DENTRIX ENTERPRISE

DENTRIX ENTERPRISE 11.0.4

LEARNER'S GUIDE

California Department of
Corrections and Rehabilitation

HENRY SCHEIN ONE

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DENTRIX ENTERPRISE AND MICROSOFT WORD

Dentrix Enterprise can share its database with Microsoft Word, a word processing product created by Microsoft Corporation. To use Dentrix Enterprise with Microsoft Word, you need to license and install Microsoft Word.

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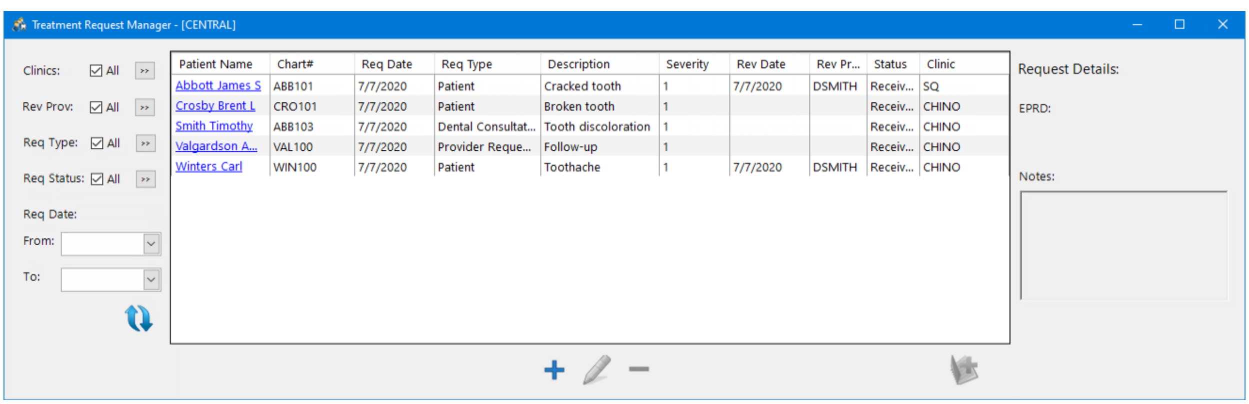
Chapter 1: Treatment Request Manager

The Treatment Request Manager module allows you to store and manage requests for treatment, from patients or providers, that require appointments to be scheduled. Prior to scheduling any appointment, except for an initial appointment for prosthetics, you must enter a treatment request for the patient. (Refer to your CDCR workflows for any other exceptions based on locations.) A provider must review the treatment request unless the request's assigned type is "RC Dental Screening." Then, you can schedule the appointment with that treatment request attached. The treatment request remains attached the appointment until that appointment is set complete.

Note: You can also create treatment requests from a patient's **More Information** window. For more information, see "Managing Treatment Requests" in Chapter 2: More Information Window.

To open the Treatment Request Manager, in the Office Manager, from the **File** menu, click **Treatment Request Manager**. Or, you can click the **Treatment Request Manager** button  on the toolbar.



Filtering the Treatment Request Manager

You can filter the list of treatment requests to suit your preferences.

Note: Any changes you make to the filter settings are saved for the next time you access the Treatment Request Manager, even after closing Dentrix Enterprise. Also, the filter settings are user specific, so each user can have his or her own filter settings to suit their preferences.

To filter the list

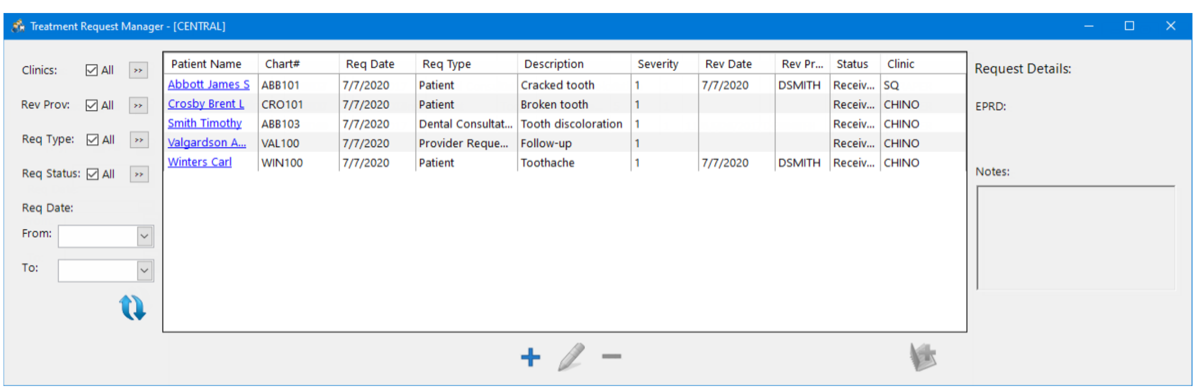
1. In the Treatment Request Manager, set up the following filters as needed:
   - **Clinics** – To view treatment requests for all clinics, select the **All** check box. Or, click the search button to select the clinics whose requests you want to view. By default, the treatment requests for the clinic you are currently logged in to are displayed.
   - **Rev Prov** – To view treatment requests that were reviewed by any provider, select the **All** check box. Or, click the search button to select the providers whose reviewed requests you want to view.
   - **Req Type** – To view treatment requests of any type, select the **All** check box. Or, click the search button to select the types of requests you want to view.
   - **Req Status** – To view treatment requests with any status, select the **All** check box. Or, click the search button to select the statuses of requests you want to view.
   - **Req Date** – To view treatment requests that are dated within a specified range of dates, enter or select the **From** and/or **To** dates (you can have an open-ended range).
2. Click the **Refresh/Apply filter settings** button.

Adding Treatment Requests

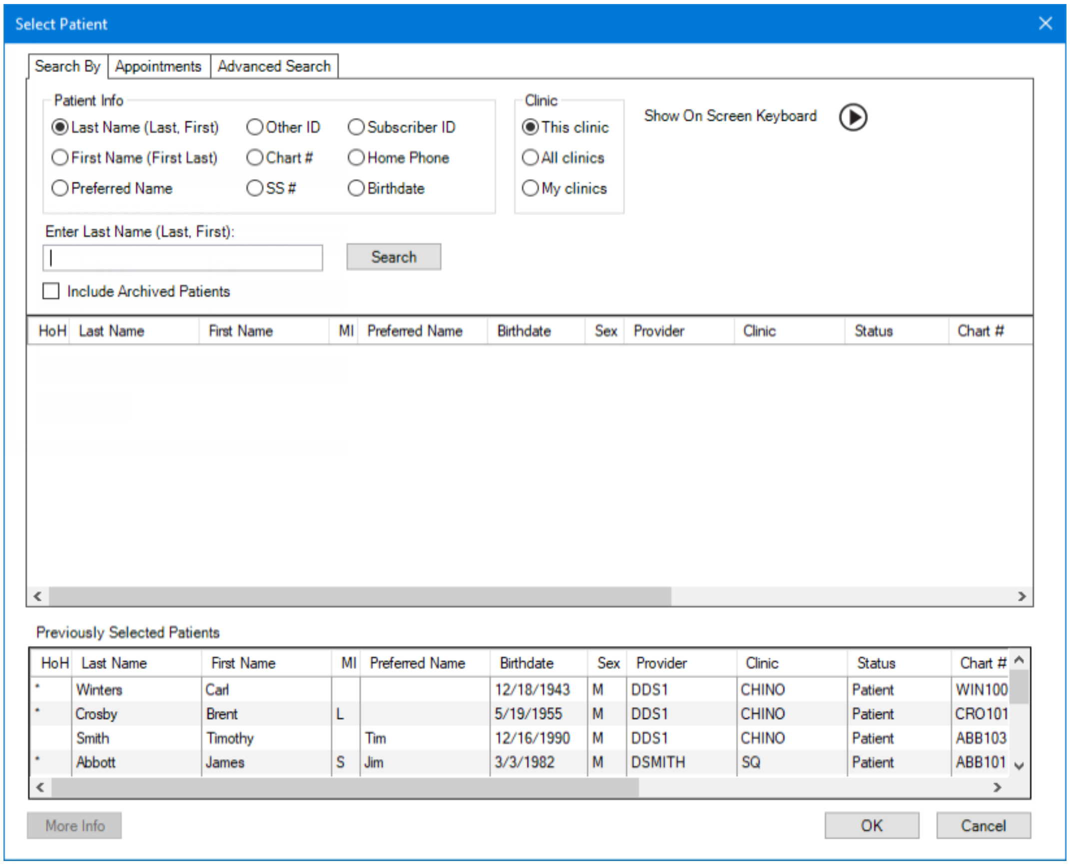
You can add a treatment request as needed. After the dentist has reviewed the 7362 paper form, in the Treatment Request Manager, the OT will add a corresponding treatment request using the information on the form, including the dentist's notations.

To add a treatment request

1. In the Treatment Request Manager, click the **Add Treatment Request** button.

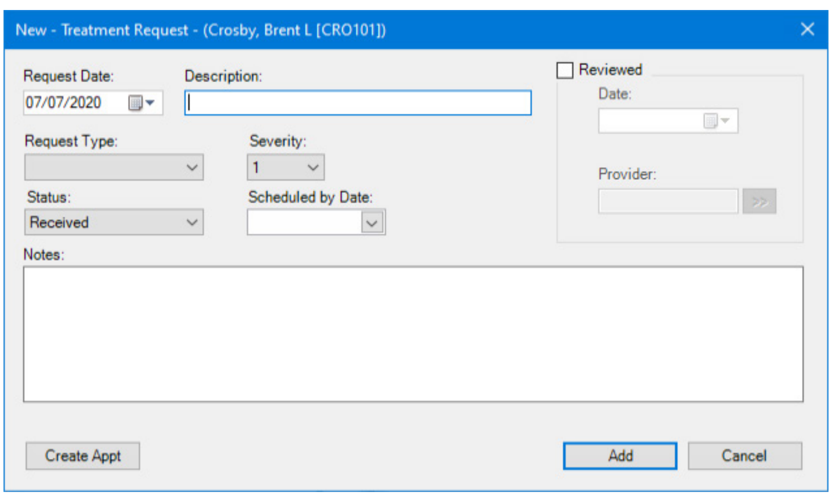


The **Select Patient** dialog box appears.



2. Select a patient.

The **New - Treatment Request** dialog box appears.



3. Set up the following options as needed:

- **Request Date** – Today's date is selected by default as the date of the treatment request, but you can specify a different date if necessary. For a patient request, enter or select date that the dental clinic received the treatment request from the patient; for a provider request for treatment, the initial date of the request; or for a provider request for a consult, the date that the consult was created.
- **Description** – Enter a brief description, such as the reason, for the treatment request.

- **Request Type** – Select a type, such as the source, to assign to the treatment request. Refer to the appropriate job aid for information about which request types should be used.

  Note: System-only request types are not available for selection. A system-only type is one that has been set up to allow requests of that type to be added only through HL7 messages.

- **Status** – Select a status to track the treatment request by. Refer to the appropriate job aid for information about which statuses should be used.
- **Severity** – This option is not used.
- **Scheduled by Date** – Enter or select the date by which an appointment for this treatment request has been requested to be scheduled. For a provider-requested treatment request, this date is the TIC date.
- **Notes** – Enter any additional information regarding the treatment request (such as information entered by the patient on Form 7362).
- **Reviewed** – To mark the treatment request as having been reviewed, select the check box. However, this can be done at a later time. For more information about reviewing a request, see “Reviewing Treatment Requests” in this chapter.

  Note: You can mark a treatment request as having been reviewed at the same time it is entered.

4. Do one of the following:
   - To save the treatment request, click **Add**. Then, on the message that appears, click **OK**.
   - To save the treatment request and schedule an appointment for it (with or without the request having been reviewed), click **Create Appt**. However, you can schedule the appointment at a later time. For information about scheduling a treatment request, see “Scheduling Appointments for Treatment Requests” in Chapter 8: Appointment Book.

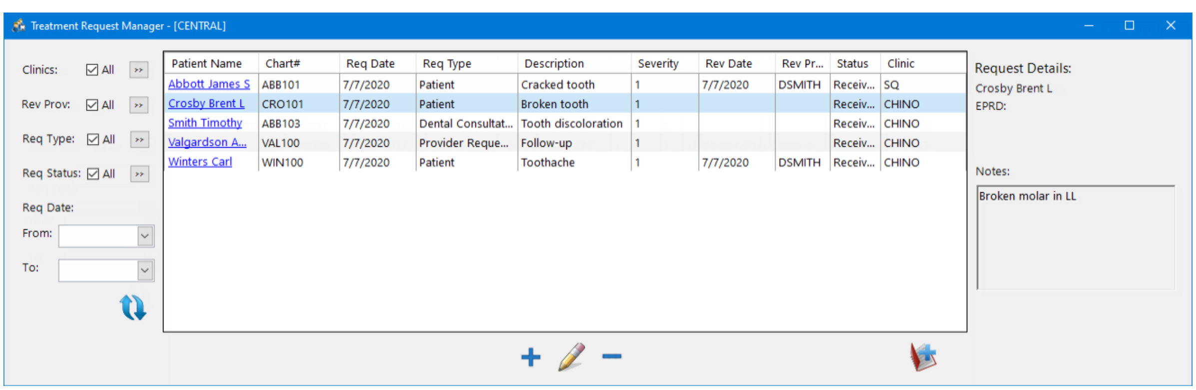
Note: After entering a treatment request, be sure to scan any forms and documents (such as Form 7362) into the patient’s Document Center.

Editing Treatment Requests

You can edit a treatment request as needed unless it has a system-only request type. A system-only request type is one that has been set up to allow requests of that type to be updated only through HL7 messages.

To edit a treatment request

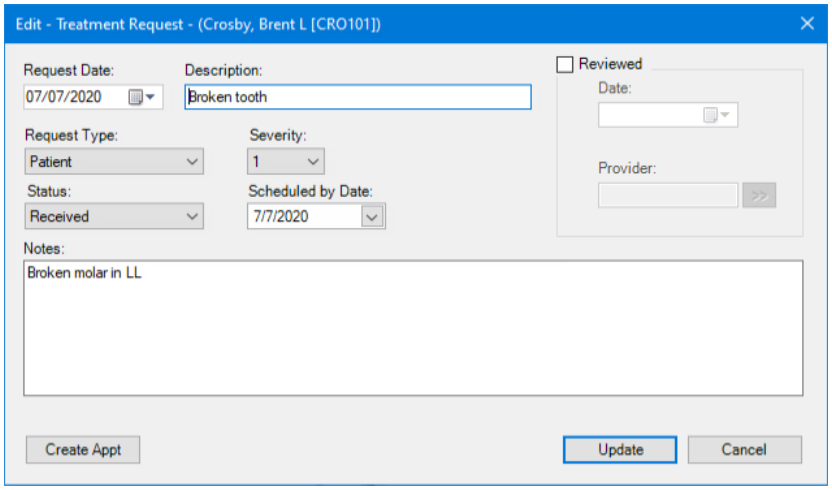
1. In the Treatment Request Manager, select a treatment request.



Note: Some details of the selected request, such as the patient name, appointment details, and notes, appear on the right side of the window. These details appear only if one request is selected.

2. Click the **Edit Treatment Request** button . This button is available only if one treatment request is selected.

   The **Edit - Treatment Request** dialog box appears.

3. Set up or modify any of the following options as needed:
   - **Request Date** – Enter or select the date that the treatment request was submitted.
   - **Description** – Enter a brief description, such as the reason, for the treatment request.
   - **Request Type** – Select a type, such as the source, to assign to the treatment request.

     Note: System-only request types are not available for selection. A system-only type is one that has been set up to allow requests of that type to be added only through HL7 messages.
   - **Status** – Select a status to track the treatment request by.
   - **Scheduled by Date** – Enter or select the date by which an appointment for this treatment request must be scheduled.
   - **Notes** – Enter any additional information regarding the treatment request.
   - **Reviewed** – To mark the treatment request as having been reviewed, select the check box. For more information about reviewing a request, see "Reviewing Treatment Requests" in this chapter.

     Note: If the treatment request has already been marked as having been reviewed, and you clear the **Reviewed** check box, the **Status** reverts to **Received** automatically unless the **Status** is **Scheduled**, in which case, the **Status** does not change.
4. Do one of the following:
   - To save the changes, click **Update**. Then, on the message that appears, click **OK**.
   - To save the changes and schedule an appointment for the treatment request (with or without the request having been reviewed), click **Create Appt**. However, you can schedule the appointment at a later time. For information about scheduling a treatment request, see "Scheduling Appointments for Treatment Requests" in Chapter 8: Appointment Book.

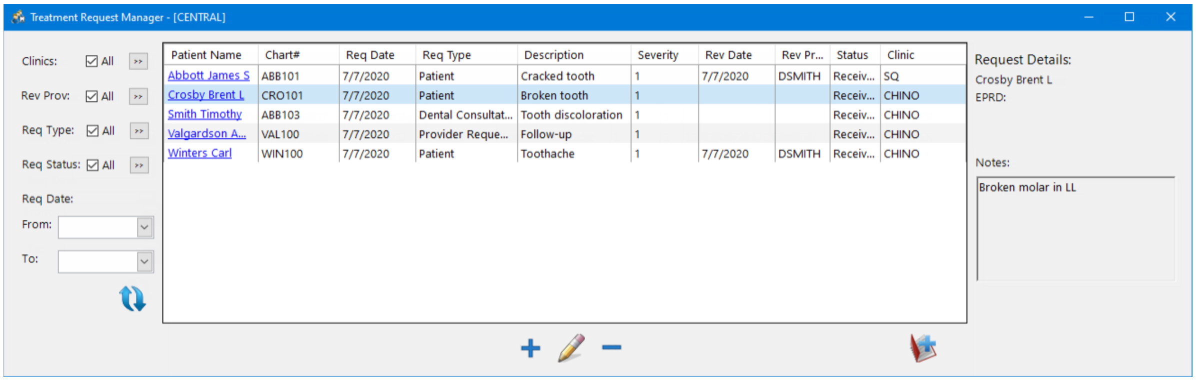
Note: If a treatment request with a Scheduled status is updated through an HL7 message, the status of the treatment request changes to Received automatically.

Deleting Treatment Requests

If the security rights assigned to your user account allow it, you can delete treatment requests as needed. If you delete a request that is linked to an appointment, that request will be unlinked from that appointment.

To delete a treatment request

1. In the Treatment Request Manager, select one or more treatment requests.



2. Click the **Delete Treatment Request** button —. This button is available only if at least one treatment request is selected.
3. On the confirmation message, click **Yes**.
4. On the message that appears, click **OK**.

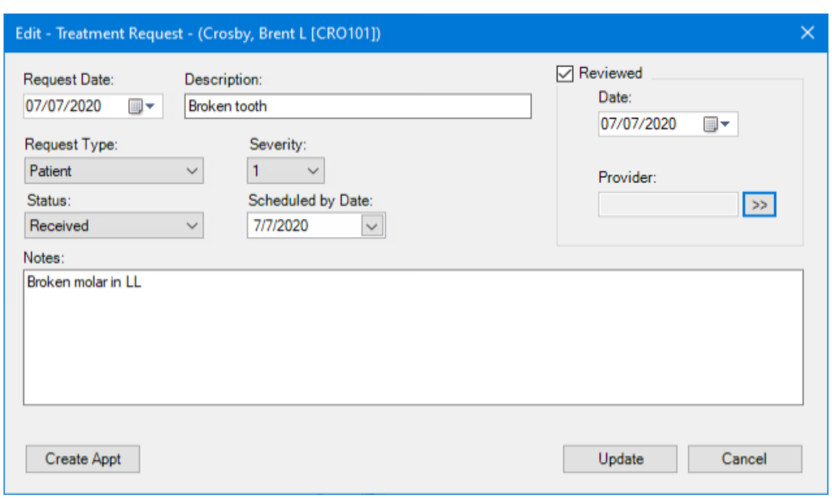
Reviewing Treatment Requests

Typically, a provider must review a treatment request before an appointment for that request is scheduled. Exceptions to the rule for reviewing a request before scheduling it may include exam requests and Reception Center dental screening requests.

To review a treatment request

1. In the **Edit - Treatment Request** (or **New - Treatment Request**) dialog box, select the **Reviewed** check box.

   The review options become available.



2. Today's date is selected by default as the **Date** of the review, but you can specify a different date if necessary. Enter or select the date that the treatment request was reviewed.
3. Click the **Provider** search button to select the provider who reviewed the treatment request.

   The **Status** changes to **Reviewed** automatically.

   Note: If you clear the **Reviewed** check box, the **Status** reverts to **Received** automatically.
4. Enter additional **Notes** as needed.
5. Do one of the following:
   - To save the changes, click **Update**. Then, on the message that appears, click **OK**.
   - To save the changes and schedule an appointment for the treatment request, click **Create Appt**. However, you can schedule the appointment at a later time. For information about scheduling a treatment request, see "Scheduling Appointments for Treatment Requests" in Chapter 8: Appointment Book.

Canceling or Completing Treatment Requests

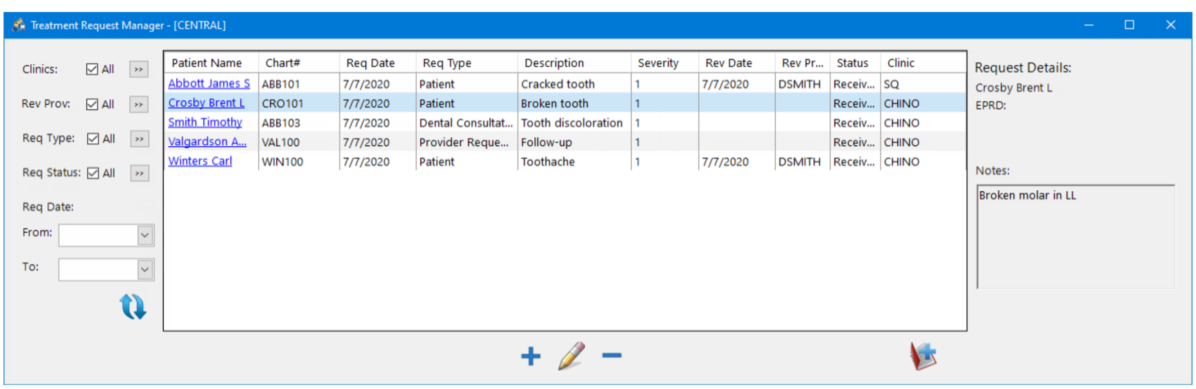
If the security rights assigned to your user account allow it, you can cancel or complete a treatment request as needed.

Notes:

- You cannot edit a treatment request once it has been canceled or completed.
- You cannot create an appointment for a treatment request that has been canceled or completed.

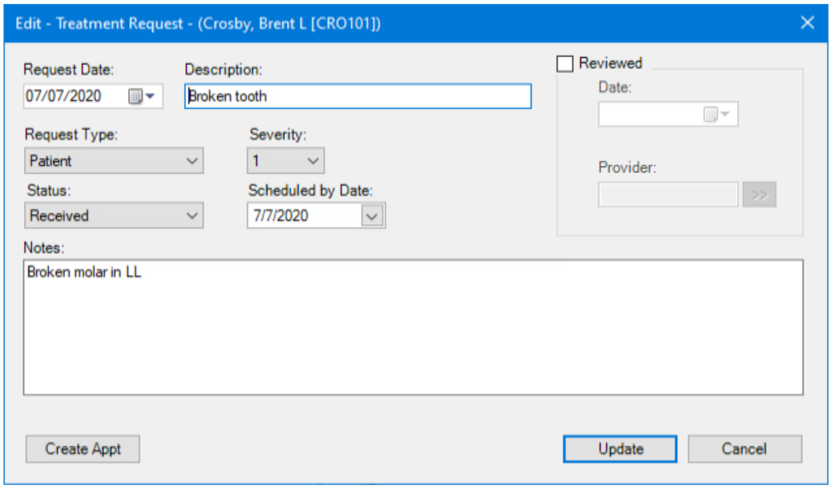
To cancel or complete a treatment request

1. In the Treatment Request Manager, select a treatment request.



2. Click the **Edit Treatment Request** button .

   The **Edit - Treatment Request** dialog box appears.



3. From the **Status** list, select **Canceled** or **Completed**.
4. Click **Update**.

   If your user account does not have the security right to cancel or complete treatment requests, a message appears and asks if another user can override the block this one time; otherwise, skip to step 7.
5. Click **Yes**.

   A password dialog box appears.
6. The overriding user enters his or her credentials, and then clicks **OK**.

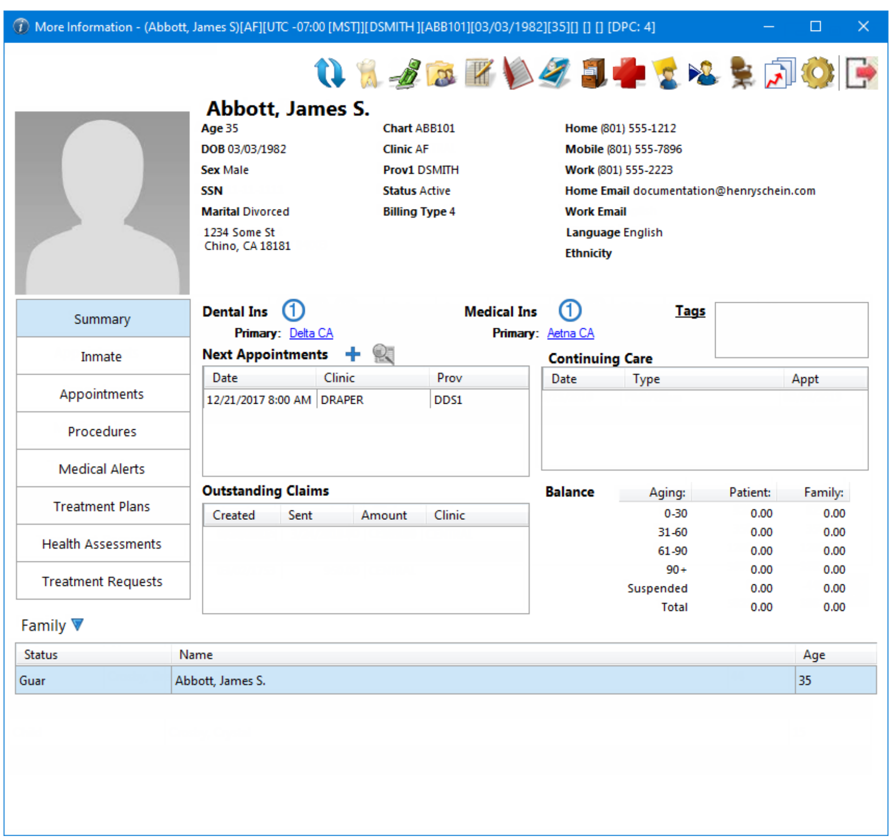
   A confirmation message appears, stating that this treatment request will no longer be editable.
7. Click **Yes**.

