3B. Medico-legal and Patient Care			Dentist name			Dentist name			Dentist name			Dentist name			Dentist name			Dentist name		
Patient dental records* demonstrate recording of:			Pt 1	Pt 2	Pt 3	Pt 1	Pt 2	Pt 3	Pt 1	Pt 2	Pt 3	Pt 1	Pt 2	Pt 3	Pt 1	Pt 2	Pt 3	Pt 1	Pt 2	Pt 3
1	A	• medical history updated at every recall and as appropriate……																		
2	A	• charting of missing/present teeth.....																		
3	B	• charting of existing restorations……																		
4	A	• soft tissue examination……..																		
5	A	• basic periodontal examination and/or periodontal charting recorded where appropriate ..……																		
6	A	• information regarding habits (behavioural and dietary) and actions taken ……....																		
7	A	• written treatment plan, including, costs given to patient and retained in patient record ……..																		
8	A	• local anaesthetic and prescription items used are recorded……..																		
9	A	• treatment notes for each visit include date name/identifier of clinician/treatment provided.....																		
10	A	• indication for radiographs recorded and radiographs reported……..																		

***Checking three records per dentist from the previous six months is recommended (additional records to be checked if standard is not met). Records to be selected by the inspector.**

Information source: PSM Record-keeping and SDCEP Oral Health Assessment and Review guidance