly what was done. Anaesthesia: type, concentration, volume, technique. Materials. Complications and how managed.

8. **Post-operative instructions** ☐
   What you told them — not just that you told them something. Diet, medications, warning signs, when to call. Specific instructions, documented specifically.

9. **Follow-up plan** ☐
   Next appointment. What to watch for. When to call. The safety net that proves you didn't treat and discharge without aftercare.

The rule: If it isn't written down, it didn't happen.

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