Chapter 2: More Information Window

The **More Information** window provides you with access to an entire overview of patient information, such as basic demographics, future appointments, treatment plans, medical information, aged balances, Dental Priority Classification, dental holds, patient movement, and effective communication requirements. You can also access other Dentrix Enterprise modules from the **More Information** window.

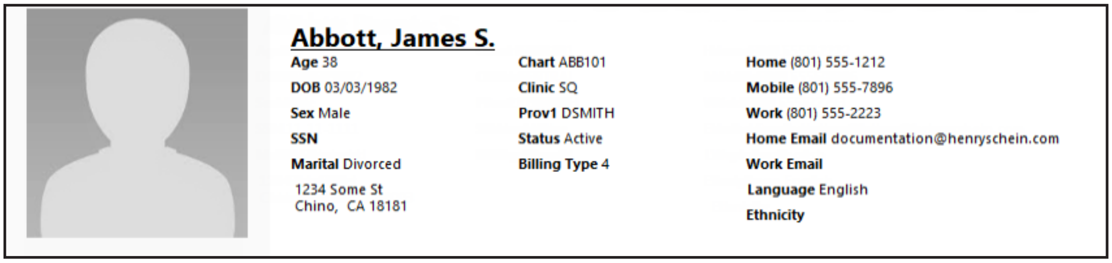
Since the **More Information** window serves as a dashboard, if the security rights assigned to your user account allow it, you will access the **More Information** window prior to working with a patient's record.

To open the **More Information** window, with a patient selected in a patient-specific module, such as the Patient Chart, with a patient's appointment selected in the Appointment Book, or from the Office Manager, click the **More Information** button  on the toolbar.



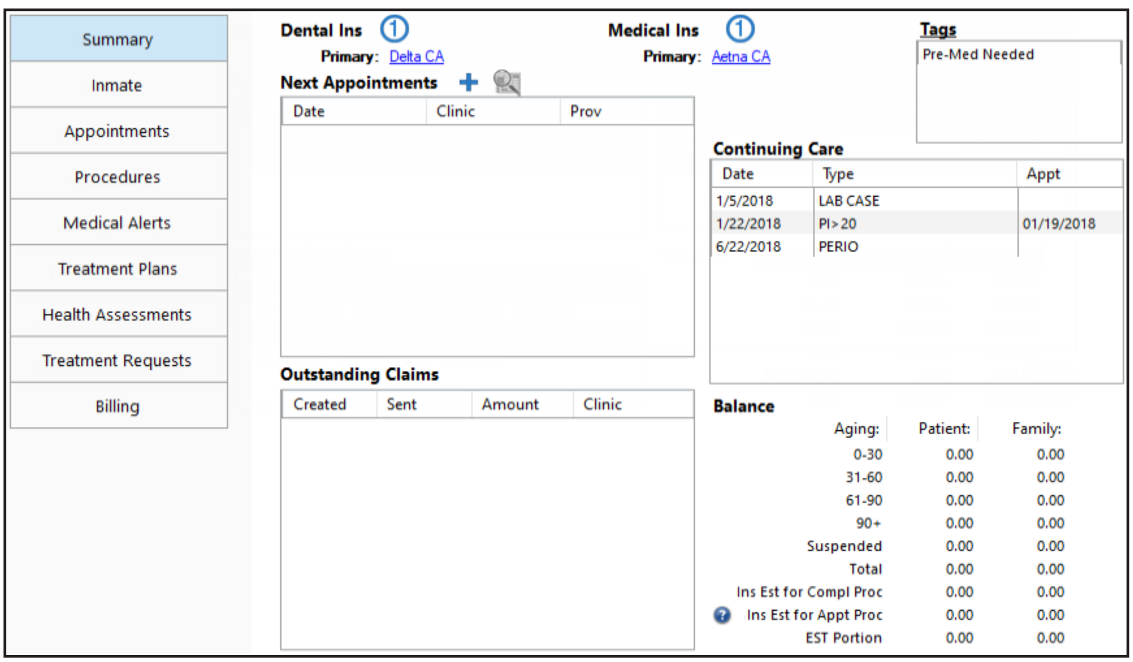
Viewing Demographics

The following information from the patient's Family File appears for your reference: age, birth date, gender, marital status, address, chart number, clinic, primary provider, patient status, billing type, home phone number, mobile phone number, work phone number, email address, and language preference.



Viewing a Summary

The **Summary** tab displays the following: the names of the dental insurance plans that are attached to the patient (if there are multiple, click a circled number icon to view the name of the corresponding plan), the names of the medical insurance plans that are attached to the patient (if there are multiple, click a circled number icon to view the name of the corresponding plan), the patient tags that are attached to the patient, the patient's future appointments, continuing care attached to the patient, and the aged balances on the patient's account.



To view a patient's insurance information, click one of the circled numbers next to **Dental Ins** or **Medical Ins**, and then click the plan name.

Adding Patient Tags

While Dentrix Enterprise does provide many options for generating reports so that they include patients that meet specific criteria, sometimes (especially for certain financial reports where filtering by account billing type isn't quite what you want) you want to filter a report further to include patients that meet custom, patient-specific criteria. For this, Dentrix Enterprise provides patient tags, which can be assigned to and removed from patients individually as needed. You can also assign patient tags to patients to quickly identify or categorize them internally instead of having to type the same thing over and over in a patient note for every applicable patient.

Important: You will assign a patient tag to a patient's record if the patient requires pre-medication before dental treatment.

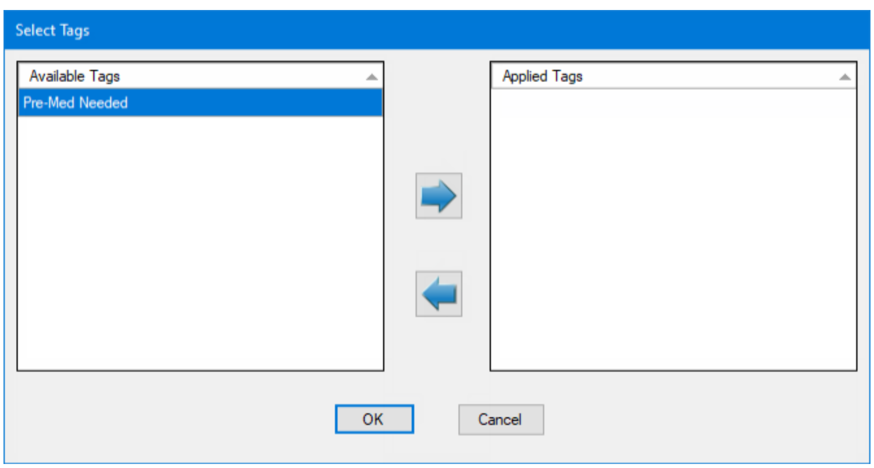
To assign a patient tag to a patient

1. On the **Summary** tab of a patient's **More Information** window, click the **Tags** link.

Note:

- If the patient does not have any tags, the tag icon on the button is white .
- If the patient has tags, the tag icon on the button is yellow .

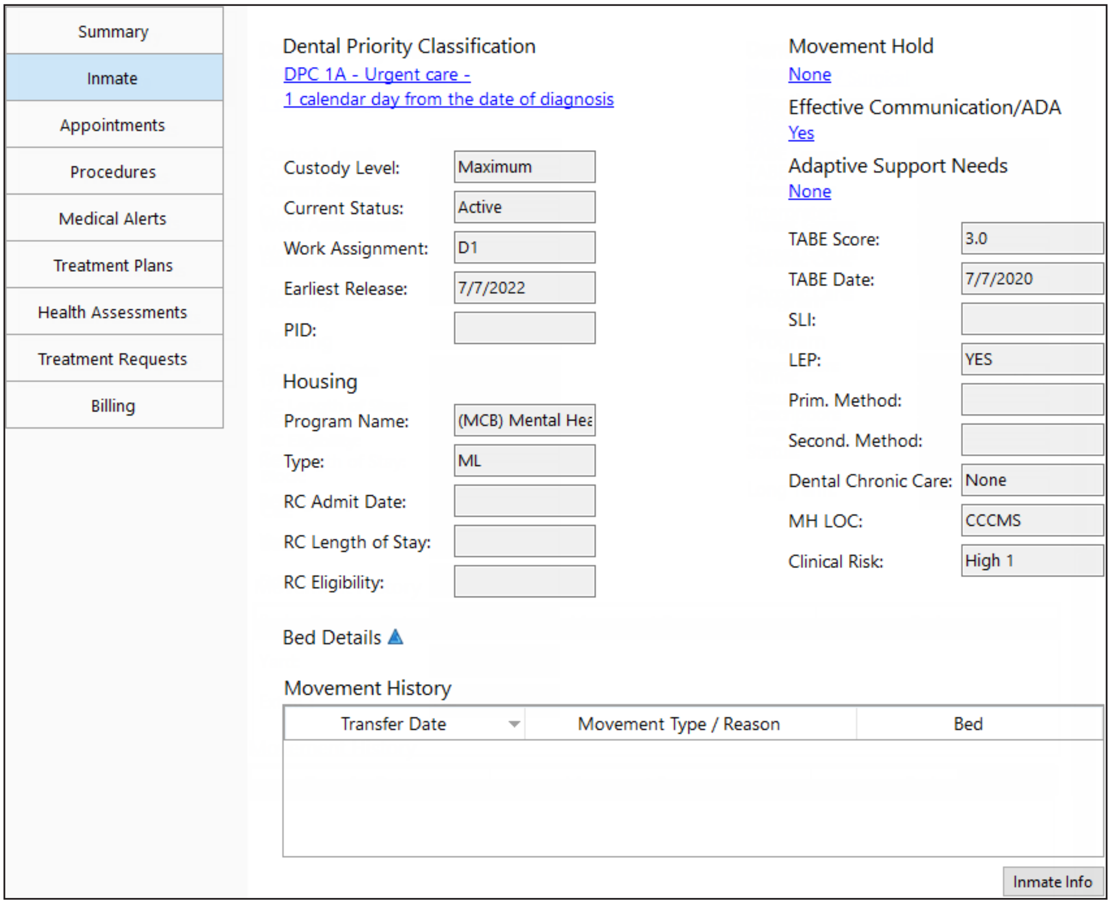
The **Select Tags** dialog box appears.



2. Select a tag in the **Available Tags** list, and then click the **Add** button .
3. Click **OK**.

Viewing Inmate Information

The **Inmate** tab displays the following information about the inmate as stored in the Strategic Offender Management System (SOMS) database: requirements for effective communication (EC) or the Americans with Disabilities Act (ADA), custody level, current status, work assignment, earliest possible release date, external patient ID, adaptive support needs, TABE score and date, SLI, LEP, primary and secondary communication methods, dental chronic care, mental health level of care (MH LOC), clinical risk, housing program and type, reception center (RC) admit date, RC length of stay, RC eligibility, bed details, and movement history. You cannot change any of this information.

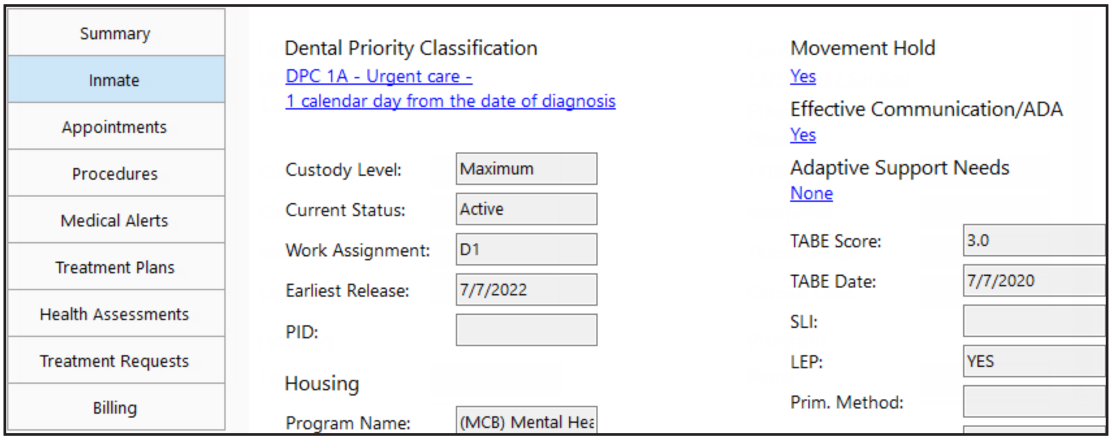


Notes:

- To view the bed details (block, cell, bed, and yard), expand **Bed Details**.
- To view the inmate's requirements for EC or ADA, click the link under **Effective Communication/ADA**. If the link text is "None," the inmate does not have any requirements. If the link text is "Yes," the inmate has requirements.
- To view the inmate's adaptive support needs, click the link under **Adaptive Support Needs**. If the link text is "None," the inmate does not have any adaptive support needs. If the link text is "Yes," the inmate has adaptive support needs. An adaptive support need appears as a category name (such as Behavior or Social Interactions) and a description or instructions.

Viewing DPCs

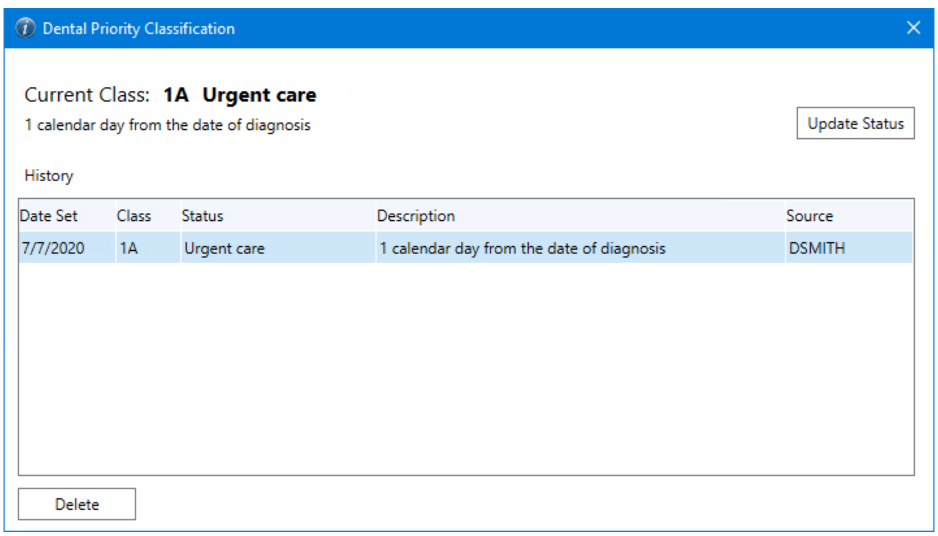
You can view an inmate's **Dental Priority Classification** (DPC) on the **Inmate** tab. If "None" appears, or if the classification is not correct, the dentist will update the DPC from the Clinical Notes module.



To view the DPC history

Click the link under **Dental Priority Classification**.

The **Dental Priority Classification** dialog box appears.

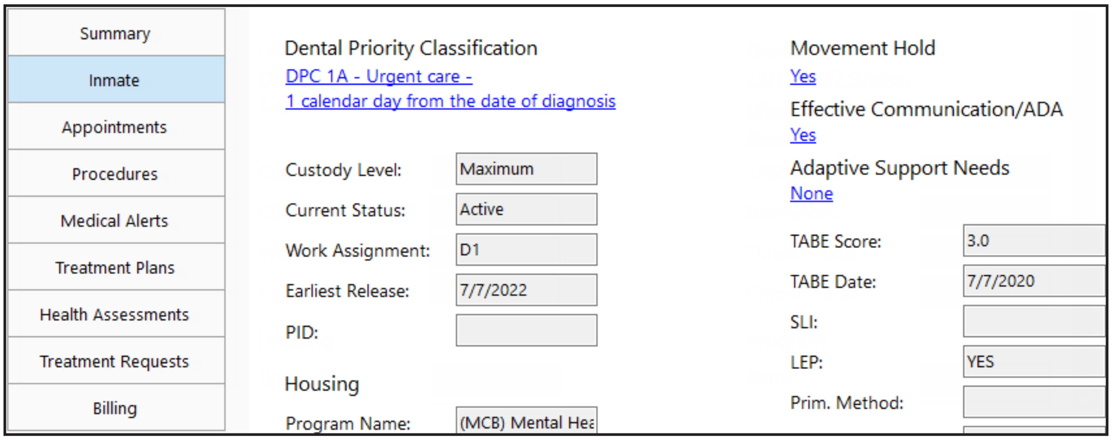


Notes:

- If a DPC update is required with every clinical note, to update a patient's DPC, you must do so by signing a clinical note and then selecting a DPC code when prompted. For information about signing clinical notes, see "Signing Clinical Notes" in Chapter 11: "Clinical Notes." However, if a DPC update is allowed without a clinical note, you can update a patient's DPC from the **More Information** window (see "Updating DPCs" in this chapter).
- In the **Dental Priority Classification** dialog box, you can also delete an entry from the **History** list by selecting that entry and then clicking **Delete**.

Updating DPCs

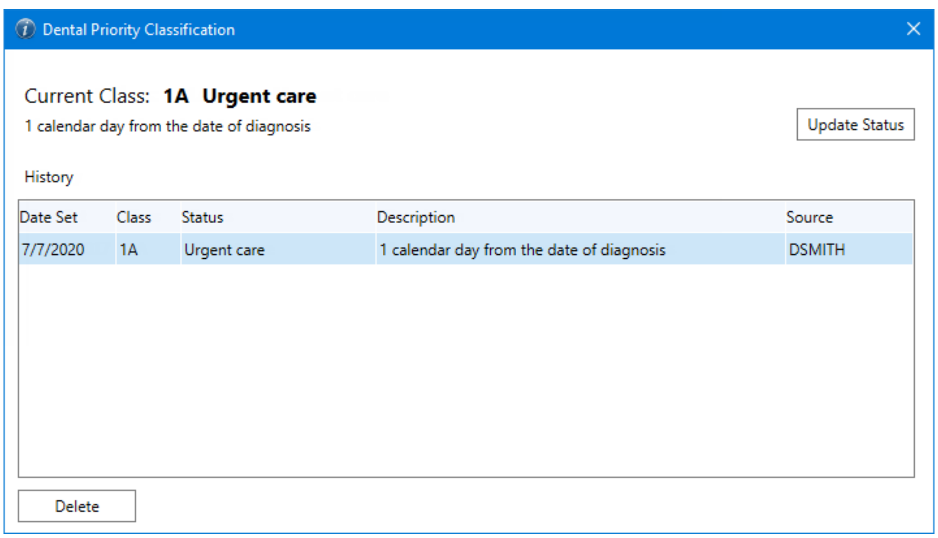
An inmate's **Dental Priority Classification** (DPC) appears on the **Inmate** tab. If a DPC update is required with every clinical note, to update a patient's DPC, you must do so by signing a clinical note and then selecting a DPC code when prompted. For information about signing clinical notes, see "Signing Clinical Notes" in Chapter 11: "Clinical Notes." However, if a DPC update is allowed without a clinical note, you can update a patient's DPC from the **More Information** window.



To update a DPC

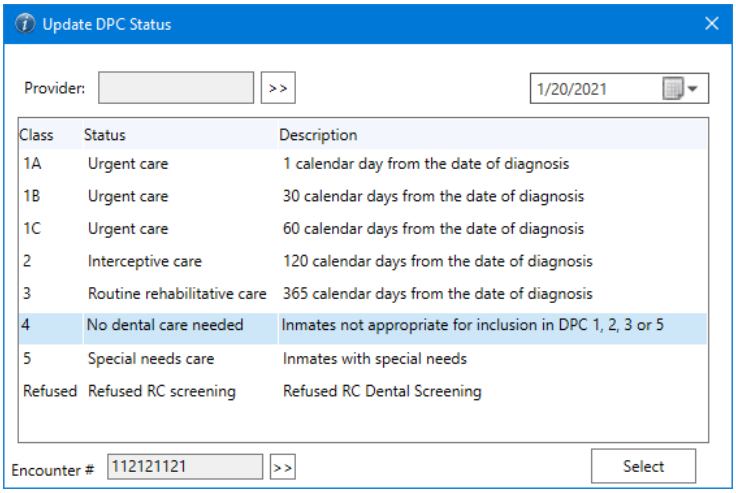
1. Click the link under **Dental Priority Classification**.

   The **Dental Priority Classification** dialog box appears.



2. Click **Update Status**.

The **Update DPC Status** dialog box appears.



3. Click the **Provider** search button >> to select the correct provider.
4. Click the **Encounter #** search button >> to select the correct encounter number.
5. Select the correct status based on the patient's treatment plans.
6. Click **Select**.

Placing Movement Holds

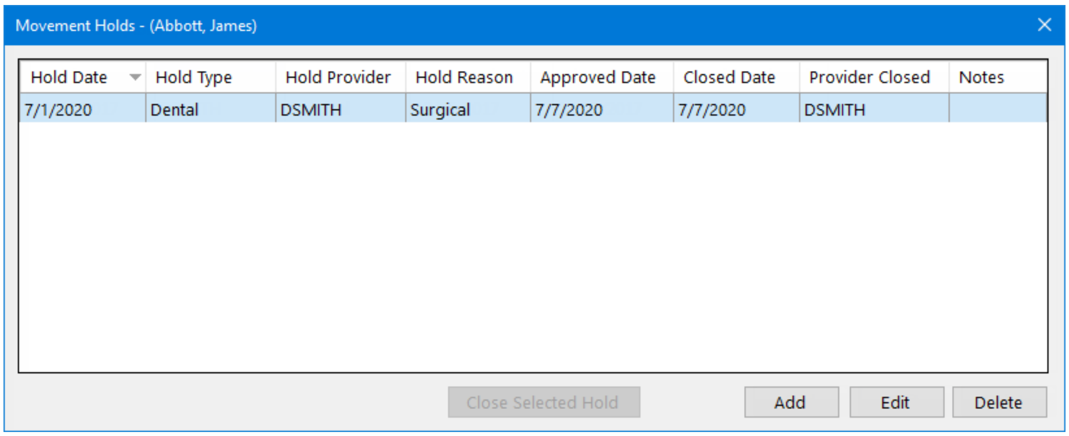
If the security rights assigned to your user account allow it, you can place a movement hold on a patient.

Note: A patient can have only one active movement hold at a time.

To place a movement hold

1. On the **Inmate** tab, click the link under **Movement Hold**. If the link text is "None," the inmate does not have an active movement hold.

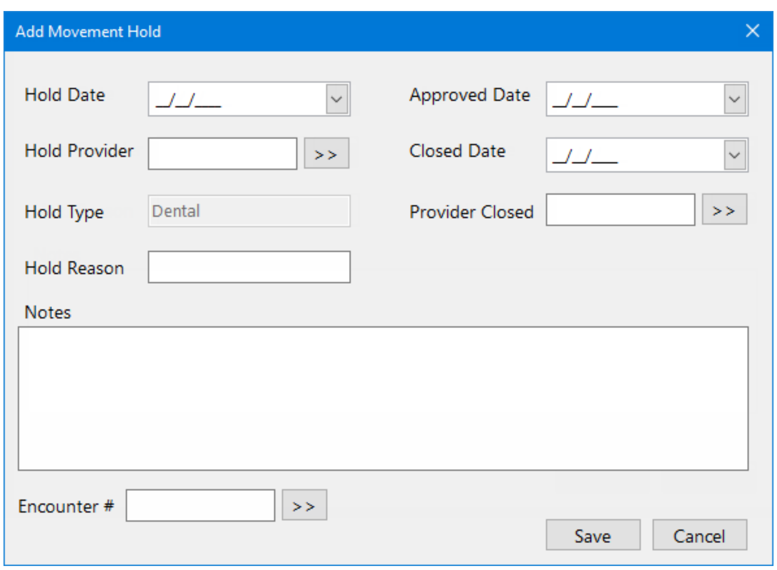
   The **Movement Holds** dialog box appears.



   Note: In this dialog box, you can also delete a hold by selecting it and then clicking **Delete**. However, you cannot delete a hold that was received through an HL7 message.

2. Click **Add**.

   The **Add Movement Hold** dialog box appears.



3. Set up the following options:
   - **Hold Date** – The date that the hold went or will go into effect.
   - **Hold Provider** – The provider placing the hold.
   - **Hold Type** – "Dental" appears for your reference.

- **Hold Reason** – The reason for the hold.
- **Approved Date** – The date that the hold was approved. This may be entered later if needed by editing the hold.
- **Notes** – Additional details regarding the hold.
- **Encounter #** – The applicable encounter number.

4. Click **Save**.

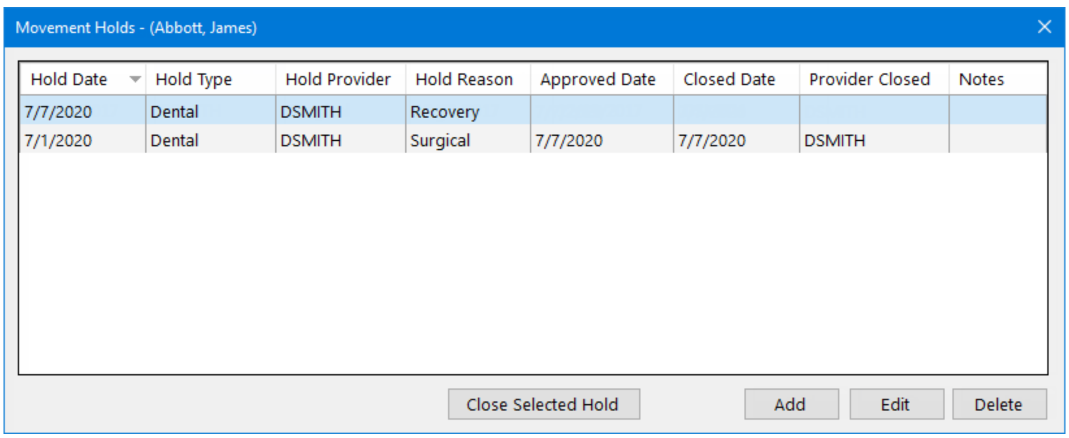
Closing Movement Holds

Once a movement hold is no longer necessary, you can close it if the security rights assigned to your user account allow it.

To close a movement hold (today only)

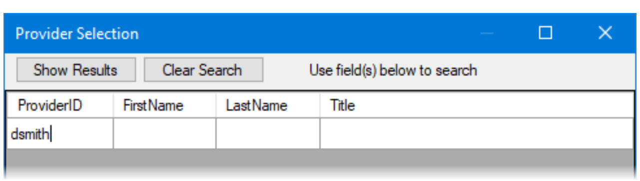
1. On the **Inmate** tab, click the link under **Movement Hold**. If the link text is "Yes," the inmate has an active movement hold.

   The **Movement Holds** dialog box appears.



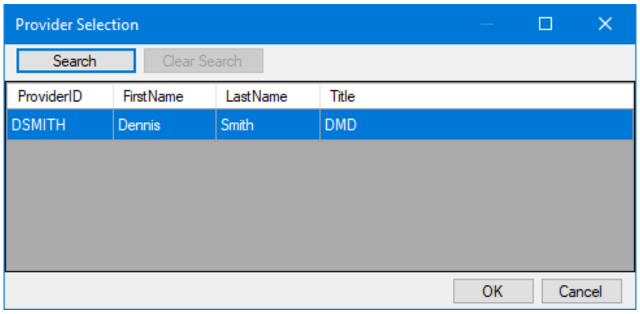
2. Select a movement hold, and then click **Close Selected Hold**.

   The **Provider Selection** dialog box appears.



3. Enter your search criteria, and then click **Show Results**.

The matching providers appear.



4. Select the provider releasing the hold, and then click **OK**.

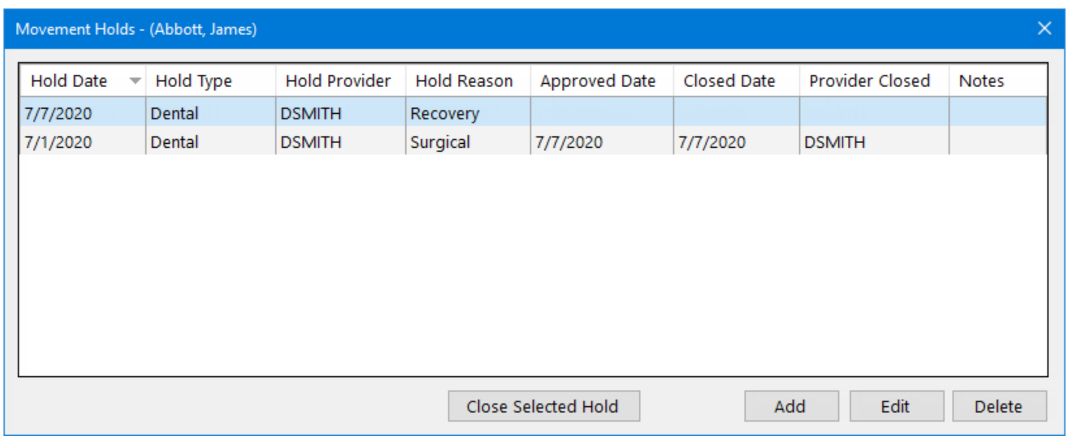
   A message appears and states that the date of the release will be today.

5. Click **OK**.

To close a movement hold (today or prior)

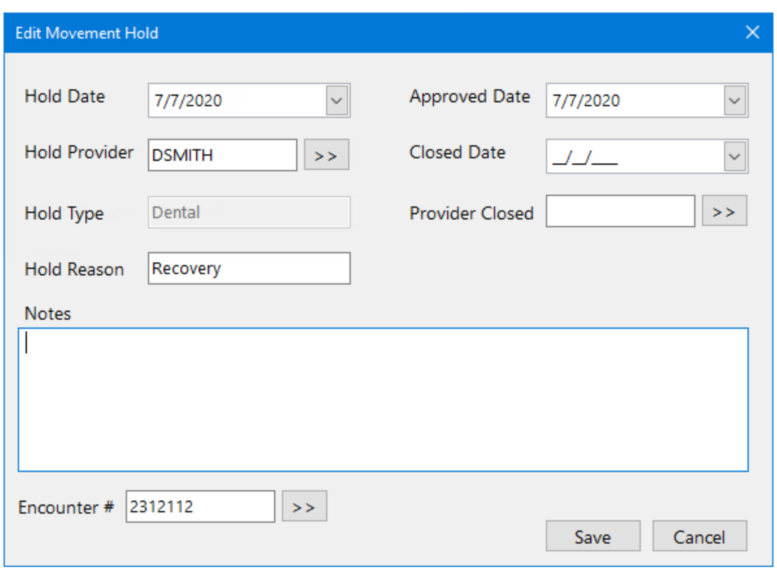
1. On the **Inmate** tab, click the link under **Movement Hold**. If the link text is "Yes," the inmate has an active movement hold.

   The **Movement Holds** dialog box appears.



2. Select a movement hold, and then click **Edit**.

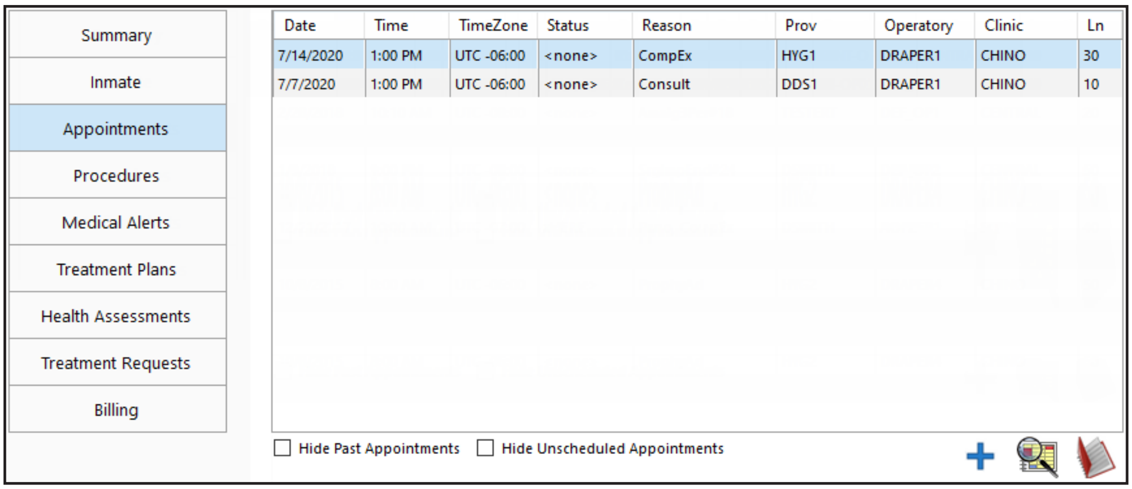
   The **Edit Movement Hold** dialog box appears.



3. Set up the following options:
   - **Closed Date** – The date that the hold is being released.
   - **Provider Closed** – The provider releasing the hold.
4. Click **Save**.

Locating Appointments

The **Appointments** tab displays the patient's past appointments (unless the **Hide Past Appointments** check box is selected), future appointments, and appointments on the Unscheduled List (unless the **Hide Unscheduled Appointments** check box is selected).

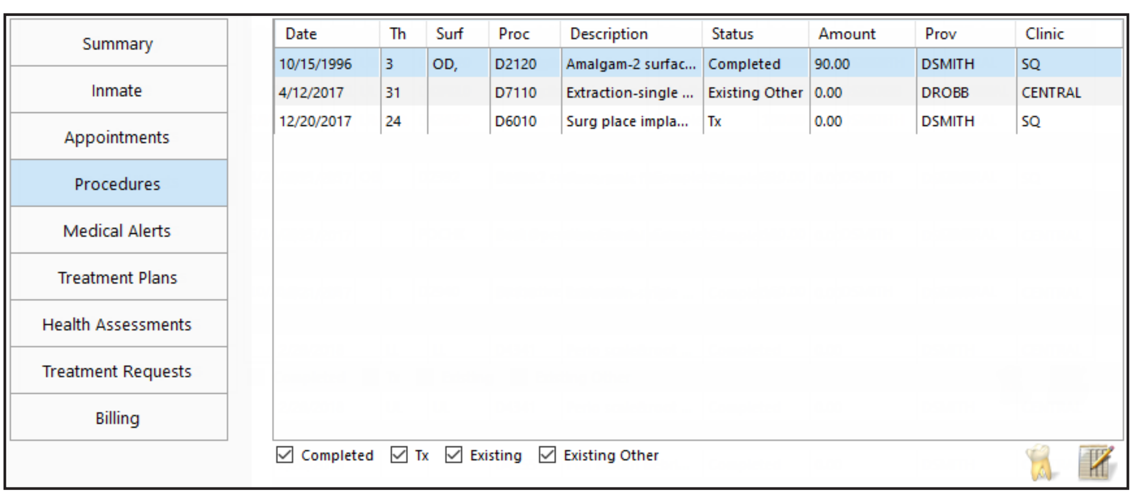


To view an existing appointment, select it, and then click the **Locate Appointment** button .

Viewing Procedures

The **Procedures** tab displays the completed, treatment-planned, and/or existing procedures for the patient, according to which check boxes are selected.

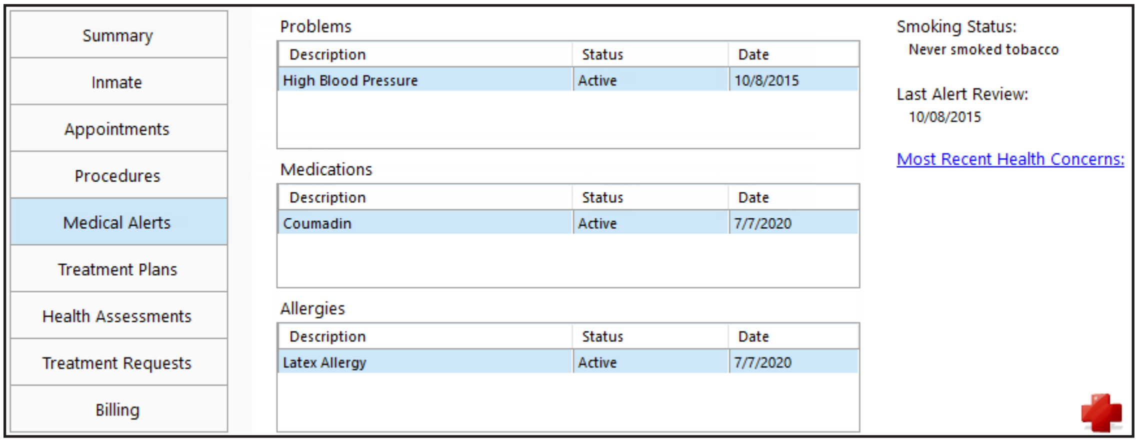
Tip: To view only completed procedures, make sure that the **Completed** check box is selected and that the other check boxes are clear.



Reviewing PAM Data

The **Medical Alerts** tab displays the patient's problems, allergies, and medications (PAM) and smoking status.

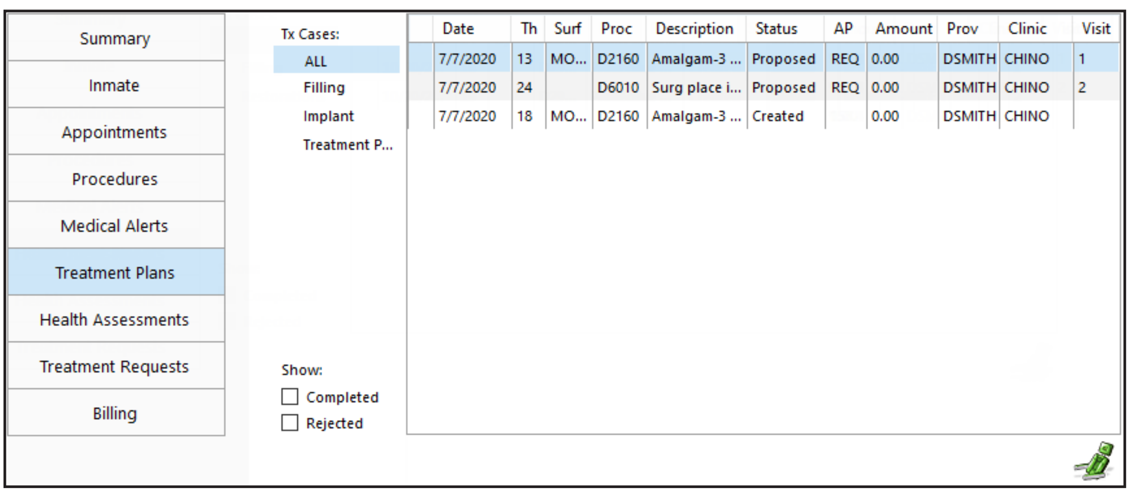
Important: Since all PAM data will be entered in PowerChart, you cannot enter or edit PAM data in Dentrix Enterprise. For information about opening PowerChart, see "Verifying and Editing PAM Data" in Chapter 9: "Patient Chart."



Viewing Treatment Plans

The **Treatment Plans** tab displays all the patient's treatment-planned procedures. You can click the name of a treatment plan to view only the treatment-planned procedures that are part of that case.

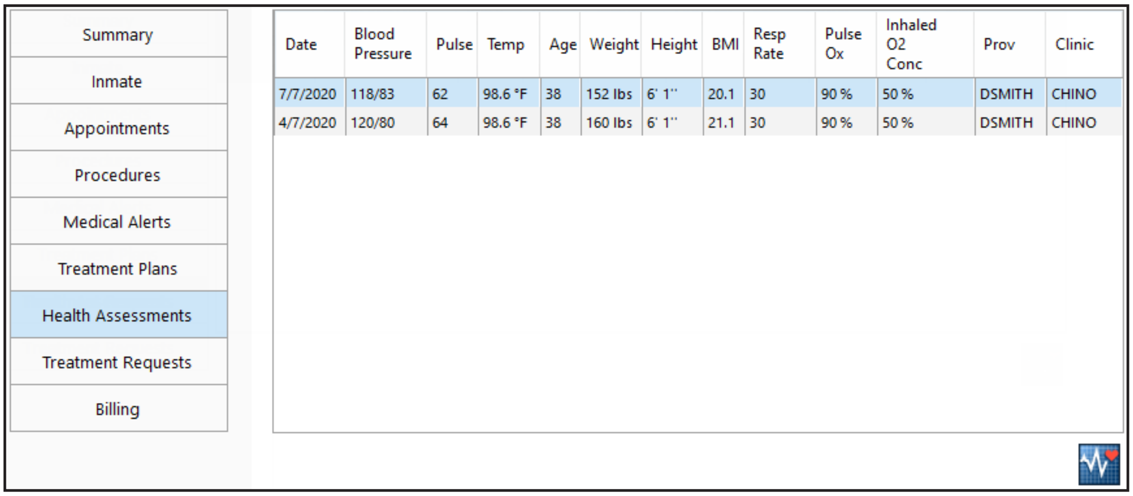
Important: Treatment that a patient has refused is placed in a rejected case in the Treatment Planner. To include rejected cases in the list, make sure that the **Rejected** check box is selected.



Reviewing Vitals

The **Health Assessments** tab displays the health assessments that were entered for the patient.

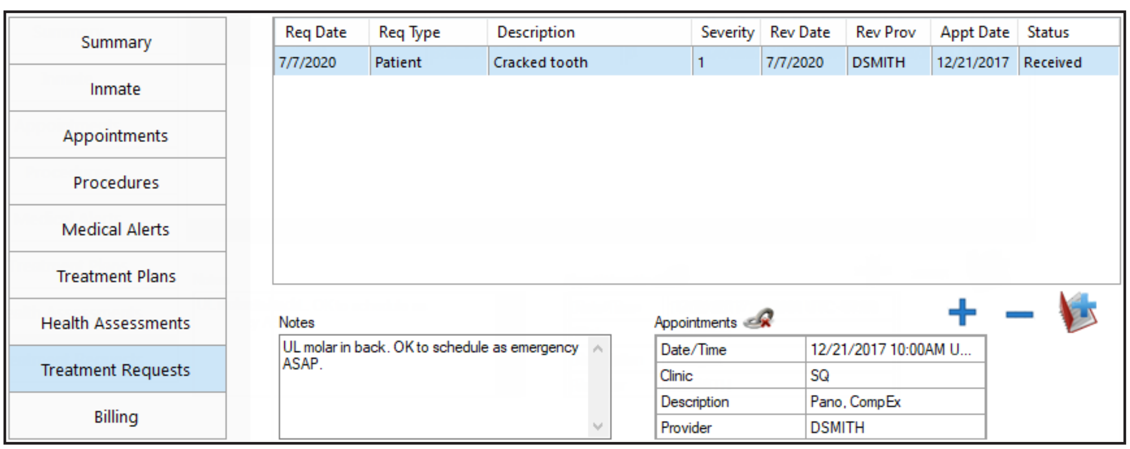
Important: Since vitals entered from Dentrix Enterprise would appear only in Dentrix Enterprise and not in PowerChart, you cannot enter or edit patient health assessments in Dentrix Enterprise. All vitals will be entered in PowerChart. For information about opening PowerChart, see "Verifying and Editing PAM Data" in Chapter 9: "Patient Chart."



To view a patient's vitals in a graph format, select a patient health assessment, and then click the **Patient Health Assessment** button.

Managing Treatment Requests

The **Treatment Requests** tab displays the treatment requests that were entered for the patient.



Do any of the following:

- To view a treatment request's notes and linked appointment's details, select the request. The details appear only if one request is selected.
- To create a new treatment request, click the **Add Request** button. For information about adding a treatment request, see "Adding Treatment Requests" in Chapter 1: Treatment Request Manager.

- To delete one or more treatment requests, select the requests, and then click the **Delete Request(s)** button . On the confirmation message that appears, click **OK**.
- To schedule an appointment for one or more treatment requests, select the requests, and then click the **Create new appointment with selected request(s)** button . If a selected request is already linked to an appointment, you will be asked if you want to unlink the request from its current appointment and link that request to the new appointment that will be created. For information about scheduling a treatment request, see "Scheduling Appointments for Treatment Requests" in Chapter 8: Appointment Book.

  Note: You cannot create an appointment for a treatment request with a Canceled or Completed status.

- To unlink a treatment request from an appointment, select the request, and then click the **Unlink** button . This button is available only if one request is selected. On the confirmation message that appears, click **Yes**.

  Note: The status of a treatment request changes automatically according to the following criteria:

  - With a reviewing provider selected, the status changes to Reviewed.

Req Date	Req Type	Description	Severity	Rev Date	Rev Prov	Appt Date	Status
12/15/2020	Patient	Broken tooth	4	12/15/2020	DSMITH		Reviewed

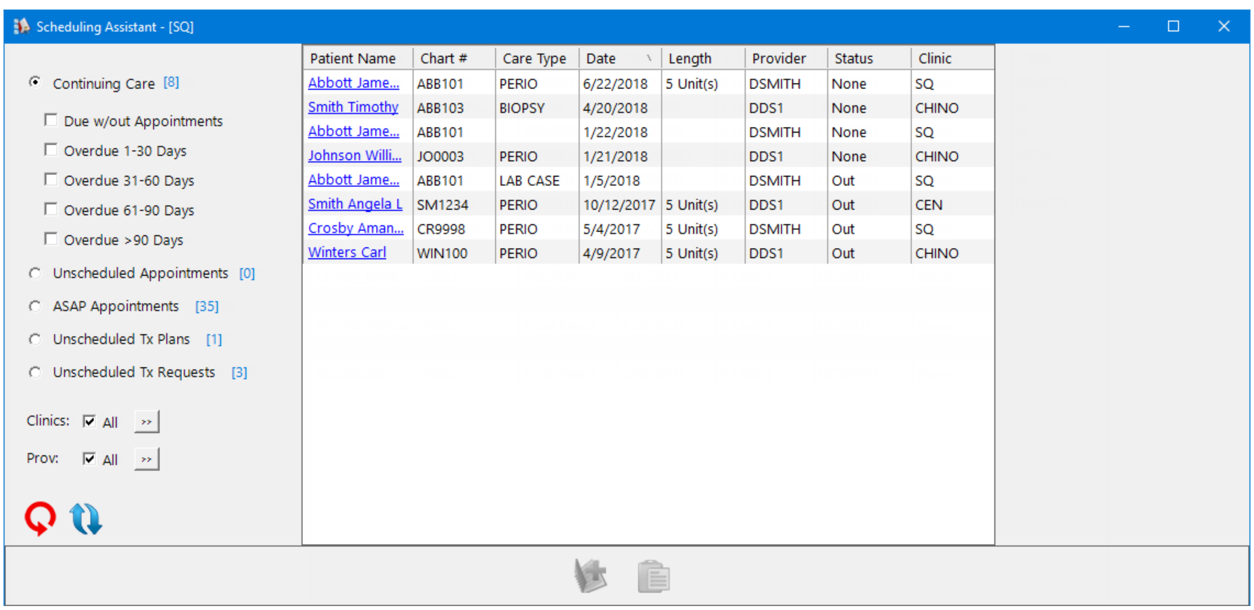
  - Without a reviewing provider selected, the status changes to Received.

Req Date	Req Type	Description	Severity	Rev Date	Rev Prov	Appt Date	Status
12/15/2020	Patient	Broken tooth	4				Received

Chapter 3: Scheduling Assistant

The Scheduling Assistant module enhances the scheduling workflow by combining the Continuing Care, Unscheduled Appointments, ASAP, Unscheduled Treatment Plans, and Treatment Request Manager lists into one window. Also, the Scheduling Assistant includes quick access to a patient's details and Office Journal entries.

To open the Scheduling Assistant, in Family File, Ledger, Chart, Appointment Book, or Office Manager, from the **File** menu, click **Scheduling Assistant**. Or, you can click the **Scheduling Assistant** button on the toolbar.



Tip: You can click the name in the **Patient Name** column of any record in the Scheduling Assistant to open that patient's **More Information** window.

Filtering the Scheduling Assistant List

You can filter the list of patients in the Scheduling Assistant to suit your preferences.

Notes:

- Any changes you make to the filter settings are saved for the next time you access the Scheduling Assistant, even after closing Dentrix Enterprise. Also, the filter settings are user specific, so each user can have his or her own filter settings to suit their preferences.
- A patient may appear more than once in the list if he or she has multiple items (continuing care types, broken appointments, ASAP appointments, treatment plans, or treatment requests) that meet the criteria of the filter settings for the selected list type.

To filter the list

1. In the Scheduling Assistant, set up the following filters as needed:
    - **List** – Select the type of list that you want to view:
        - **Continuing Care** – The list displays patients with continuing care attached to their records and/or who need continuing care appointments scheduled. The number in square brackets is a count of patients that meet the **Continuing Care** filter settings.

          If none of the check boxes under **Continuing Care** are selected, the list displays patients with continuing care attached to their records, whether or not appointments have been scheduled for those continuing care types. To view patients with unscheduled continuing care types that will be due starting at a certain time and/or that have been overdue for a certain length of time, select any of the following check boxes:

            - **Due w/out Appointments** – Any continuing care types that will be due.
            - **Overdue 1-30 Days** – Any continuing care types that have been overdue for one to 30 days.
            - **Overdue 31-60 Days** – Any continuing care types that have been overdue for 31 to 60 days.
            - **Overdue 61-90 Days** – Any continuing care types that have been overdue for 61 to 90 days.
            - **Overdue >90 Days** – Any continuing care types that have been overdue for more than 90 days.

          Notes:

            - When selecting and clearing check boxes, the list of results will not be updated until you click the **Refresh/Apply filter settings** button.
            - A continuing care type is considered due or overdue according to the specified **Due w/out Appointments Date Range** of the **Continuing Care** filter. For information about customizing the **Continuing Care** filter, see "Customizing the Continuing Care Filter Settings" in this chapter.
            - The only continuing care types that will be used are those for tracking outstanding lab cases, tracking patients with plaque indexes over 20, biopsies, and periodontal maintenance. However, the plaque index and perio maintenance types will be for informational purposes only. Prophy and perio maintenance will be tracked through treatment plans. Exams will be tracked with an external report.

    - **Unscheduled Appointments** – The list displays patients who have broken appointments that need to be rescheduled. The number in square brackets is a count of patients that meet the **Unscheduled Appointments** filter settings.

      Notes:

      - If a patient is transferred, Dentrix Enterprise will automatically cancel his or her existing appointment and place the patient onto the Unscheduled Appointments list at the new location. The broken appointment reason will be Patient Transfer.
      - For information about customizing the **Unscheduled Appointments** filter, see “Customizing the Unscheduled Appointments Filter Settings” in this chapter.

    - **ASAP Appointments** – This list is not used because appointments are not pre-booked. The patient count for this list should always be zero.
    - **Unscheduled Tx Plans** – The list displays patients who have unscheduled treatment plans. The number in square brackets is a count of patients that meet the **Unscheduled Tx Plans** filter settings.

      Note: For information about customizing the **Unscheduled Tx Plans** filter, see “Customizing the Unscheduled Tx Plans Filter Settings” in this chapter.

    - **Unscheduled Tx Requests** – The list displays patients who have unscheduled treatment requests. The number in square brackets is a count of patients that meet the **Unscheduled Tx Requests** filter settings. This list is the same list that is shown in the Treatment Request Manager (see Chapter 1: Treatment Request Manager); however, it is provided in the Scheduling Assistant, so staff can work in a centralized area to schedule appointments.

      Note: For information about customizing the **Unscheduled Tx Requests** filter, see “Customizing the Unscheduled Tx Requests Filter Settings” in this chapter.

  - **Clinics** – To view patients in all clinics, select the **All** check box. Or, click the search button to select the clinics whose patients you want to view. By default, the patients for the clinic that you are currently logged in to are displayed.
  - **Prov** – To view patients for any provider, select the **All** check box. Or, click the search button to select the providers whose patients you want to view.

2. Click the **Refresh/Apply filter settings** button.

Customizing the Scheduling Assistant Filters

In the Scheduling Assistant, you can customize the filter settings for the Continuing Care, Unscheduled Appointments, Unscheduled Tx Plans, and Unscheduled Tx Requests lists.

Note: Any changes you make to the filter settings are saved for the next time you access the Scheduling Assistant, even after closing Dentrix Enterprise. Also, the filter settings are user specific, so each user can have his or her own filter settings to suit their preferences.

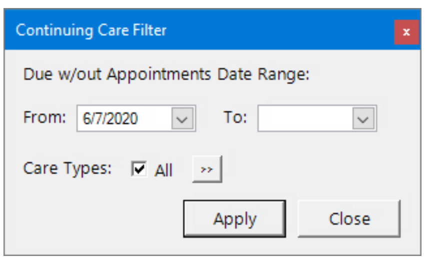
Tip: You can reset all filter settings for the Scheduling Assistant to the system defaults by clicking the **Reset Filters** button.

Customizing the Continuing Care Filter Settings

1. Click **Continuing Care** (it becomes a hyperlink when you position your pointer over it).

   The **Continuing Care Filter** dialog box appears.

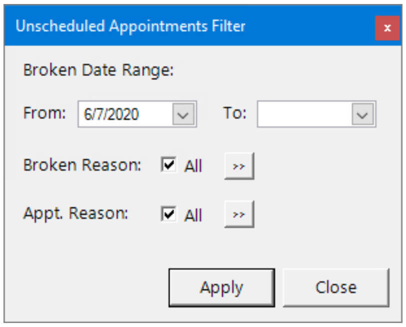
   

2. Set up the following options:
   - **Due w/out Appointments Date Range** – To include patients with unscheduled continuing care types that have due dates within a specified range of dates, enter or select the **From** and/or **To** dates (you can have an open-ended range). One month prior to today is selected as the **From** date by default.
   - **Care Types** – To include patients with unscheduled continuing care of any type, select the **All** check box. Or, click the search button >> to select the desired continuing care types. The **All** check box is selected by default.
3. Click **Apply**.

Customizing the Unscheduled Appointments Filter Settings

1. Click **Unscheduled Appointments** (it becomes a hyperlink when you position your pointer over it).

The **Unscheduled Appointments Filter** dialog box appears.

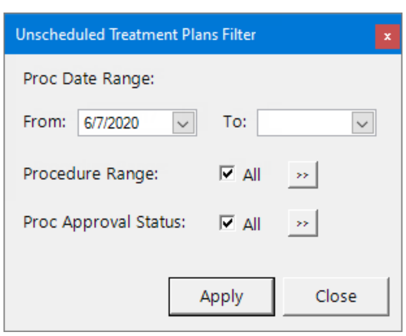


2. Set up the following options:
   - **Broken Date Range** – To include patients with appointments that were broken within a specified range of dates, enter or select the **From** and/or **To** dates (you can have an open-ended range). One month prior to today is selected as the **From** date by default.
   - **Broken Reason** – To include patients with broken appointments that were broken for any reason, select the **All** check box. Or, click the search button to select the desired reasons. The **All** check box is selected by default.
   - **Appt. Reason** – To include patients with broken appointments that have any appointment reason attached, select the **All** check box. Or, click the search button to select the desired appointment reasons. The **All** check box is selected by default.
3. Click **Apply**.

Customizing the Unscheduled Tx Plans Filter Settings

1. Click **Unscheduled Tx Plans** (it becomes a hyperlink when you position your pointer over it).

The **Unscheduled Treatment Plans Filter** dialog box appears.



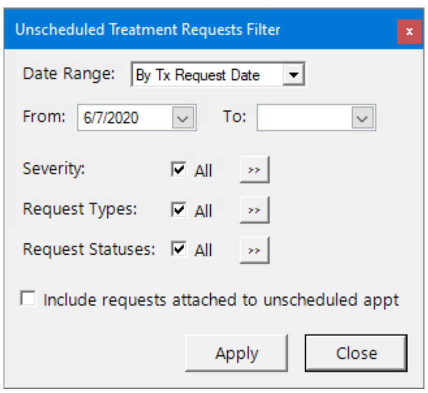
2. Set up the following options:
   - **Proc Date Range** – To include patients with unscheduled treatment-planned procedures within a specified range of dates, enter or select the **From** and/or **To** dates (you can have an open-ended range). One month prior to today is selected as the **From** date by default.
   - **Procedure Range** – To include patients with unscheduled treatment-planned procedures for any procedure code, select the **All** check box. Or, click the search button >> to select the desired procedure codes. The **All** check box is selected by default.
   - **Proc Approval Status** – To include patients with unscheduled treatment-planned procedures regardless of the approval status, select the **All** check box. Or, click the search button >> to select the desired approval statuses. The **All** check box is selected by default.
3. Click **Apply**.

Customizing the Unscheduled Tx Requests Filter Settings

1. Click **Unscheduled Tx Requests** (it becomes a hyperlink when you position your pointer over it).

   The **Unscheduled Treatment Requests Filter** dialog box appears.

2. Set up the following options:
   - **Date Range** – Select whether to include patients with treatment requests by the request date or the schedule-by date
   - **From/To** – To include patients with treatment requests that have either a request date or a schedule-by date (according to the **Date Range** selection) within a specified range of dates, enter or select the **From** and/or **To** dates (you can have an open-ended range). One month prior to today is selected as the **From** date by default.
   - **Severity** – This option is not used.
   - **Request Types** – To include patients with treatment requests of any type, select the **All** check box. Or, click the search button >> to select the desired types. The **All** check box is selected by default.
   - **Request Statuses** – To include patients with treatment requests regardless of the status, select the **All** check box. Or, click the search button >> to select the desired statuses. The **All** check box is selected by default.
   - **Include requests attached to unscheduled appt** – Either select this check box to include patients with unscheduled and scheduled treatment requests, or clear this check box to include only patients with scheduled treatment requests.
3. Click **Apply**.

Copying the List of Records to other Programs

You can copy selected records to the Windows Clipboard, so you can paste the content into another program, such as Microsoft Word or Excel. Only the details that you can see in the columns of the list are copied.

To copy the list

1. In the Scheduling Assistant, select one or more records. To select multiple, non-adjacent records, while pressing Ctrl, click the desired records. Alternatively, to select a range of adjacent records, click the first record of the desired range, and then, while pressing Shift, click the last record of the desired range.

Patient Name	Chart #	Req Type	Description	Severity	Date	Provider	Status	Clinic
Crosby Brent L	CRO101	Patient	Broken tooth	1	12/20/2017		Received	DRAPER
Smith Timothy	ABB103	Dental Con...	Tooth discol...	1	12/20/2017		Received	DRAPER
Valgardson A...	VAL100	Provider R...	Follow-up	1	12/20/2017		Received	DRAPER

2. Click the **Copy Selected to Clipboard** button.
3. Use your third-party program's paste functionality to paste the contents into that program.

Crosby Brent L	CRO101	Patient	Broken tooth	1	12/20/2017		Received	DRAPER
Smith Timothy	ABB103	Dental Consultation	Tooth discoloration	1	12/20/2017		Received	DRAPER
Valgardson Adrian	VAL100	Provider Requested	Follow-up	1	12/20/2017		Received	DRAPER

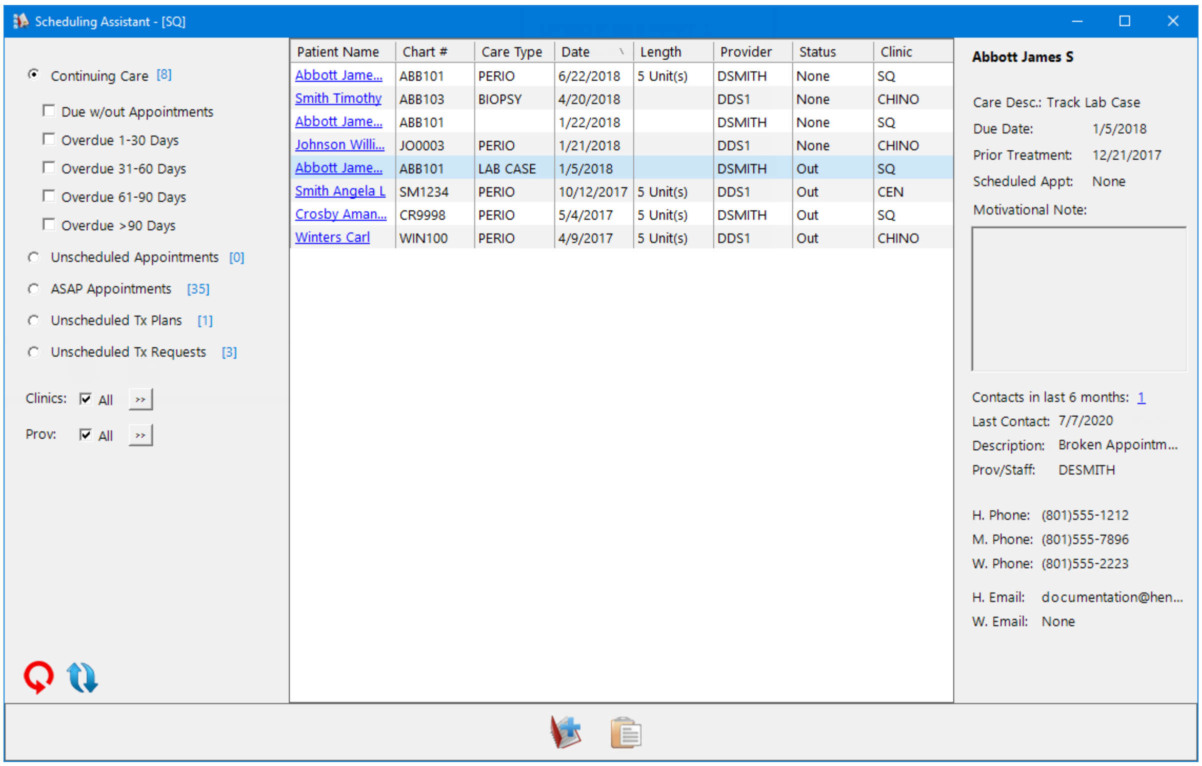
Scheduling Appointments from the Scheduling Assistant

You can schedule an appointment from the Scheduling Assistant.

Note: You cannot create an appointment for a treatment request with a Canceled or Completed status.

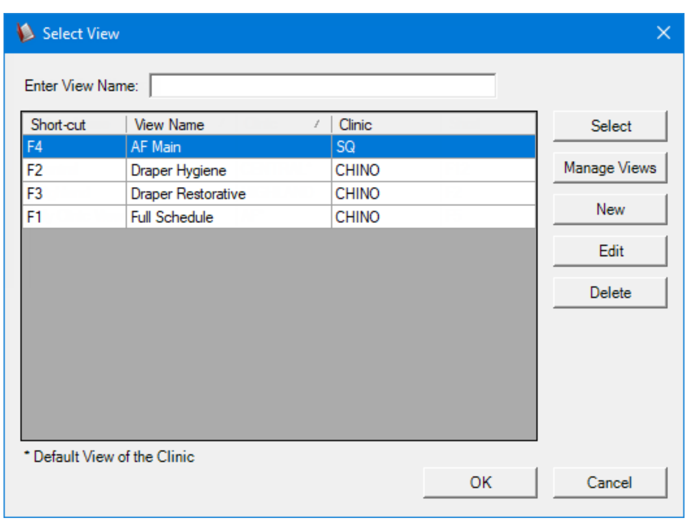
To schedule an appointment

1. In the Scheduling Assistant, select a record.



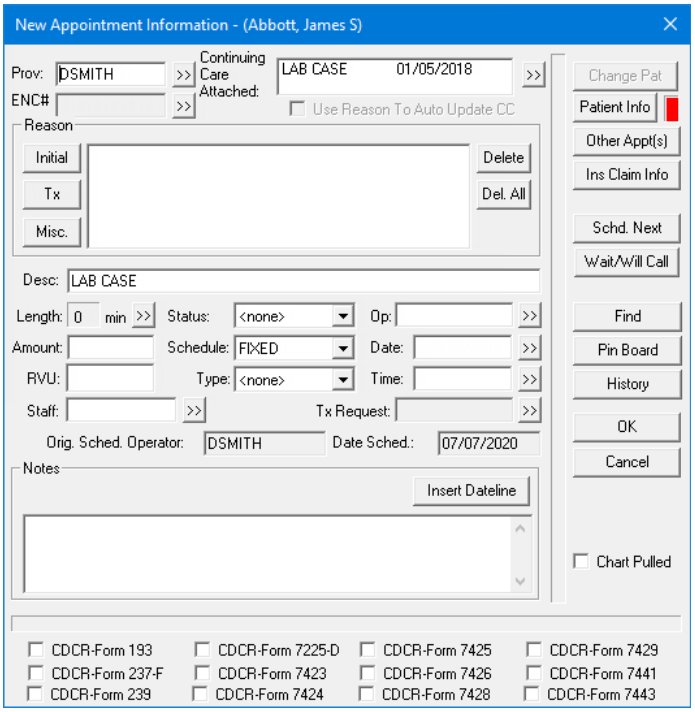
2. Click the **Create Appointment** button . This button is available only if one record is selected.

   The **Select View** dialog box appears. Also, the Appointment Book opens in the background if it is not already open.



3. Select an Appointment Book view.
4. Click either **Select** or **OK**.

   The **New Appointment Information** dialog box appears.



Notes:

- If you are scheduling a continuing care appointment, the continuing care type and assigned provider are attached to the appointment automatically.
- If you are rescheduling a broken appointment, the original appointment details, such as the provider, reason, description, length, and amount, are entered automatically in the new appointment.
- If you are scheduling a treatment-planned procedure, it is linked to the appointment automatically along with the assigned provider and any corresponding continuing care.
- If you are scheduling a treatment request, it is linked to the appointment automatically along with the patient's provider.

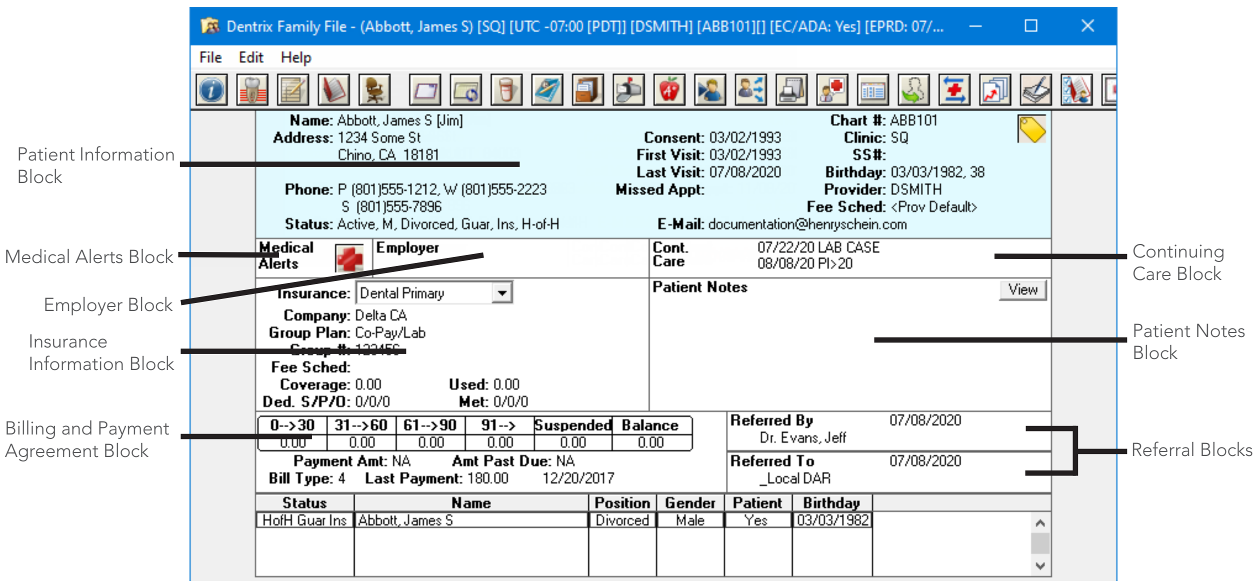
5. Set up the appointment details, such as the provider, encounter number, and reason.
6. Click **Pin Board**.
7. Navigate to the desired date for the appointment, and then drag the patient's appointment from the Pinboard to the desired time slot in the correct operatory.
8. On the confirmation message, click **Yes**.

Chapter 4: Family File

The Family File stores and displays important patient information, such as a patient's name, address, phone number, medical alerts, birth date, insurance coverage, employer, and referral information.

Note: Each patient will have a separate Family File record.

The Family File window contains several sections, called "blocks," that display information. By double-clicking any of these blocks, you can enter, edit, or delete corresponding patient information.

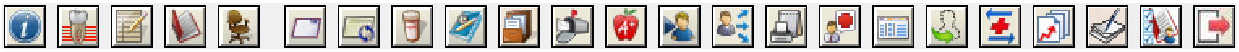


Notes:

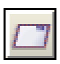
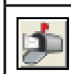
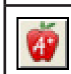
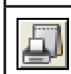
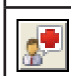
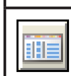
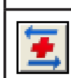
- Patient information in the Family File will be downloaded automatically from SOMS, but some information will need to be added manually.
- When a patient is paroled or discharged, Dentrix Enterprise will automatically change the patient's assigned clinic to the clinic named Z_Paroled/DC and change the patient's status to Archived. If the patient re-offends, his or her record will be reactivated automatically.

Family File Toolbar

The toolbar contains several buttons that you can click to access certain areas or features of Dentrix Enterprise.



The function of each button on the toolbar is explained in the following table.

Button	Name	Description
	More Information	Opens the selected patient's **More Information** window.
	Patient Chart	Opens the selected patient's Patient Chart.
	Ledger	Opens the selected patient's Ledger.
	Appointment Book	Opens the Appointment Book module.
	Office Manager	Opens the Office Manager module.
	Quick Letters	Opens the **Quick Letters** dialog box.
	Continuing Care	Opens the selected patient's Continuing Care list.
	Prescriptions	Opens PowerChart.
	Office Journal	Opens the selected patient's Office Journal.
	Document Center	Opens the selected patient's Document Center.
	Message Center	Opens the Cerner Message Center.
	Patient Education	Opens the **Patient Education** dialog box.
	Select Patient	Opens the **Select Patient** dialog box to select a patient.
	Referral Analysis	Opens the selected patient's **Referral Analysis** dialog box.
	Patient Notes Report	Opens the **Patient Notes Report** dialog box to print notes.
	Medical Consultation	Opens PowerChart.
	Clinical Notes	Opens the selected patient's **Clinical Notes** window.
	Patient Referrals	Opens the selected patient's **Patient Referrals** dialog box.
	Patient Health Exchange	Opens the selected patient's **Patient Health Exchange** dialog box.

Button	Name	Description
	DXOne Reports	Click to open DXOne Reporting to generate and manage reports.
	Signature Manager	Click to open the **Signature Manager** dialog box to sign multiple clinical notes at one time.
	Scheduling Assistant	Click to open the **Scheduling Assistant** window, which can help enhance your scheduling workflow.

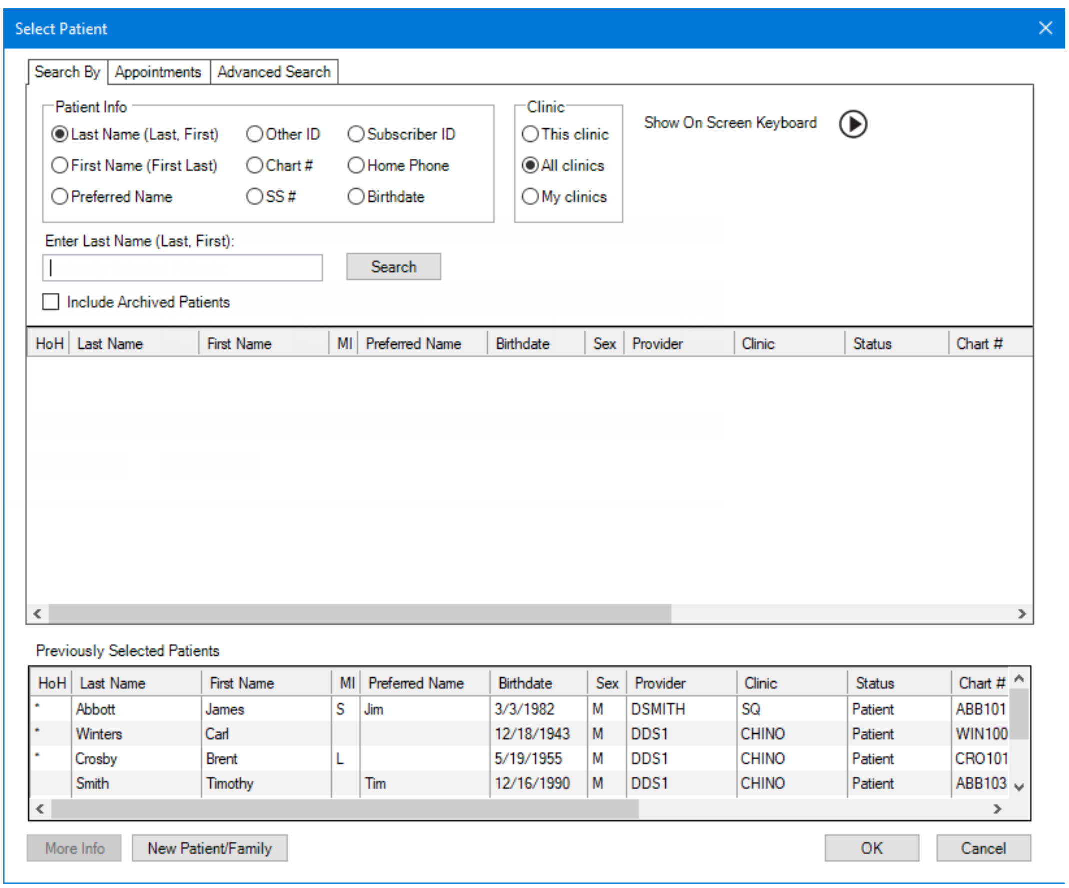
Selecting a Patient

If you want to view or edit a patient's information in any patient-specific module (the Family File, Ledger, Patient Chart, Treatment Planner, Document Center, and Office Journal) or schedule an appointment for a patient (in the Appointment Book), you must first select the patient.

To select a patient

1. In a patient-specific module, click the **Select Patient** button  on the toolbar.

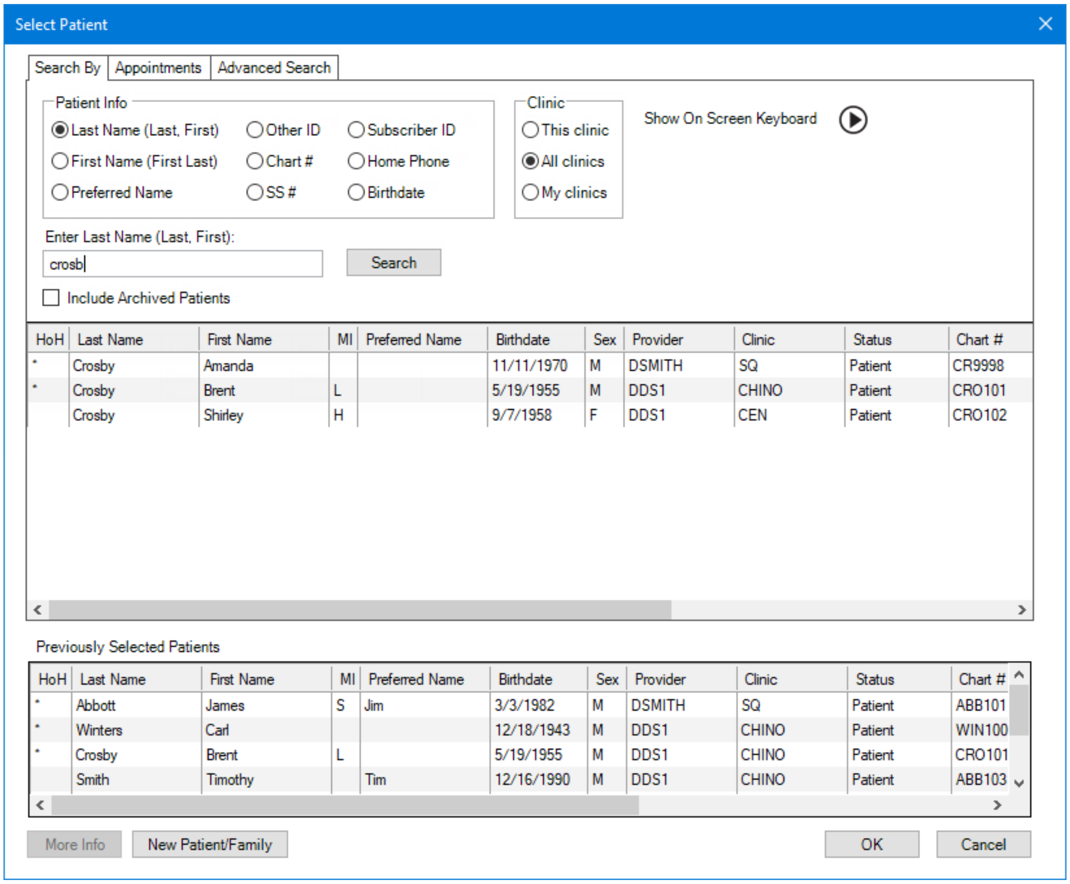
   The **Select Patient** dialog box appears.



Tip: For your convenience, the patients that were selected most recently appear under **Previously Selected Patients**. If the patient you are looking for appears in the list box, you can select that patient's name without having to search for it first.

2. Do one the following:

   - On the **Search By** tab, select which type of patient information that you want to search by, select which clinics you want to search in, and then begin typing letters or numbers (depending on the type of information).



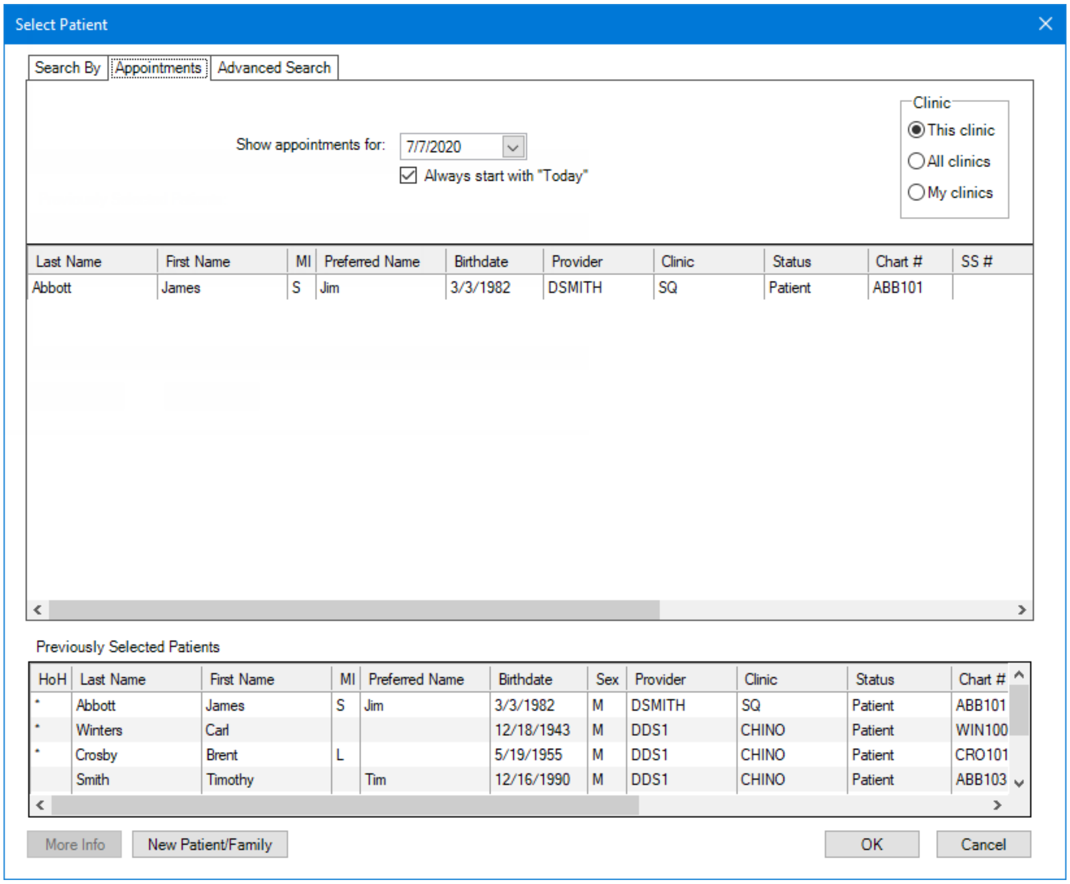
If you type at least three letters or numbers (or all digits of a birth date), any patients that match your search criteria appear automatically in the results list. Continue typing as needed to narrow the search results. If you have only one or two letters or numbers entered, click Search to view the patients that match your search criteria.

Tip: You can use the wildcard character (%) when performing searches.

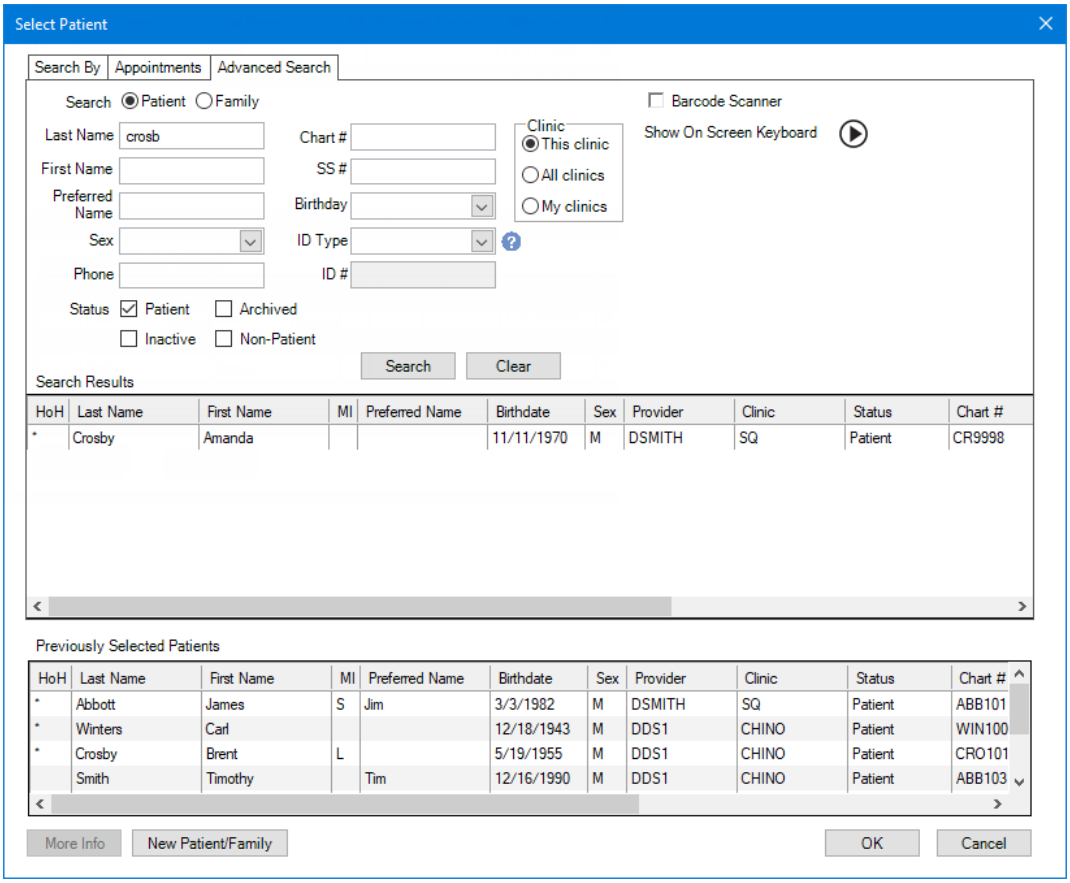
Notes:

- The **Chart #** in Dentrix Enterprise corresponds to the CDCR #. For patients with multiple CDCR #s, Dentrix Enterprise uses only the controlling CDCR #, which should match PowerChart and SOMS. To view other CDCR #s, open PowerChart, and then review the Identifiers section within the Patient Information. Also, you can review patient identification numbers in SOMS.
- The **Other ID** in Dentrix Enterprise corresponds to the PID. Scroll to the right in either the results list or the **Previously Selected Patients** list to see the **Other ID**.

- On the **Appointments** tab, select a date (the default date will be today's date each time you open the **Select Patient** dialog box if the **Always start with "Today"** check box is selected), and select which clinics you want to search in. The patients who have an appointment on the selected day appear in the results list.



- On the **Advanced Search** tab, type part or all of any of the types of patient information that you want to search by (you can search by multiple criteria), select any of the patient statuses, select which clinics you want to search in, and then click **Search**.

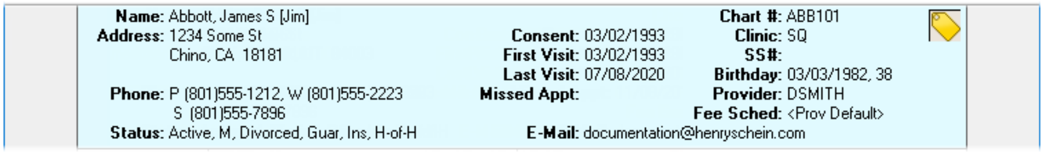


Note: You can search for a patient by last name, first name, chart number (CDCR number), or date of birth. If you cannot locate the patient in the dental database, create a ticket in Solution Center.

3. Double-click a patient name in the results list.

Viewing Patient Demographics

The **Patient Information** block (the top section) displays a patient's demographics. To view more details, double-click the **Patient Information** block.



Note: Certain pre-populated information from SOMS cannot be edited. This includes the patient's name, date of birth, and other assigned IDs.

Entering Patient Notes

A patient note can include any information about a patient that you want to be viewed internally in your office and not be seen by the patient.

Note: Patient notes apply to an individual patient, and you can view them only from the patient's appointment information in the Appointment Book, from the patient's Family File, or on the patient notes report.

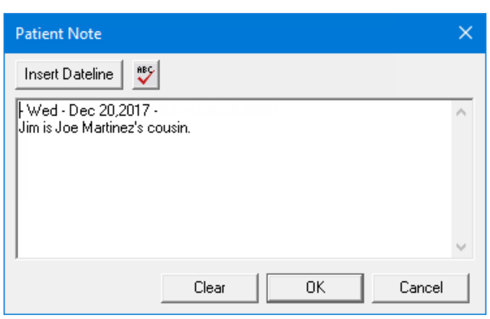
Important: Anyone can edit and delete the text of a patient note. Use a clinical note to add any information that you want to remain permanently on a patient's record.

To enter a patient note

1. With a patient selected in the Family File, double-click the **Patient Notes** block.

   The **Patient Note** dialog box appears.

2. To insert the current date where the text cursor is positioned in the field, click **Insert Dateline**.
3. Type the note. A patient note is limited to 4,000 characters.

   Note: You `can click the **Check Spelling** button to check the spelling of the note text (this button is available only if a certain preference setting has been enabled).

4. Click **OK**.

Viewing and Hiding Patient Notes

Each time you log on to Dentrix Enterprise, patient notes are hidden for all patients by default. When you first open the Family File of a patient with a patient note, the patient note is hidden by default. Afterwards, for each patient that you select in the Family File, the notes are viewed or hidden depending on the state of the previously selected patient's notes.

Notes:

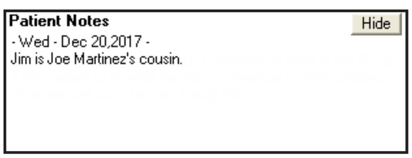
- Patient notes apply to an individual patient, and you can view them only from the patient's appointment information in the Appointment Book, from the patient's Family File, or on the patient notes report.
- If no notes have been entered for the patient, the block displays "No Note," and the **View/Hide** option is not available.

To view patient notes

If the notes are being hidden, you can view the notes by clicking **View**. (When you click **View**, the button label changes to, "Hide.")

To hide patient notes

If the notes contain confidential information, it is recommended that you hide the notes by clicking **Hide** after each time the notes are viewed. (When you click **Hide**, the button label changes to, "View.")



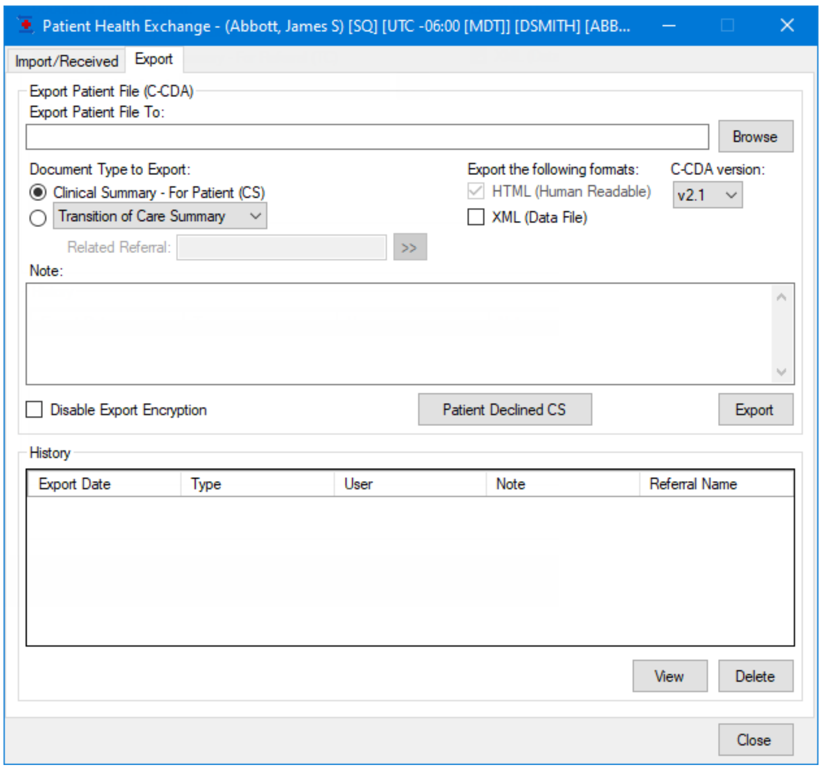
Exporting C-CDA Files

If the security rights assigned to your user account allow it, you can export a C-CDA (Consolidated-Clinical Document Architecture) file that can be shared with another healthcare professional. The C-CDA file contains a summary of a patient's clinical information from the following: the most recent visit, laboratory test results, medical alerts/problems, and medications.

To export a patient's health information

1. With a patient selected in the Family File, click the **Health Exchange** button on the toolbar.

   The **Patient Health Exchange** dialog box appears.



2. On the **Export** tab, next to **Export Patient File To**, click **Browse** to select the location where you want to save the .html file (a human-readable format) and C-CDA file (an .xml file that is computer readable).
3. Under **Document Type to Export**, select **Transition of Care For Referral (TC)**. Click the **Related Referral** search button >> to select the referral (to) that you want to associate with the summary. The related referral is required for you to be able to export the summary.

   Note: Under **Export the following formats**, the **HTML (Human Readable)** check box is always selected and cannot be cleared. Leave the **XML (Data File)** check box selected to have the file contain data in an XML format.

4. In the **Note** field, type any notes that you want to attach to the export. Notes are only for your reference and are not included in the text of the file.
5. Click **Export**.

   A message appears when the export is complete.

6. Click **OK**.

Note: Each time a C-CDA file is exported, an entry is added to the **History** list on the **Export** tab. To view a file, select it, and then click **View**.

Chapter 5: Quick Letters

With Quick Letters you can quickly generate a pre-determined form with patient information, Dentrix Enterprise will insert as much information as possible into the form, such as his or her name and CDCR number.

Note: To use this feature, Microsoft Word must be installed.

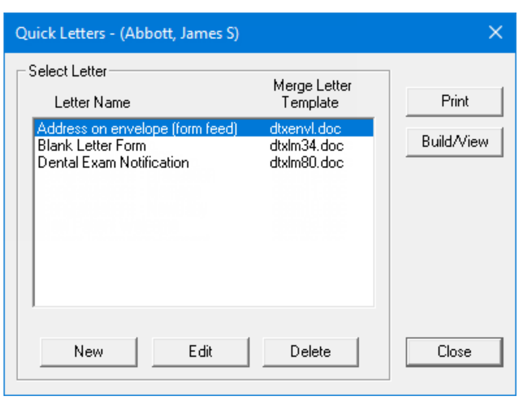
Quick Letter examples:
- CDCT-239_Prosthetic Rx, which is a Prosthetic Prescription
- CDCR-7225_D, which is a Refusal of Examination and/or Treatment
- CDCR-7423_RC, which is a Notification of Reception Center Dental Screening
- CDCR-7424, which is a Consent for Root Canal Treatment

Note: An outside report will be provided for all patients who are due for their Dental Exam. In Quick Letters, you can print the Exam Notification, so the notification is logged in the Office Journal.

To generate and print a quick letter

1. In the Family File, Ledger, or Patient Chart, with a patient selected (or in the Appointment Book, with a patient's appointment selected), click the **Quick Letters** button  on the toolbar.

   The **Quick Letters** dialog box appears.

2. Select the letter that you want to print.

3. Do one of the following:
    - To create and print the letter without reviewing it, click **Print**.
    - To create and review the letter in Microsoft Word prior to printing it, click **Build/View**.

      Important: Use **Build/View** to add custom language to a letter, such as a refusal form or a written response, before printing it.

   Note: Dentrix Enterprise adds an entry in the Office Journal that indicates a letter has been sent to the patient.

Chapter 6: Office Journal

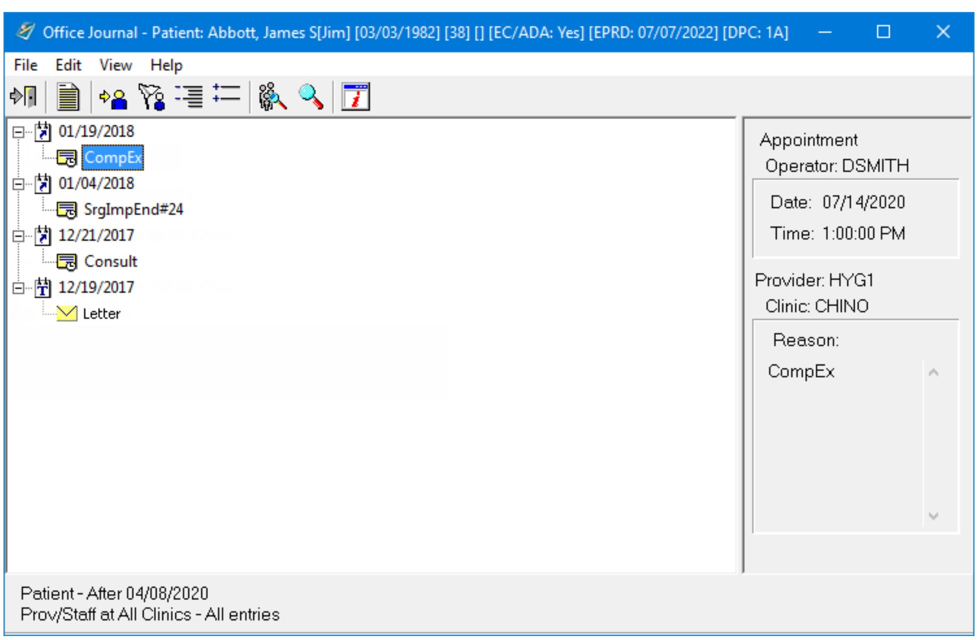
With the Dentrix Enterprise Office Journal, you can do the following:

- Record contact among patients, providers, and staff
- Enter administrative notes

Dentrix Enterprise automatically adds entries in the Office Journal for activities such as scheduling an appointment and printing Quick Letters.

To open a patient's Office Journal, do one of the following:

- From any Dentrix Enterprise module (except the Office Manager), select a patient, and then click the **Office Journal** button  on the toolbar.
- From the Appointment Book, select a patient's appointment, and then click the **Office Journal** button  on the toolbar.
- From the Office Manager, click the **Office Journal** button  on the toolbar; cancel the dialog box that prompts you to select a provider or staff member; from the **View** menu, click **By Patient**; and then select a patient.



Viewing Office Journal Entries

Do any of the following:

- Click the **Expand List** button  to expand the list of entry dates to see more information.
- Click the **Collapse List** button  to collapse the list of entries to see only the entry dates.
- Click the **View Filters** button  to customize the view when viewing patient, provider, staff, or referral journal entries.
- Click the **Hide/Show Info** button  to show or hide additional information on the right side of the window for a selected entry.

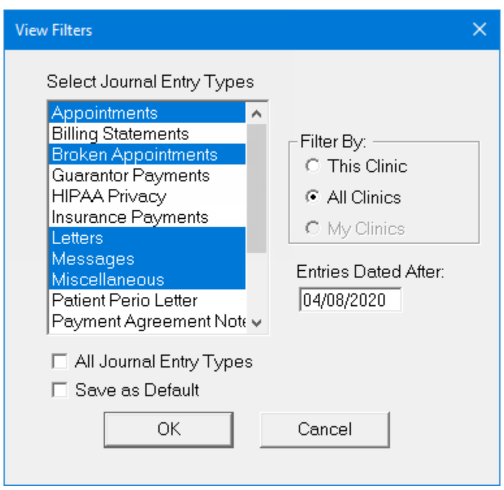
Viewing Patient Journal Entries

You can display all the entries for a certain patient. Also, you can customize what types of entries are displayed in the Office Journal.

To customize the view

1. If you are not viewing the Office Journal by a patient name, from the **View** menu, click **By Patient**, and then select a patient.
2. From the **View** menu, click **Filters**.

   The **View Filters** dialog box appears.

3. Set up the following view options:
   - **Select Journal Entry Types** – Select the entry types you want to be displayed, or select **All Journal Entry Types** to view all entry types.
   - **Filter By** – Click **This Clinic** if you want entries from the current clinic to be displayed, or **All Clinics** if you want entries from all clinics to be displayed.
   - **Entries Dated After** – To only display items after a certain date, leave the default date, or type a different cut-off date.
4. Select **Save as Default** if you want to save the current settings for the next time you open the Office Journal.
5. Click **OK** to return to the Office Journal with the selected view settings.

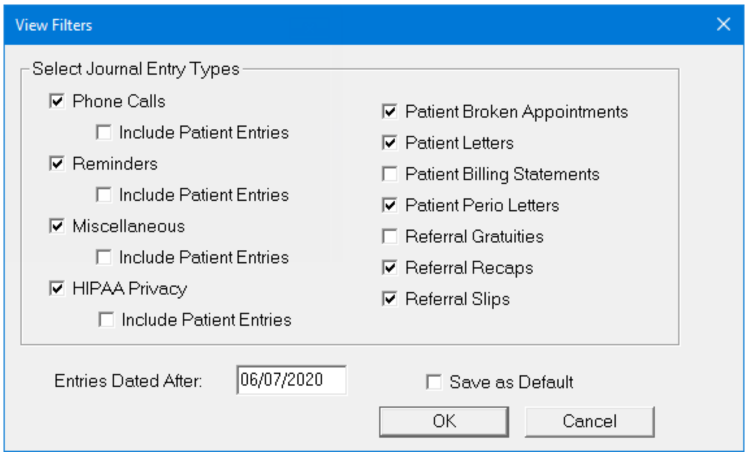
Viewing Provider or Staff Journal Entries

You can display entries for a specific provider or staff member. Also, you can customize what types of entries are displayed in the Office Journal.

To customize the view

1. If you are not viewing the Office Journal by a provider or staff member, from the **View** menu, click **By Provider/Staff**, and then select a provider or staff member.
2. From the **View** menu, click **Filters**.

   The **View Filters** dialog box appears.

3. Set up the following view options:
   - **Select Journal Entry Types** – Select the entry types you want to be displayed. For Phone Calls, Reminders, Miscellaneous, and HIPAA Privacy, you can select the accompanying **Include Patient Entries** check box to include all patient entries for any of those types, as well.
   - **Entries Dated After** – To only display items after a certain date, leave the default date, or type a different cut-off date.
4. Select **Save as Default** if you want to save the current settings for the next time you open the Office Journal.
5. Click **OK** to return to the Office Journal with the selected view settings.

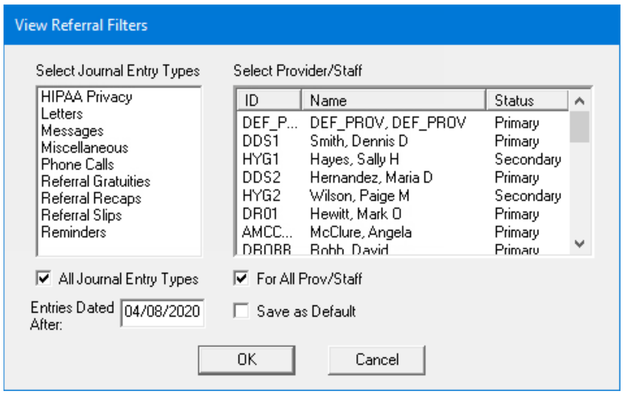
Viewing Referral Journal Entries

You can display entries for a specific referral (inbound or outbound). Also, you can customize what types of entries are displayed in the Office Journal.

To customize the view

1. If you are not viewing the Office Journal by a referral, from the **View** menu, click **By Referral By** or **By Referred To**, and then select a referral.
2. From the **View** menu, click **Filters**.

   The **View Referral Filters** dialog box appears.



3. Set up the following view options:
   - **Select Journal Entry Types** – Select the entry types you want to be displayed, or select **All Journal Entry Types** to view all entry types.
   - **Select Provider/Staff** – Select the providers and/or staff you want to view, or select **For All Prov/Staff** to view entries for all providers and staff
   - **Entries Dated After** – To only display items after a certain date, leave the default date, or type a different cut-off date.
4. Select **Save as Default** if you want to save the current settings for the next time you open the Office Journal.
5. Click **OK** to return to the Office Journal with the selected view settings.

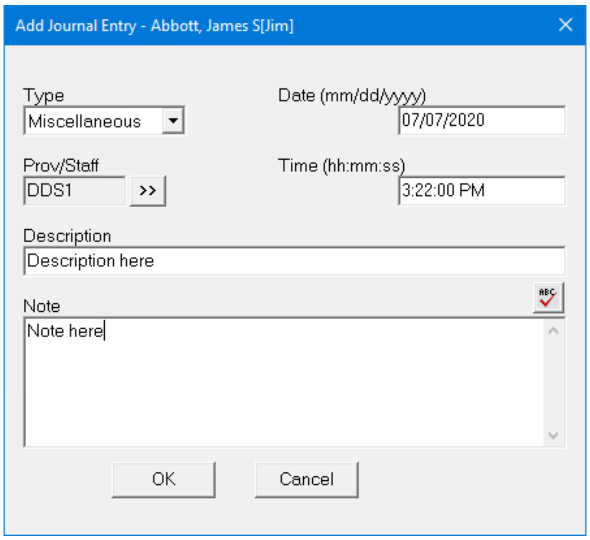
Adding Office Journal Entries

You can manually add four types journal entries into the Office Journal: Phone Call, Reminder, Misc, and HIPAA. These entries will include the date, time (except for reminders), and provider/staff members, and you can add a note.

To add a manual entry

1. In the Office Journal, click the **Add Journal Entry** button on the toolbar.

   The **Add Journal Entry** dialog box appears.

2. Set up the following options:
   - **Type** – Select **Miscellaneous**.
   - **Prov/Staff** – If you want to assign a provider or staff member to this journal entry, click the search button >>, and then select a provider or staff member.
   - **Description** – Type a short description (up to 40 characters in length) for the journal entry.
   - **Note** – Type a longer description (up to 4,000 characters in length) for the journal entry. Also, you can click the **Check Spelling** button to check the spelling of the note text (this button is available only if a certain preference setting has been enabled).
   - **Date** – If needed, change the date of the journal entry.
   - **Time** – If needed, change the time of the journal entry.
3. Click **OK**.

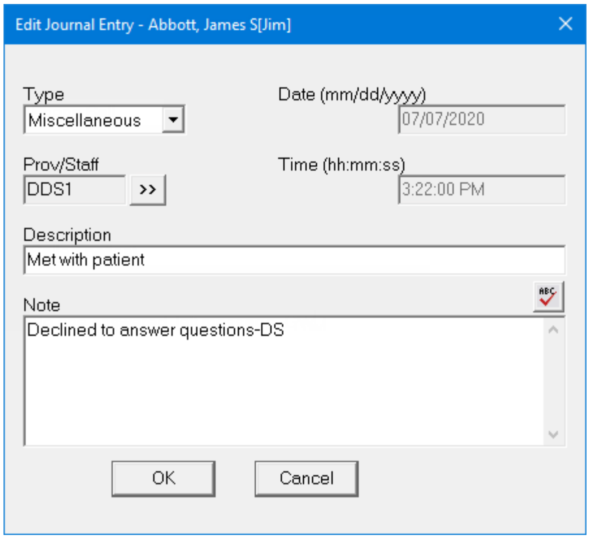
Editing Office Journal Entries

Automatic entries (for appointments, billing statements, etc.) cannot be edited, but if the security rights assigned to your user account allow it, you can edit manual journal entries.

To edit a manual entry

1. In the Office Journal, expand an entry date item, and then select the manual entry that you want to edit.
2. From the **Edit** menu, click **Edit**.

   The **Edit Journal Entry** dialog box appears.



3. Make any necessary changes:
   - **Prov/Staff** – If you want to assign a different provider or staff member to this journal entry, click the search button , and then select a provider or staff member.
   - **Description** – Type a new or change the existing short description (up to 40 characters in length) for the journal entry.
   - **Note** – Type a new or change the existing longer description (up to 4,000 characters in length) for the journal entry. Also, you can click the **Check Spelling** button  to check the spelling of the note text (this button is available only if a certain preference setting has been enabled).
   - **Date** – If needed, change the date of the journal entry.
   - **Time** – If needed, change the time of the journal entry.
4. Click **OK**.

Deleting Office Journal Entries

Payment, appointment, and payment agreement note entries cannot be deleted from the Office Journal, but if the security rights assigned to your user account allow it, you can delete letters and manual journal entries.

To delete a manual journal entry

1. In the Office Journal, expand an entry date item, and then select the manual entry that you want to delete.
2. From the **Edit** menu, click **Delete**.

   A confirmation message appears.
3. Click the **Yes** to delete the entry.

Printing Office Journal Entries

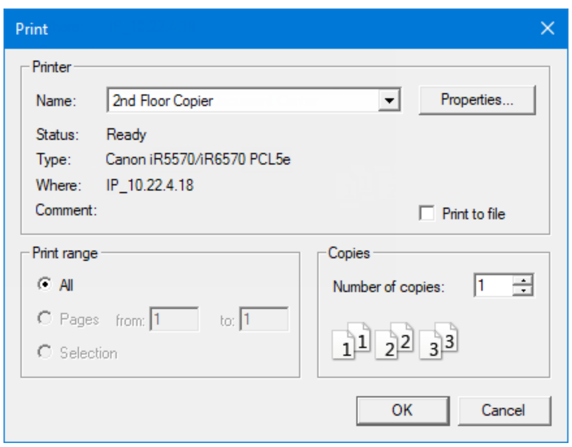
You can print the entries currently being displayed in the Office Journal.

Note: Dentrix Enterprise will print whatever entries are currently being displayed in the Office Journal regardless of which entry dates are collapsed or expanded.

To print Office Journal entries

1. In the Office Journal, from the **File** menu, click **Print**.

   The **Print** dialog box appears.



2. Select a printer.
3. Set up any other options as needed, and then click **OK**.

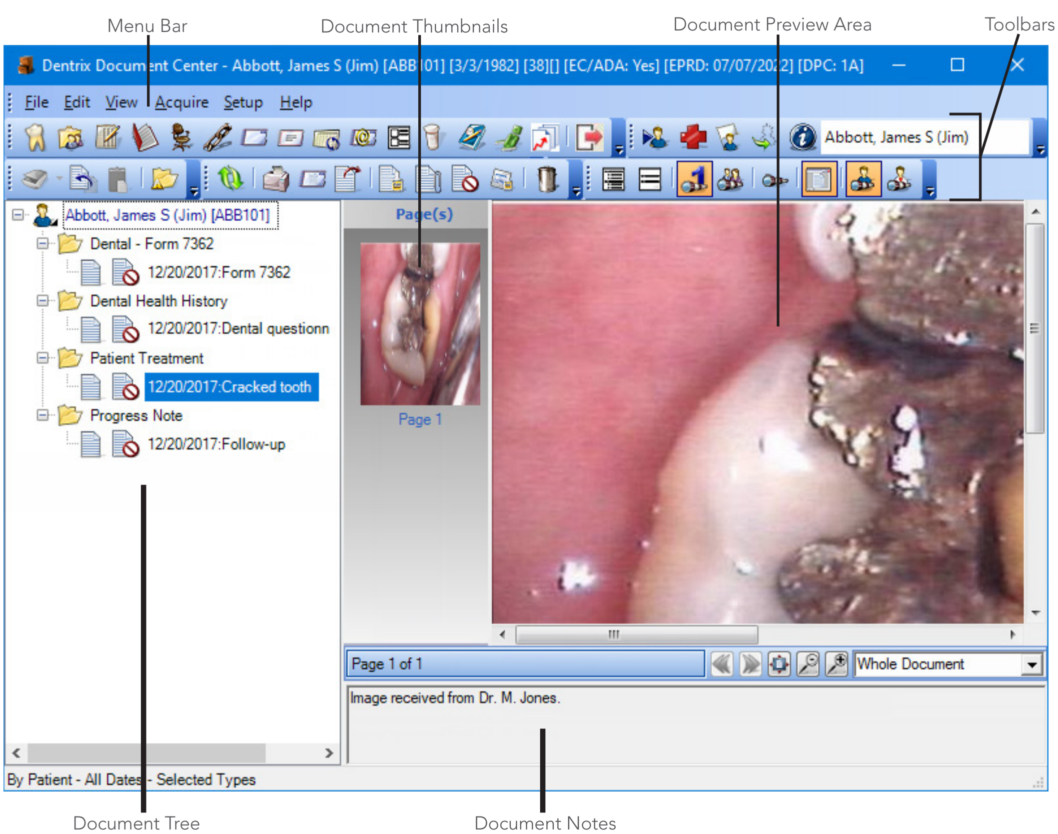
Chapter 7: Document Center

The Document Center can help your office become paperless. You can scan, capture, and import documents (such as patient forms and referral letters) and images (such as patient pictures and X-rays). You can then attach these documents to patients, providers, employers, insurance plans, and referral sources. Also, these documents can be printed, emailed, or sent electronically (for claims).

A document in the Document Center can be a document file type (.txt, .rtf, .doc, .docx, and .pdf), an image file type (.bmp, .gif, .jpg, .png, and .tif), a slide show presentation file type (.ppt. .pptx), a spreadsheet file type (.xls or .xlsx), or any other file type (which can be stored but not previewed in the Document Center).

You can open the Document Center from the Family File, Ledger, Chart, Appointment Book, Treatment Planner, Collections Manager, and Office Manager by clicking the Document Center button on the toolbar.

The Document Center window consists of a menu bar, toolbars, a document tree, a document thumbnails pane, a document preview area, and a document notes pane.



Scanning Documents

You can acquire documents and images in the Document Center with a scanner or digital camera.

The Dentrix Document Center can store any important document or image that you may need to attach to a patient, provider, staff member, insurance carrier, employer, and/or referral.

To scan a document

1. In the Document Center, from the **From Device** button menu, click the appropriate device.

   The corresponding third-party program opens.

2. Select the documents or images you want to acquire, and follow the program's instructions for acquiring the document or image. The specific steps to complete this process depend on the device that you are using.
3. When the acquisition is complete, the **Document Information** dialog box appears. Enter the appropriate document information as explained in "Editing Document Information" in this chapter.

Importing Documents

You can import documents and images into the Document Center from a file on your computer, another computer on your office's network, a disc, an external drive, or a saved email attachment.

Important: Without encryption, transmitting patient health information by email is not secure. Refer to the CCHCS Information Security and Privacy for guidelines on sharing and transmitting patient health information.

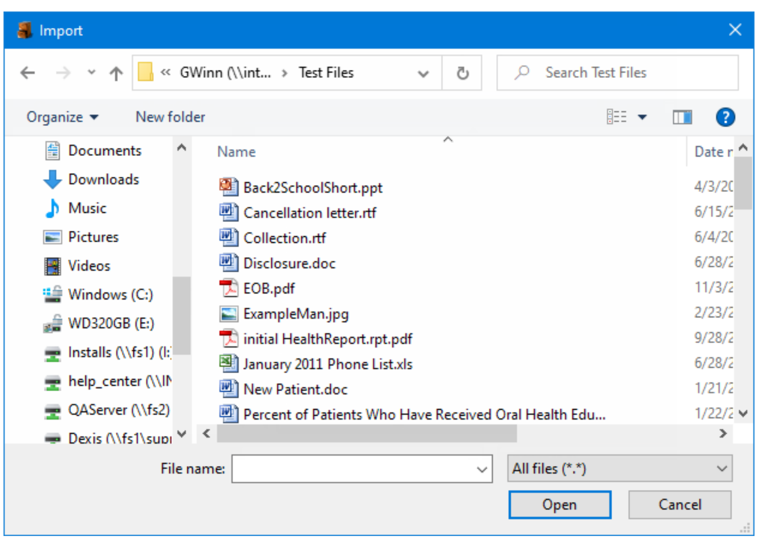
The Dentrix Document Center can store any important document or image that you may need to attach to a patient, provider, staff member, insurance carrier, employer, and/or referral.

Important: Do not attach documents to providers, staff, or insurance carriers.

To import a document

1. In the Document Center, click the **Import from File** button.

   The **Import** dialog appears.



2. Locate the directory where the file is stored, select the desired file, and then click **Open**.
3. When the acquisition is complete, the **Document Information** dialog box appears. Enter the appropriate document information as explained in "Editing Document Information" in this chapter.

Printing Documents

The Document Center provides the following ways to print documents:

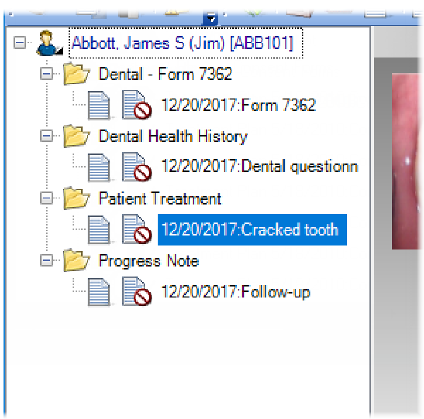
- **Print the Document Center List** – The Document Center List consists of the contents in the document tree for the current view. It will list all attached documents, according to the filters selected. In the Document Center, from the **File** menu, point to **Print**, and then click **Document Center List**.
- **Print documents** – You can print a specific document or multiple documents. In the Document Center document tree, select the documents you want to print. Then, from the **File** menu, point to **Print**, and then click **Print Document(s)**.

Editing Document Information

You can edit the date, type, description, note, attachments, and signatures assigned to a document as long as the document has not been signed. Once a document has been signed, you cannot change that document's date, type, description, or note, but you can attach more sources to it.

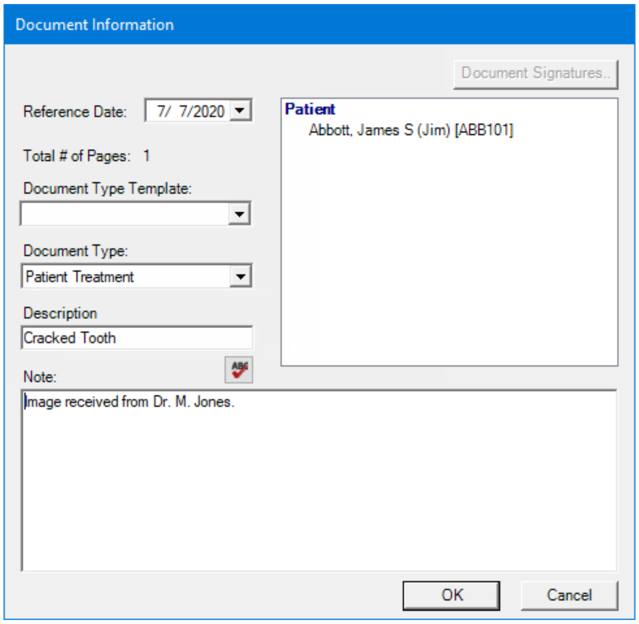
To edit document information

1. In the Document Center document tree, select the document that has information you want to edit.



2. Click the **Document Information** button .

The **Document Information** dialog box appears.



3. Make the necessary changes to any of the following options:

- **Reference Date** – By default, the date of the document is the current system date, but you can change it as needed to reflect the correct date of service (dental encounter). This date will appear for this document in the document tree and when it is printed.
- **Document Type Template** – Select the template that corresponds to the type of document being added. The **Document Type** and **Description** will be populated automatically based on the selected template.

  Notes:

  - Each template corresponds to a CDCR form number. Use the **Outside Provider** template when you are adding non-CDCR documents (such as clinical notes or oral surgery notes) from outside providers.
  - The **Document Type** and **Description** associated with each template are configured to match the setup in PowerChart, so do not change them in the **Document Information** dialog box.
  - If a template needs to be changed or a new one added, create a ticket in Solution Center.

- **Document Type** – The type is determined by the selected **Document Type Template**. Do not change the type.
- **Description** – The description is determined by the selected **Document Type Template**. Do not change the description. This description will appear for this document in the document tree and be used as a file name for the document when the document is exported or attached to an email message.

  Important: Without encryption, transmitting patient health information by email is not secure. Refer to the CCHCS Information Security and Privacy for guidelines on sharing and transmitting patient health information.

- **Note** – Type any pertinent notes regarding the document. The note text will be appended automatically to the text of an email message with this document attached, and you can view the note when previewing this document.

- **Modify Attachments** – To associate the document with a patient, provider/staff, employer, insurance plan, and/or referral other than the current patient, provider/staff, employer, insurance plan, or referral currently being viewed in the Document Center, click this button. For more information about document sources, see “Modifying Document Attachments” in this chapter.

  Note: If you are acquiring from the Document Center printer driver or the **Document Center Unfiled Documents** window, by default, the document does not have any attachments associated with it.

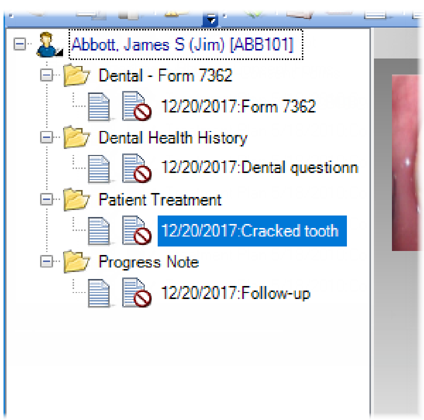
4. Click **OK**.

Modifying Document Attachments

If the security rights assigned to your user account allow it, you can modify attachment sources for a specific document as needed (for example, to transfer a document that was scanned into the wrong patient’s record to the correct patient’s record). You can associate a document with a patient, provider/staff, employer, dental insurance plan, medical insurance plan, inbound referral, and/or outbound referral. Also, you can assign additional sources to a document that has been signed.

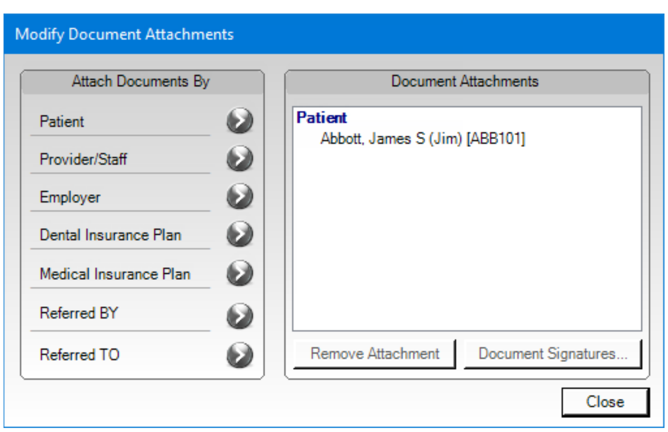
To modify a document’s attachments

1. In the Document Center document tree, select a document.



2. Click the **Modify Document Attachments** button .

   The **Modify Document Attachments** dialog box appears.



3. Make the necessary changes:
   - **Attach Document By** – For each entity that you want to attach to the document, click the corresponding entity's search button, and make your selection:
     - **Patient** – In the **Select Patient** dialog box that appears, select a patient.
     - **Provider/Staff** – In the **Select Provider/Staff** dialog box that appears, select the desired provider or staff member.
     - **Dental Insurance Plan** – In the **Select Dental Insurance Plan** dialog box that appears, select the desired insurance plan.
     - **Medical Insurance Plan** – In the **Select Medical Insurance Plan** dialog box that appears, select the desired insurance plan.
     - **Referred BY** – In the **Select Referred By** dialog box that appears, select the desired referral source.

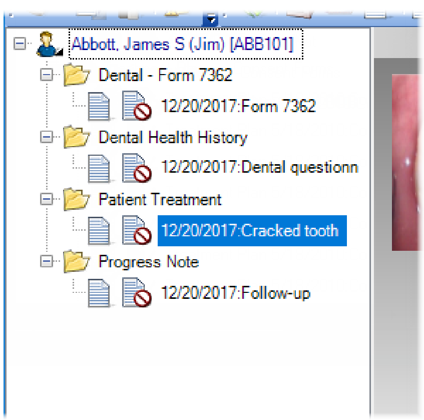
     The attachment associations appear in the **Document Attachments** list box.
   - **Remove Attachment** – To remove an attachment, select it in the **Document Attachments** list box, and then click **Remove Attachment**.
4. Click **Close**.

Deleting Documents

If the security rights assigned to your user account allow it, you can delete a document as needed. Dentrix Enterprise will not delete the original document from the computer but will remove it from the Document Center.

To delete a document

1. In the Document Center document tree, select the document you want to delete.



2. Click the **Delete Selected Document(s)** button.

   Do one of the following:
   - If the document has multiple attachment sources, a dialog box appears. Select whether you want to delete the document for only the current attachment source being viewed in the Document Center or delete the document for all attachment sources, and then click **OK**.
   - If the document is attached to only the source being viewed in the Document Center, a confirmation message appears. Click **OK**.

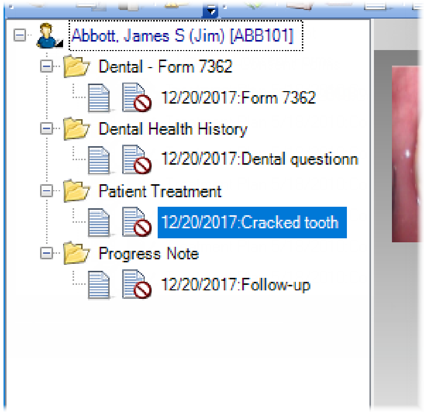
Signing Documents

You can apply signatures to a document attached only to patients, providers, and/or staff. You can apply a signature to a document for each patient, provider, or staff member attached to the document.

Important: Once a document has been signed, you cannot change the document information, but you can attach the document to additional sources.

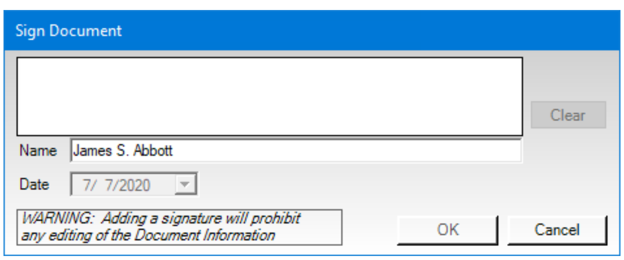
To sign a document

1. In the Document Center document tree, select the document you want to sign.



2. Click the **Sign Document** button . (If the selected document already has at least one signature, the button looks different. )

   The **Sign Document** dialog box appears.

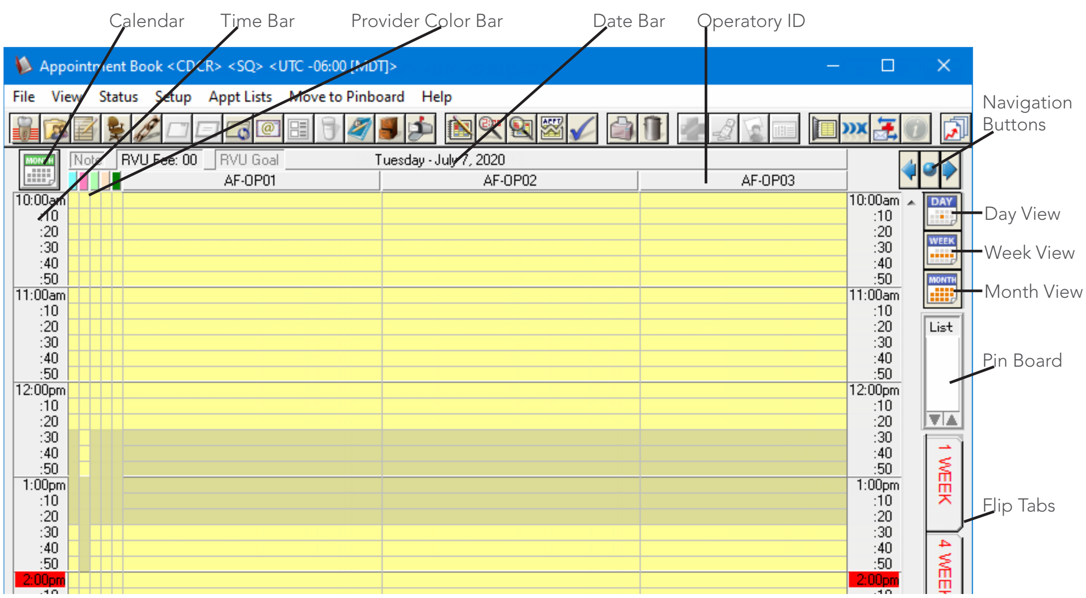


3. The **Name** field automatically displays the patient, provider, or staff member selected in the Document Center, but you can change the name as needed.
4. Use a mouse or other supported device to add your signature in the **Signature** box. If you need to erase the signature so that you can re-sign, click **Clear**.
5. Click **OK**.

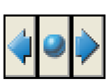
Chapter 8: Appointment Book

The Dentrix Enterprise Appointment Book provides tools to help you navigate through the schedule, search for open times, and manage appointments. Typically, you will identify appointment needs and schedule appointments from the Treatment Request Manager and Scheduling Assistant. However, in the Appointment Book, you can record broken appointments and print the schedule.

The Appointment Book is divided into the menu bar, calendar, time bar, provider color bar, date bar, operatory ID, toolbar, navigation buttons, pin board, day view, week view, month view, and flip tabs.



Since most appointments will be made with a couple of days of receiving a treatment request, you can use the navigation buttons to navigate to the correct date.

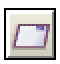
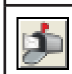
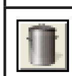
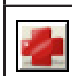
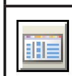
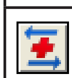


To search for an open time for a particular day of the week or time, click the **Find New Appointment Time** button  on the toolbar.

Appointment Book Toolbar

The toolbar contains several buttons that you can click to access certain areas or features of Dentrix Enterprise.

The function of each button on the toolbar is explained in the following table.

Button	Name	Description
	More Information	Opens the **More Information** window of the patient scheduled for the selected appointment.
	Patient Chart	Opens the Patient Chart of the patient scheduled for the selected appointment.
	Family File	Opens the Family File of the patient scheduled for the selected appointment.
	Ledger	Opens the Ledger of the patient scheduled for the selected appointment.
	Office Manager	Opens the Office Manager module.
	Quick Letters	Opens the **Quick Letters** dialog box.
	Prescriptions	Opens PowerChart.
	Office Journal	Opens the Office Journal of the patient scheduled for the selected appointment.
	Document Center	Opens the Document Center of the patient scheduled for the selected appointment.
	Message Center	Opens the Cerner Message Center.
	Break Appointment	Opens the **Break Appointment** dialog box to select a reason for breaking the selected appointment.
	Schedule Appointment	Opens the **Select Patient** dialog box to select a patient, and then the **New Appointment Information** dialog box opens.
	Find New Appointment Time	Opens the **Find New Appointment Time** dialog box to find an available appointment time by entering search criteria.
	Locate Appointment	Opens the **Select Patient** dialog box to select a patient, and then the **Appointments** dialog box appears.
	Set Complete	Opens the **Set Appointment Procedures Complete** dialog box.
	Delete Appointment	Deletes the selected appointment.
	Medical Alerts	Opens the **Medical Alerts** window of the patient scheduled for the selected appointment.
	Clinical Notes	Opens the **Clinical Notes** window of the patient scheduled for the selected appointment.
	Patient Health Exchange	Opens the **Patient Health Exchange** dialog box of the patient scheduled for the selected appointment.

Button	Name	Description
	DXOne Reports	Click to open DXOne Reporting to generate and manage reports.
	Signature Manager	Click to open the **Signature Manager** dialog box to sign multiple clinical notes at one time.
	Scheduling Assistant	Click to open the **Scheduling Assistant** window, which can help enhance your scheduling workflow.

Scheduling Appointments for Treatment Requests

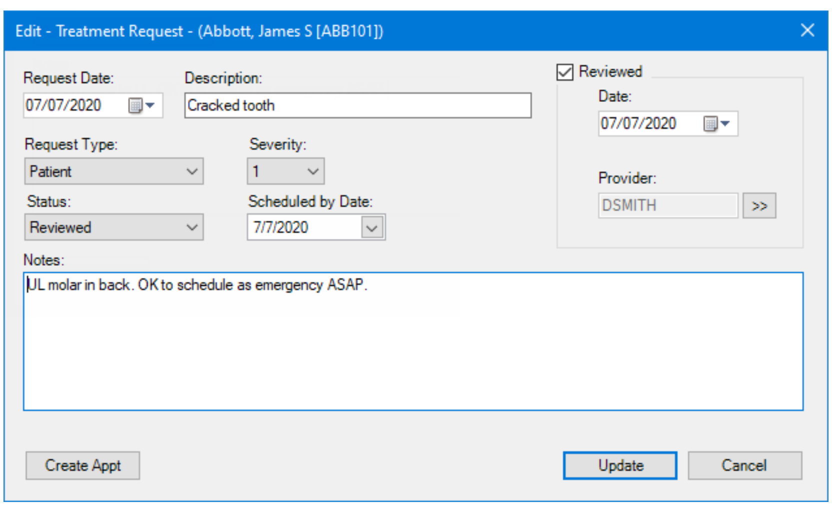
You can schedule an appointment for treatment requests from the Treatment Request Manager. For information about using the Treatment Request Manager, see Chapter 1: Treatment Request Manager.

Tip: You can also schedule appointments for existing treatment requests from the Scheduling Assistant. For information about using the Scheduling Assistant, see Chapter 3: Scheduling Assistant.

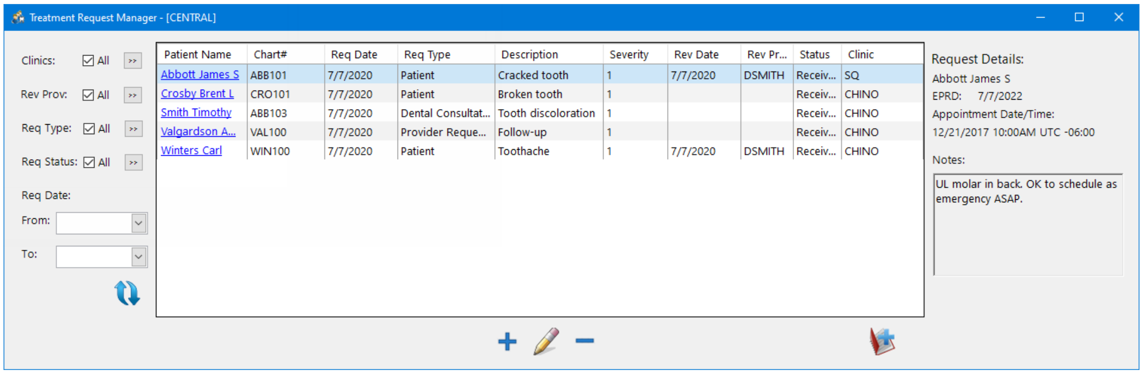
Note: When scheduling an appointment for a treatment request, the treatment request will automatically be attached to the appointment. If the appointment requires additional treatment requests, you can attach those requests, too.

To schedule an appointment for a treatment request

1. Do one of the following:
   - In the **Edit - Treatment Request** (or **New - Treatment Request**) dialog box, click **Create Appt**.

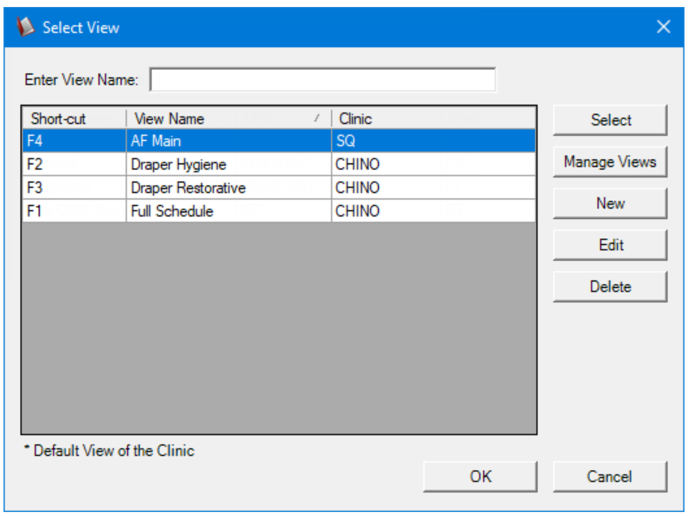


- With one or more treatment requests selected in the Treatment Request Manager, click the **Create Appointment** button . This button is available only if at least one request is selected.



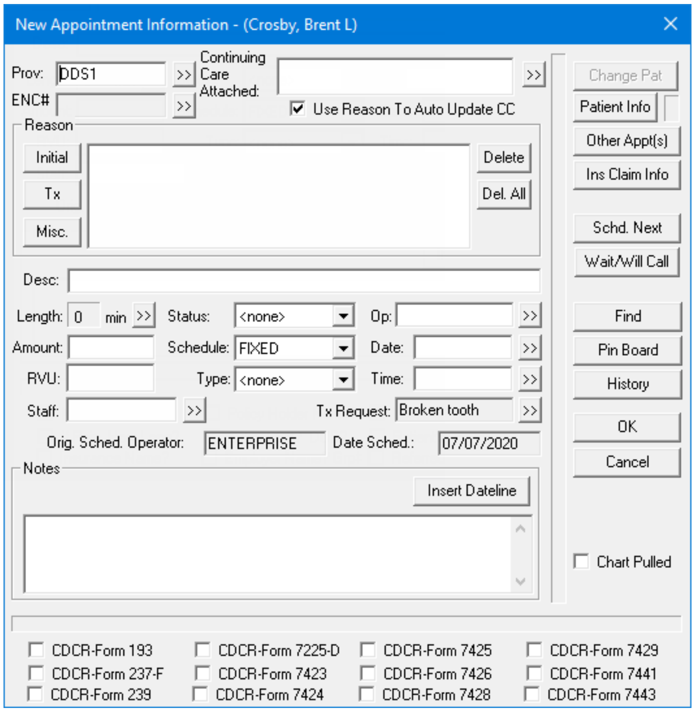
Note: You cannot create an appointment for a treatment request with a Canceled or Completed status.

The **Select View** dialog box appears. Also, the Appointment Book opens in the background if it is not already open.



2. Select an Appointment Book view.
3. Click either **Select** or **OK**.

The **New Appointment Information** dialog box appears.



Note: The treatment request is linked to the appointment automatically along with the patient's provider.

The status of the linked treatment request changes to Scheduled automatically.

4. Set up the appointment details, such as the provider, encounter number, and reason.

   Note: The encounter number is required because it is used to send the clinical notes over to Millennium.

5. Use one of the following methods to find an available time slot for the appointment:

   - **Pinboard**: (This is the preferred method since appointments are not pre-booked more than a few days in advance.)

     a. Click **Pin Board**.

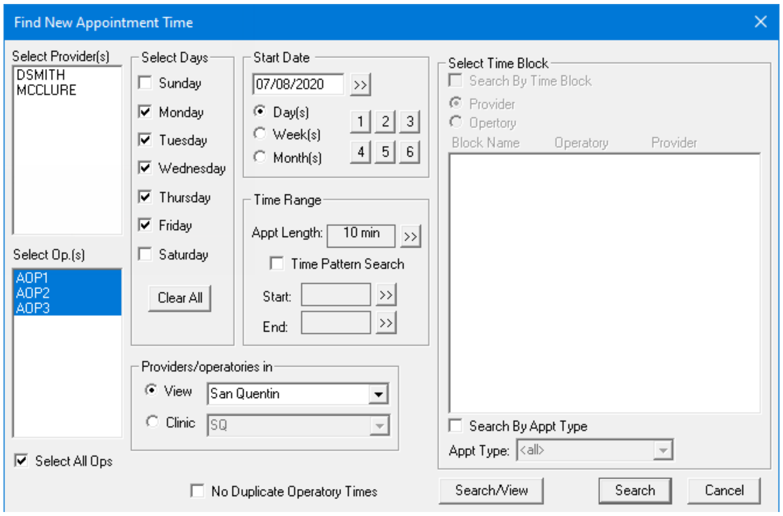
     b. Navigate to the desired date for the appointment, and then drag the patient's appointment from the Pinboard to the desired time slot in the correct operatory.

     c. On the confirmation message, click **Yes**.

- **Find New Appointment Time tool**:

  a. Click **Find**.

  The **Find New Appointment Time** dialog box appears.



  b. Set up the following options:

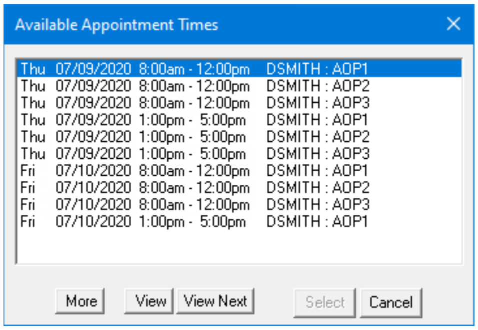
  - **Select Provider(s)** – Select the providers whose availability you want to search for. By default, the providers assigned to the current view being used in the Appointment Book appear in the list.
  - **Select Op(s)** – Leave **Select All Ops** selected to search for open times in all operatories, or deselect the operatories that you do not want to search for open times in. By default, the operatories assigned to the current view being used in the Appointment Book appear in the list.
  - **Providers/operatories in** – By default, **View** is selected, and the providers and operatories assigned to the current view being used in the Appointment Book appear in the **Select Provider(s)** and **Select Op.(s)** lists. To display providers and operatories assigned to a different view, select the desired view from the list. Or, to display the providers and operatories for the clinic that you are currently logged in to, select **Clinic**.

    If you change the current selection under **Providers/operatories in**, you must make new selections in the **Select Provider(s)** and **Select Op.(s)** lists.
  - **Select Days** – Select the days of the week that you want to include in the search.
  - **Start Date** – Enter the date from which you want to start searching, or click the search button  to select the date from a calendar. By default, this is today's date.

    Note: Alternatively, to advance the **Start Date** by a specified interval relative to the date currently entered, select an interval type (**Day(s)**, **Week(s)**, or **Month(s)**), and then click a number button. For example, if you want to look for an available appointment time starting six months from today, click **Month(s)** and then **6** to advance the starting date by six months.
  - **Appt Length** – Leave the default length selected, or click the search button  to set the amount of time needed for the appointment. You can also indicate a time pattern: chair (blank), assistant (/), and provider (X) time.
  - **No Duplicate Operatory Times** – If the search finds the same open time in multiple operatories on a given date, and you want only the first of those duplicate times to be listed, select this check box.

c. Click **Search/View**.

The **Available Appointment Times** dialog box appears and lists the first 10 available times that match your search criteria.



d. Select the date and time that you want to preview in the Appointment Book, and then click **View**. The Appointment Book displays that date and outlines that time.

Tip: If none of the 10 displayed dates and times will work, click More to list the next 10 available dates and times.

e. To use the selected date and time to schedule the appointment, click **Select**; otherwise, click Cancel to change your search criteria.

Notes:

- All appointments must have a yellow E on them. This denotes that insurance has been attached to the patient's record (refer to step 5c).
- If you schedule a patient and the appointment color is white, the provider chosen for this appointment has not be sent up correctly. To resolve the issue, create a ticket in Solution Center.

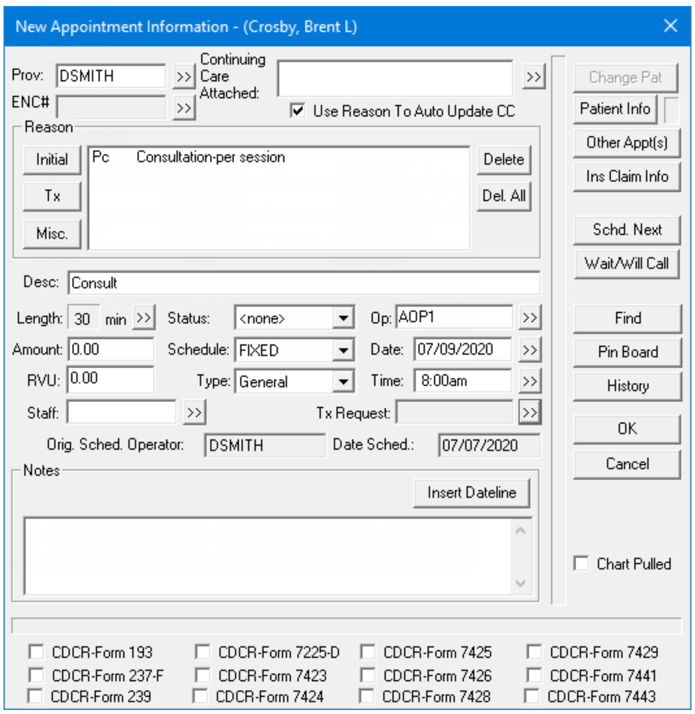
Linking Treatment Requests to Appointments

If a patient already has an appointment scheduled to which you need to link a treatment request, you can link that treatment request to that existing appointment. You can link multiple requests to one appointment, but you cannot link a request to multiple appointments.

To link a treatment request to an appointment

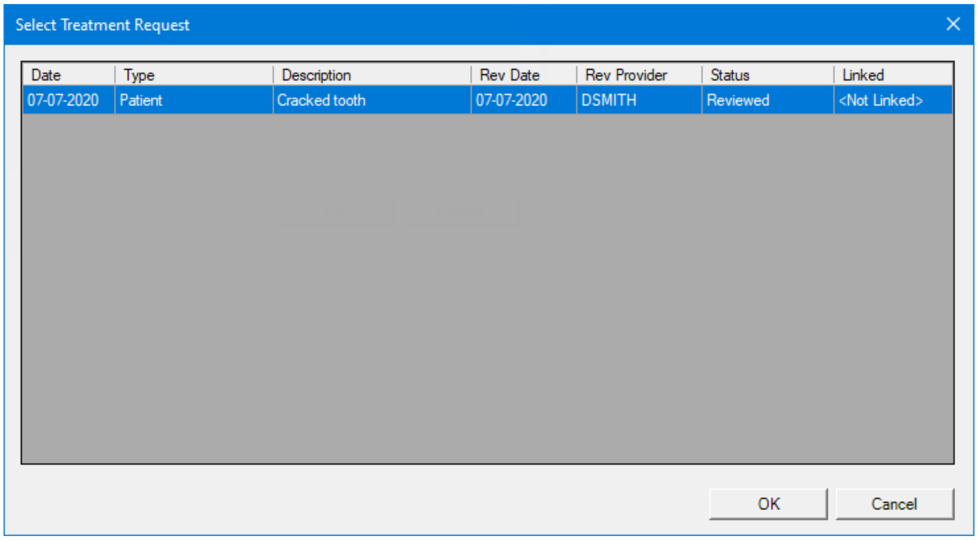
1. In the Appointment Book, double-click an appointment.

The **Appointment Information** dialog box appears.



2. Click the **Tx Request** search button .

The **Select Treatment Request** dialog box appears.



3. Select the treatment requests that you want to link to this appointment. To select multiple requests, while pressing Ctrl, click the desired requests. Only treatment requests that have been created for the patient whose appointment you are viewing are available. Also, if a selected request is already linked to another appointment, you will be asked if you want to unlink the request from its current appointment and link the request to this appointment.

   Note: You cannot attach a treatment request with a Canceled or Completed status to an appointment.

4. Click **OK**.

   The status of any linked treatment requests changes to Scheduled automatically.

5. In the **Appointment Information** dialog box, click **OK**.

Breaking Appointments

When a patient doesn't show up for or cancels his or her appointment, or, if for some reason, your office has to cancel the appointment, you can break the appointment. To prevent these broken appointments from being forgotten, Dentrix Enterprise moves them to the Unscheduled List, where they can be reviewed on a regular basis. When you break an appointment, Dentrix Enterprise moves all of the entered information to the Unscheduled List so that you don't have to re-enter it later. The appointment remains on the Unscheduled List until you reschedule it.

Also, when you try to schedule an appointment for a patient with a broken appointment, Dentrix Enterprise displays a message that states that the patient has a broken appointment and prompts you to reschedule it.

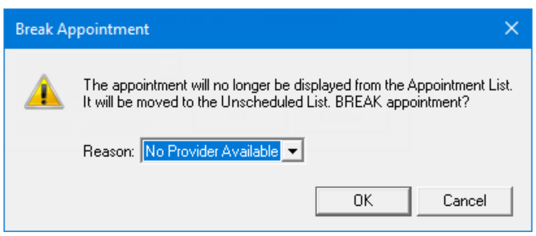
To break an appointment

1. In the Appointment Book, select the appointment.

2. Do one of the following:
   - If ducats have already been produced, or if it is past the ducat cut-off time, break the appointment:

     a. With the appointment selected, click the **Break Appointment** button  on the toolbar.

     The **Break Appointment** dialog box appears.

     b. Select the **Reason** that corresponds to the broken appointment code that you entered in the Patient Chart.

     c. Click **OK**.

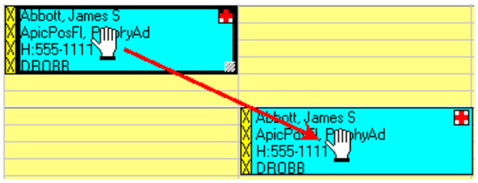
     Note: Dentrix Enterprise moves the appointment from the Appointment Book window to the Unscheduled List and updates the last missed appointment information in the Family File to reflect the date the patient broke the appointment and the number of times the patient has broken appointments. Also, Dentrix Enterprise automatically adds an entry in the patient's Office Journal.

   - If you are going to reschedule the appointment immediately, do so as explained in "Moving Appointments" in this chapter.

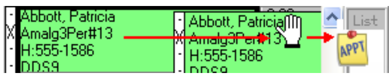
Moving Appointments

You can quickly move an appointment to a new day, time, and/or operatory as needed.

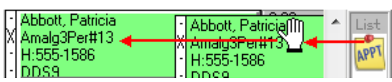
- **By dragging** (same day):
  1. In the Appointment Book, click and drag the appointment to a new time and/or operatory.

  2. On the confirmation message that appears, click **OK**.
- **With the Pinboard** (same day or different day):
  1. In the Appointment Book, click and drag the appointment to the Pinboard.

     Tip: To return an appointment on the Pinboard to its original time and operatory, from the **File** menu, click **Refresh**.
  2. Once you find a new day, time, and/or operatory for the appointment, click and drag the appointment to the desired spot on the schedule.

  3. On the confirmation message that appears, click **OK**.

Changing the Status of an Appointment

You can change an appointment's status to track the stages of the corresponding patient's visit.

Note: When the patient arrives on site, you will change his or her appointment status to Here. This will change the color of the bar on the left side of the appointment to blue to visually indicate to the staff that the patient has arrived for his or her appointment.

To change an appointment's status

1. In the Appointment Book, select the appointment.

2. From the **Status** menu, select a status.

Working with ASAP Appointments

With Dentrix Enterprise, you can flag scheduled appointments as ASAP (As Soon As Possible). Once you have flagged an appointment as ASAP, it appears on the ASAP List.

Note: Since you will rarely pre-book dental appointments, you will likely not flag appointments as ASAP very often. However, there may be a scenario where an oral surgeon needs to schedule an additional day or a lab case comes in early; in which case, you may want to flag the patient's appointment as ASAP to put him or her on a quick call list.

To flag an appointment as ASAP

While scheduling or editing an appointment, in the **New Appointment Information** or **Appointment Information** dialog box, select **ASAP** from the **Schedule** list.

To schedule an ASAP appointment

1. In the Scheduling Assistant, select **ASAP Appointments** to view appointments that have been marked as ASAP. For more information about opening and filtering the Scheduling Assistant list, see Chapter 3: Scheduling Assistant.
2. Locate an ASAP appointment, and verify that the patient is available.
3. Reschedule the ASAP appointment as explained in "Scheduling Appointments from the Scheduling Assistant" in Chapter 3: Scheduling Assistant.

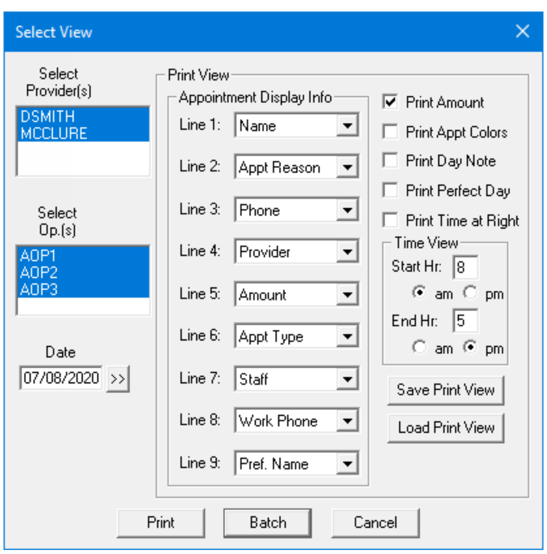
Printing the Appointment Book View

The Appointment Book View Report shows your daily schedule.

To print the Appointment Book View Report

1. In the Appointment Book, from the **File** menu, click **Print Appointment Book View**.

   The **Select View** dialog box appears.



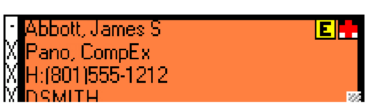
2. The current view in the Appointment Book determines the default settings for the report, but you can change any of the following options as needed:
   - **Select Provider(s)** – Select up to 10 providers to include on the report.
   - **Select Op(s)** – Select up to 10 operatories to include on the report.
   - **Date** – By default, the current date is used as the date for which the schedule will be printed, but you can type a new date in the Date field or click the search button >> to select a date.
   - **Appointment Display Info** – Depending on the length of an appointment, up to nine lines of information can be displayed on the face of an appointment. For each Line, select the information you want to have displayed on that line, or select [None] to leave that line blank.
   - **View Options** – Select any of the following:
     - **Print Amount** – To print the scheduled production amount for the day, week, or month.
     - **Print Appt Colors** – To print in color if you are using a color printer instead of in grayscale.
     - **Print Day Note** – To print the Appointment Book day note for the date being printed.
     - **Print Perfect Day** – To print the perfect Day Scheduling time blocks.
     - **Print Time at Right** – To include the time bar on the right side of the appointments in addition to the time bar along the left side.
     - **Time View** – Type the earliest hour of appointments that you want to print in the **Start Hr** field. Type the latest hour of appointments that you want to print in the **End Hr** field. Click **am** or **pm** for both fields.
3. If you want to save the current settings for the next time you print the Appointment Book View, click **Save Print View**. Only one Appointment Book View per computer can be saved.
4. Click **Print** to print the report to the default printer for the Office Manager, or click **Batch** to send the report to the Batch Processor in the Office Manager.

Completing Appointments

You will post/charge procedures from the Appointment Book by marking patients' appointments as "Complete." When you are completing an appointment, you can choose to post the procedures attached to that appointment to the Ledger and Patient Chart.

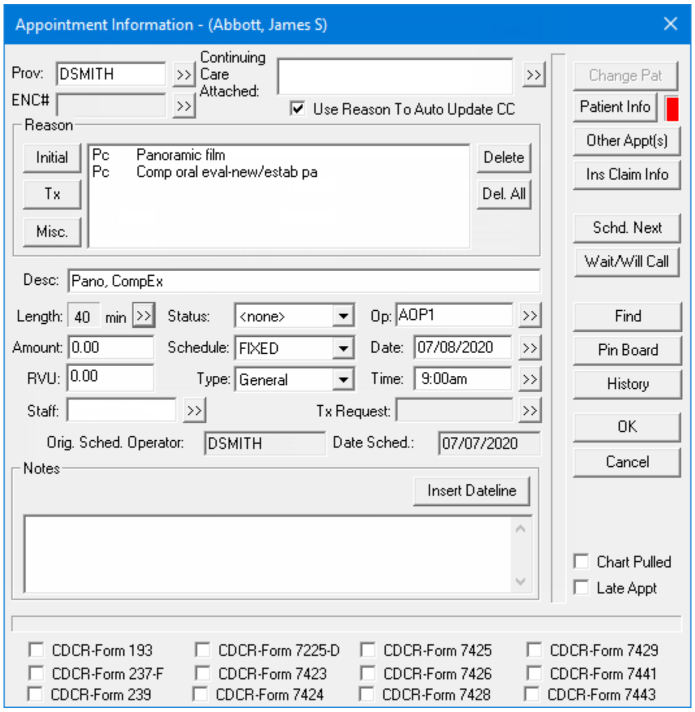
To complete an appointment

1. In the Appointment Book, locate the appointment. If the appointment's provider and/or reasons do not need to be changed, select it. (Skip step 2.)



2. If the appointment's provider and/or reasons need to be changed, do the following to edit the appointment:
   a. Double-click the appointment.

The **Appointment Information** dialog box appears.



b. Make any necessary changes to the **Prov** or **Reason** as needed.

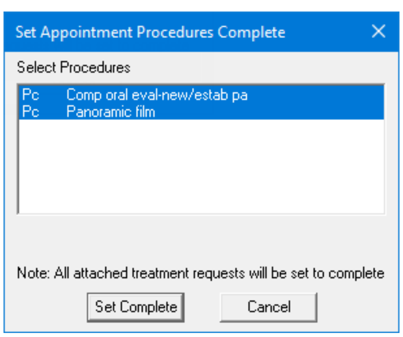
Notes:

- If the appointment requires a $5.00 co-pay, click **Initial** to select **Co-Pay Visit** as an appointment reason.
- If the patient has refused treatment, remove any treatment that has not been completed, and then click **Initial** to select **Patient Refusal** as an appointment reason.

c. Click **OK**.

3. Click the **Set Complete** button  on the toolbar.

The **Set Appointments Complete** dialog box appears.



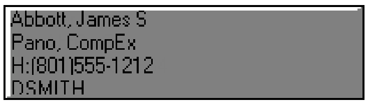
Notes:

- All procedures attached to the appointment are selected. If a procedure has not been completed on this visit, deselect that procedure.
- For prosthetic procedures, the ADA code will be charged out with the Final Impression. If there is a Preliminary Impression first, that will be no charge. At the final impression appointment, the ADA code and in-house code for the Final Impression will be charged out.

- For after-hours emergency visits, in addition to the ADA codes being posted, the ADA code of D9440 (Office visit-after regular hrs.) will be posted.
- If a procedure that requires additional treatment information (such as a tooth number or surface) has been attached to the appointment (by clicking **Misc.** in the **New Appointment Information** dialog box), that procedure will not be set complete. Deselect it. You will have to post it to the patient's Patient Chart or Ledger separately, specifying the appropriate treatment areas.

3. Click **Set Complete**.

   Dentrix Enterprise posts the procedures to the Patient Chart and Ledger, and the appointment in the Appointment Book becomes gray to indicate that the appointment has been completed.



Notes:

- The goal is to have all appointments grayed out or rescheduled by the end of the day.
- Each patient's Dental Priority Classification (DPC) should be confirmed and, if needed, edited. This can be done when the patient's clinical note is signed.

Editing Appointments

You change the provider and/or reasons pertaining to an appointment if those options need to be changed when you are completing that appointment. For information about how to complete an appointment, see "Completing Appointments" in this chapter.

Unlinking Treatment Requests

If you need to unlink a treatment request from an appointment, you can do so from the corresponding patient's **More Information** window. For information about how to unlink a treatment request, see "Managing Treatment Requests" in Chapter 2: More Information Window.

Deleting Appointments

You can permanently delete an appointment from the Appointment Book. The only time you should delete an appointment for patient of record is if you scheduled the appointment for the wrong patient or the appointment should not have been scheduled in the first place.

Note: When you delete an appointment, Dentrix Enterprise makes an entry in the audit trail, indicating the date and time you deleted the appointment.

To delete an appointment

1. In the Appointment Book, select the appointment.

2. Click the **Delete Appointment** button  on the toolbar.

   A confirmation message appears.

3. Click **Yes**.

   Note: If a treatment request was attached to the appointment, the status of that treatment request changes automatically according to the following criteria:

   - With a reviewing provider selected, the status changes to Reviewed.

Req Date	Req Type	Description	Severity	Rev Date	Rev Prov	Appt Date	Status
12/15/2020	Patient	Broken tooth	4	12/15/2020	DSMITH		Reviewed

   - Without a reviewing provider selected, the status changes to Received.

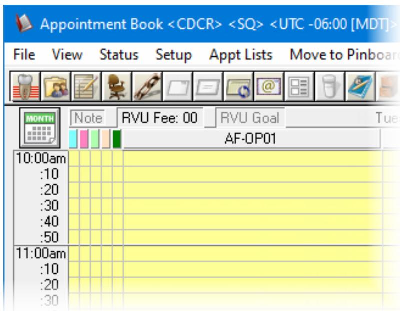
Req Date	Req Type	Description	Severity	Rev Date	Rev Prov	Appt Date	Status
12/15/2020	Patient	Broken tooth	4				Received

Scheduling Events

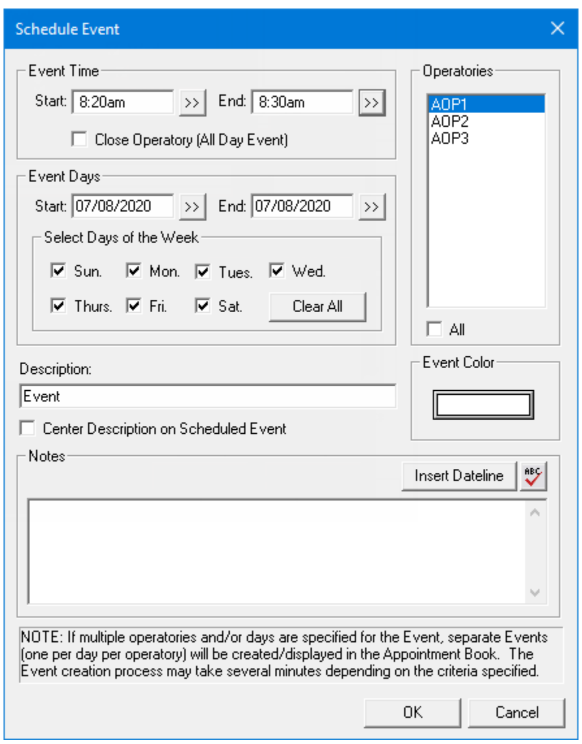
The Dentrix Enterprise Appointment Book is not just for managing patient appointments. It also allows you to schedule events, such as staff meetings, vacations, and activity reminders. You can use an event to block out time or close one or all operatories in the Appointment Book, so you have a visual reminder that you cannot schedule during that time. An event can be for a single day or be a recurring event for up to one year.

To schedule an event or a series of events

1. In the Appointment Book, navigate to the starting date of the event, right-click in the desired operatory at the desired starting time for the event, and then click **Schedule Event**.



The **Schedule Event** dialog box appears.



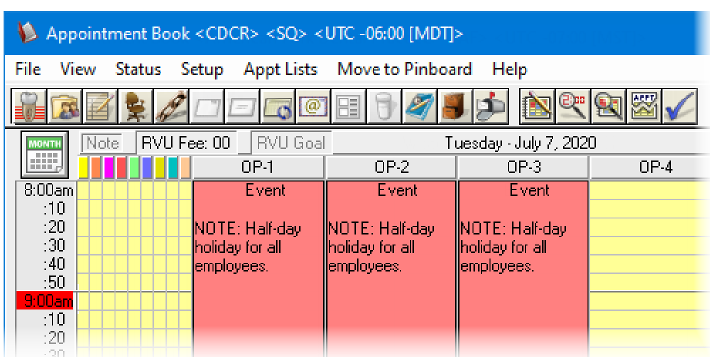
2. Set up the following options:
   - **Time, Days, Operatories** – By default, Dentrix Enterprise uses the operatory, date, and time for the event that corresponds to the time slot where you right-clicked to begin scheduling this event. You can change the **Event Time**, **Event Days**, and/or **Operatories** as needed. If the event will last the entire day, select **Close Operatory (All Day Event)**.

     Notes:
     - You must select at least one day. If the event starts and ends on the same day, select that day of the week.
     - You cannot schedule an event that overlaps a scheduled appointment or another event.
   - **Description** – Type a description for the event or series. To center the description horizontally at the top of the event block in the Appointment Book, select **Center Description on Scheduled Event**. With this check box cleared, the description is left aligned.
   - **Event Color** – Click the button to choose a color for the event.

     Tip: When choosing a color for the event, choose a light color that contrasts with the black text of the event description, so you can see the words easily. For example, black text will not be easily readable on a dark blue background.
   - **Notes** – Type any notes that apply to the event.

   Important: If you create a repeating event, be aware that if you want to delete the whole series, you must delete each event in that series one at a time.

3. Click **OK**.



Notes:
- The event creation process may take several minutes, depending on the date range specified, the days of the week selected, the number of operatories selected, and the number of future appointments scheduled.
- If you attempt to schedule a single event that overlaps with an existing appointment or event, a message appears and states that the operatory is already scheduled at the requested time.
- If Dentrix could not create an event that is part of a series because that event overlaps with an existing appointment or event, a log file appears for your reference. You can correct the conflicts and then schedule events to match those in the series you created previously.

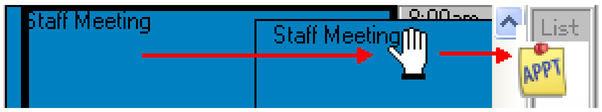
Rescheduling Events Using the Pinboard

You can use the Pinboard to quickly reschedule an event.

To reschedule an event using the Pinboard

1. Drag a partial-day or all-day event to the Pinboard.

   A copy of the event appears as an event icon on the Pinboard.



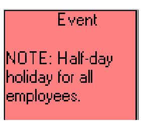
2. Drag the icon from the Pinboard to the desired date, time, and operatory.

Editing Events

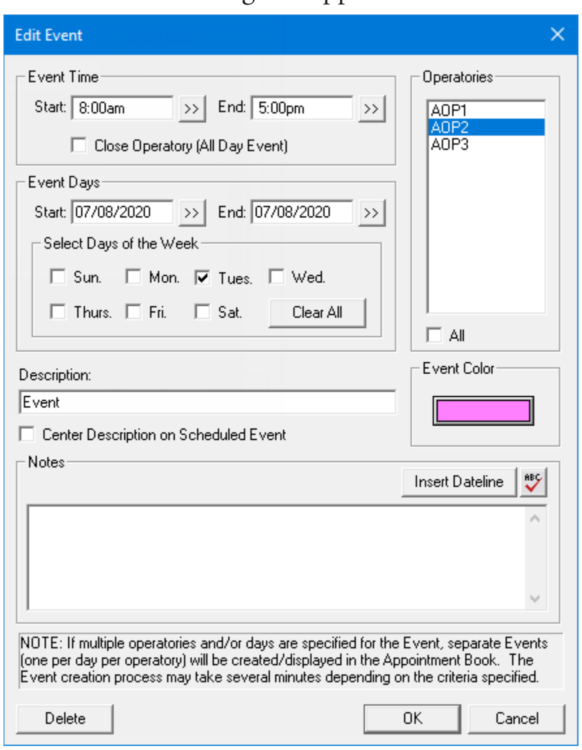
You can edit an event's details as needed. If the event is part of a series (an event that repeats at regular intervals), only the occurrence you are editing is affected.

To edit an event

1. In the Appointment Book, double-click the event you want to edit.



   The **Edit Event** dialog box appears.



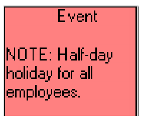
2. Edit the various event options as needed. For information on setting up event options, see "Scheduling Events" in this chapter.
3. Click **OK**.

Deleting Events

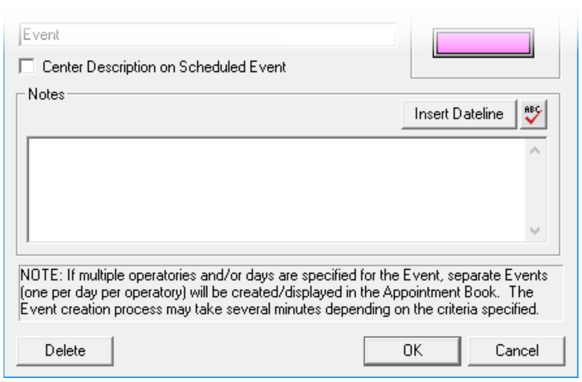
You can delete a single event or an event that is part of a series. You cannot delete a whole series of events at one time; you must delete each occurrence separately.

To delete an event

1. In the Appointment Book, double-click the event you want to delete.



The **Edit Event** dialog box appears.

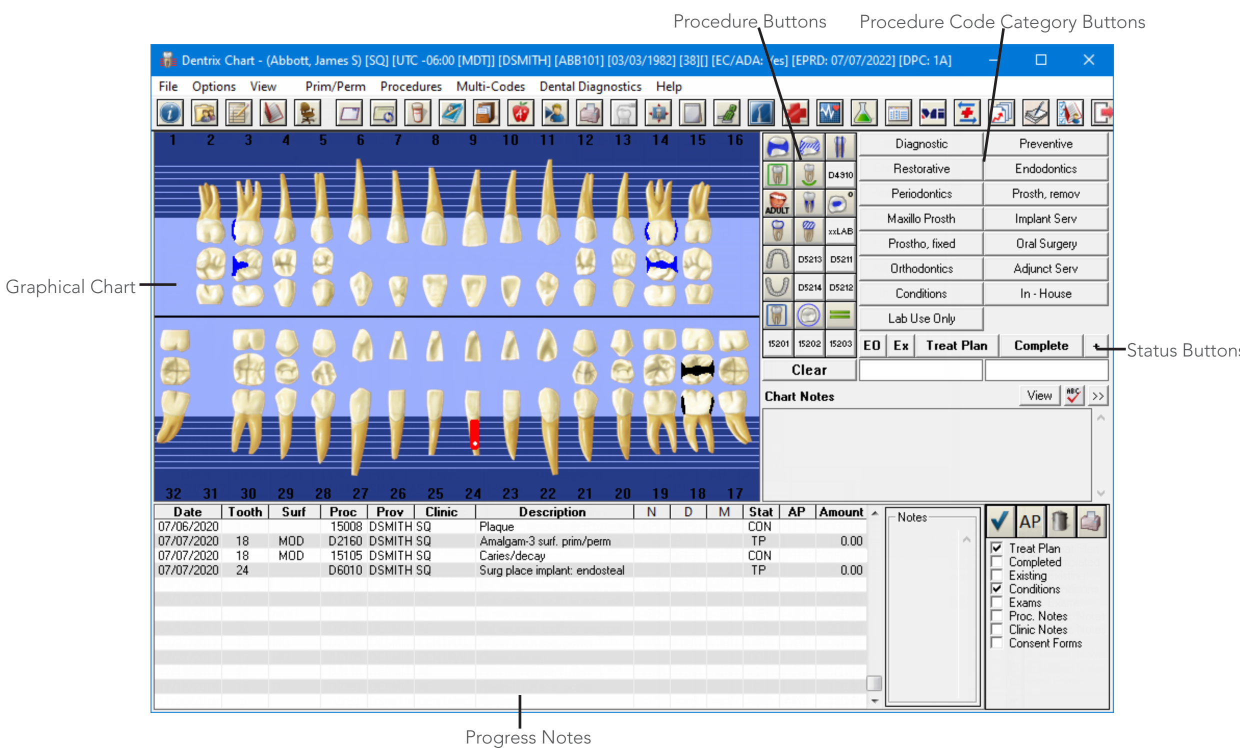


2. Click **Delete**. On the confirmation message that appears, click **Yes**.

Chapter 9: Patient Chart

The Patient Chart is the clinician's working chart for the patients' clinical treatment information. Clinical staff will enter existing dental restorations, current conditions, and completed treatment. You can access the Periodontal Chart, Treatment Planner, and Clinical Notes from the Patient Chart.

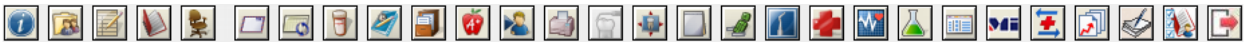
The Patient Chart window consists of the menu bar, toolbar, graphical chart, procedure buttons, procedure code category buttons, status buttons, and progress notes.



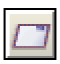
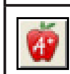
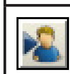
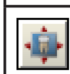
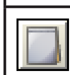
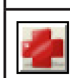
Note: On the title bar, when you have a patient selected, you will be able to view the patient's name, clinic, appointment provider, CDCR number, date of birth, age, bed, TABE score, EPRD and DPC code.

Patient Chart Toolbar

The Patient Chart includes a toolbar to provide easy access to most of the charting tools and other areas of Dentrix Enterprise.



The function of each button on the toolbar is explained in the following table.

Button	Name	Description
	More Information	Opens the selected patient's **More Information** window.
	Family File	Opens the selected patient's Family File.
	Ledger	Opens the selected patient's Ledger.
	Appointment Book	Opens the Appointment Book module.
	Office Manager	Opens the Office Manager module.
	Quick Letters	Opens the **Quick Letters** dialog box.
	Continuing Care	Opens the selected patient's Continuing Care list.
	Prescriptions	Opens PowerChart.
	Office Journal	Opens the selected patient's Office Journal.
	Document Center	Opens the selected patient's Document Center.
	Patient Education	Opens the **Patient Education** dialog box.
	Select Patient	Opens the **Select Patient** dialog box to select a patient.
	Print Dental Chart	Prints the patient chart.
	Work Chart	Displays the work chart view.
	Full Screen Chart	Displays the fullscreen chart view.
	Progress Notes	Expands the Progress Notes panel to fill the window.
	Treatment Planner	Opens the selected patient's Treatment Planner.
	Perio Chart	Opens the selected patient's Perio Chart.
	Medical Alerts	Opens the selected patient's **Medical Alerts** window.

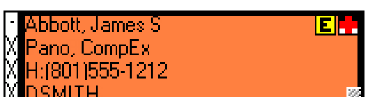
Button	Name	Description
	Patient Health Assessment	Opens the **Patient Health Assessment** dialog box.
	Orders	Opens the **Orders** dialog box.
	Clinical Notes	Opens the selected patient's **Clinical Notes** window.
	MiPACS	Opens MiPACS.
	Patient Health Exchange	Opens the selected patient's **Patient Health Exchange** dialog box.
	DXOne Reports	Click to open DXOne Reporting to generate and manage reports.
	Signature Manager	Click to open the **Signature Manager** dialog box to sign multiple clinical notes at one time.
	Scheduling Assistant	Click to open the **Scheduling Assistant** window, which can help enhance your scheduling workflow.

Opening the Patient Chart

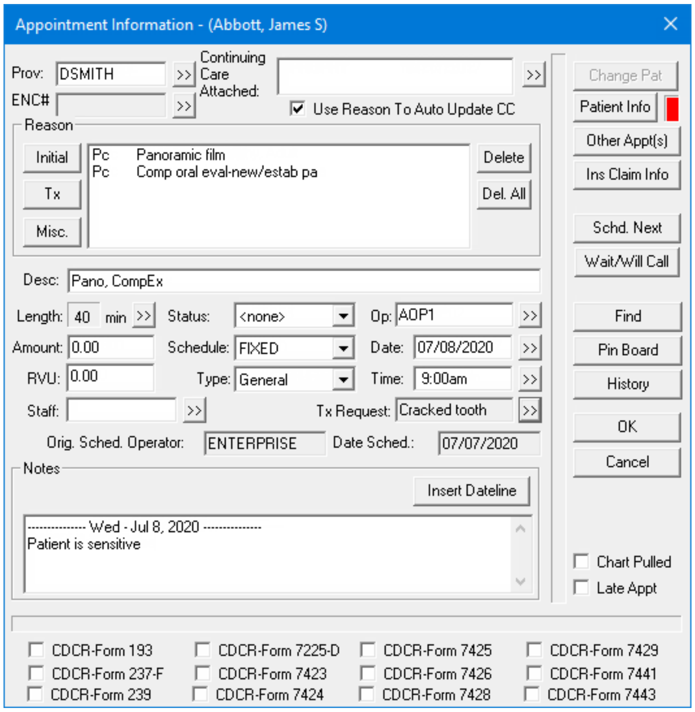
You can open the Patient Chart from the Appointment Book.

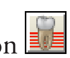
To open a patient's Chart

1. In the Appointment Book, double-click the patient's appointment.



The **Appointment Information** dialog box appears.



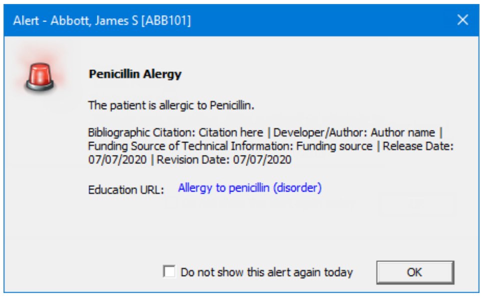
2. Verify that the treating provider is correct. If not, click the **Prov** search button  to select the correct provider.
3. Click **OK**.
4. With the patient's appointment still selected, click the **Patient Chart** button  on the toolbar.

Handling Global Alerts

Global alerts, which are attached to problems, allergies, and medications (PAM), will appear mainly when you open the Patient Chart. For example, for a patient who is allergic to Penicillin, not only will the Medical Alert icon be a red cross, but an a notification will appear when you open his or her Patient Chart.

To handle a global alert

When a notification appears, select the **Do not show this alert again today** check box to suspend the alert for this patient for today only, and then click **OK** to dismiss the message.



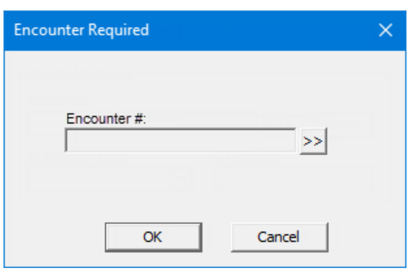
Assigning Encounter Numbers

If the Patient Chart is the first area you open for a patient during his or her visit, you must assign an encounter number to the patient's visit. This encounter number is used to send the clinical notes over to Millennium.

To assign an encounter number

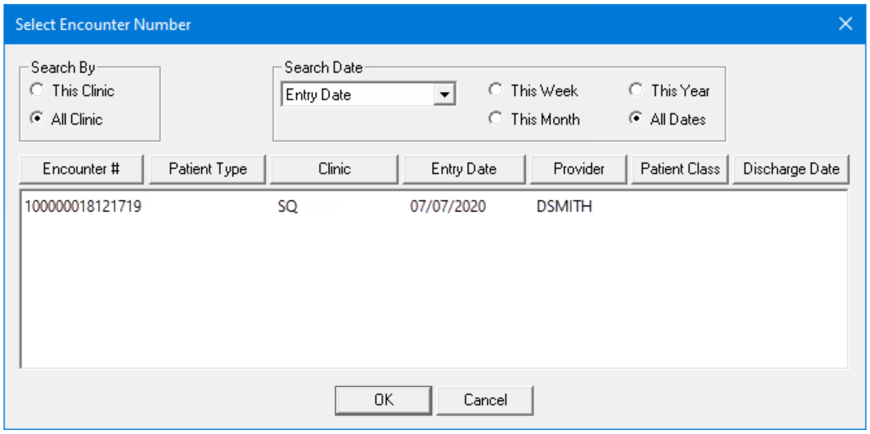
1. Open a patient's Patient Chart.

   The **Encounter Required** dialog box appears.



2. Click the **Encounter#** search button .

The **Select Encounter Number** dialog box appears.



Note: Typically, Dentrix Enterprise will show only the encounters that are currently open in Millennium. If there are multiple encounters listed, make sure you select the encounter that you want your clinical note attached to. For example, for an inpatient visit, you should select the inpatient encounter. To verify which is the correct encounter, open Millennium.

3. Select the encounter number to attach to this visit, and then click **OK**.
4. Click **OK**.

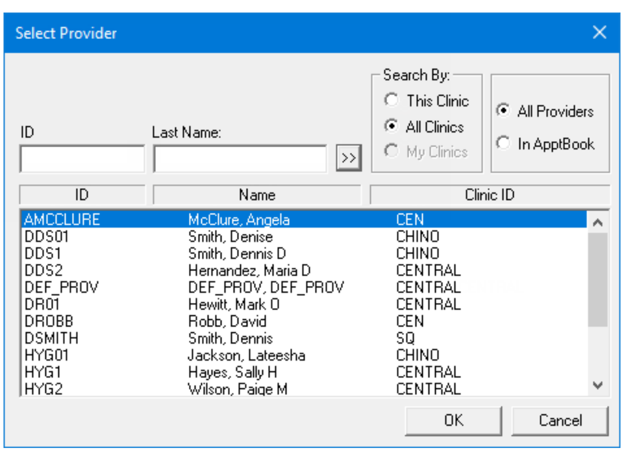
Changing the Provider for a Charting Session

When you open a patient's Chart, the appointment provider's name should appear on the title bar. If the provider displayed is not the treating provider, select the correct provider.

To change the provider for a charting session

1. In the Patient Chart, with a patient selected, from the **File** menu, click **Change Provider**.

   The **Select Provider** dialog box appears.



2. Select the provider to whom all work posted during this session should be assigned.
3. Click **OK**.

Note: You can change the provider for an individual procedure by editing it after it has been posted.

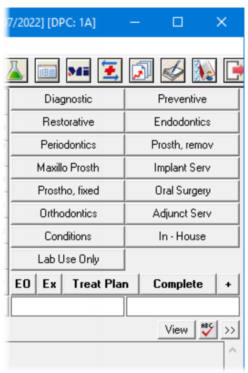
Posting a Code for No Screening

For a patient who is not in need of an RC screening, you must post the in-house code "No RC Screening Needed" and enter a clinical note that explains why the RC screening is not needed.

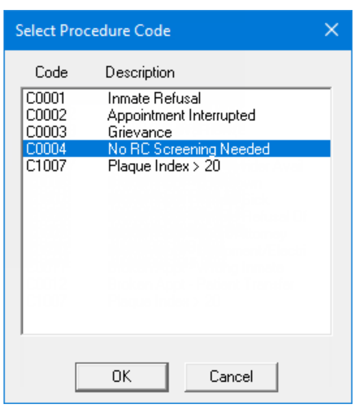
Note: This is for rare cases when a dentist administratively completes an RC Screening as outlined in IDSP/P.

To post a code for no screening

1. In the Patient Chart, with a patient selected, make sure the appointment provider's name appears on the title bar. If not, change the provider as explained in "Changing the Provider for a Charting Session" in this chapter.
2. Click the **In-House** procedure code category button.



   The **Select Procedure Code** dialog box appears.



3. Double-click **C0004 No RC Screening Needed**.
4. Click **Comp**.
5. To create the clinical note that explains why the RC screening is not needed, do the following:

   a. Click the **Clinical Notes** button  on the toolbar to open the Clinical Notes.

   b. Expand the **Administrative** template category, and then double-click the **RC Screening** template.

   c. Answer the prompts that appear.

   Notes:

   - This clinical note will appear in the Signature Manager for signing.
   - For more information about entering a clinical note, see "Entering Clinical Notes Using Templates" in Chapter 11: Clinical Notes.

Verifying and Editing PAM Data

You must confirm and/or edit a patient's problems, allergies, and medications (PAM) in PowerChart.

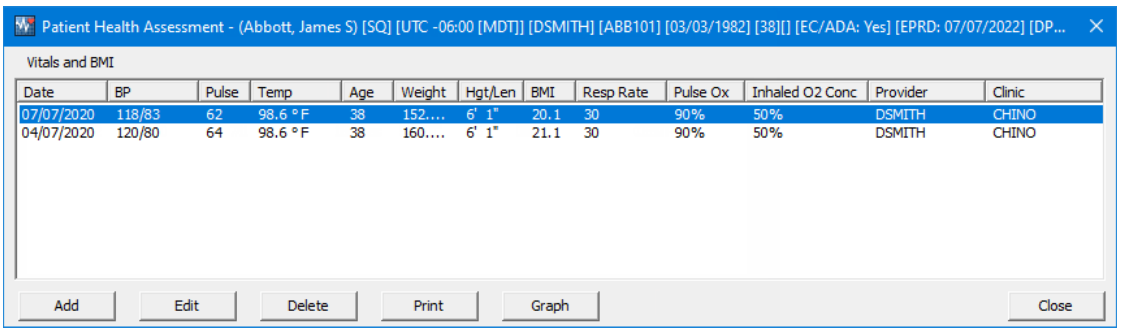
To open PowerChart, with a patient selected in the Patient Chart, click the **Prescriptions** button on the toolbar.

Verifying Patient Health Assessments

A patient health assessment (PHA) is an electronic record of a patient's vitals (height, weight, blood pressure, and so forth). A patient's health assessment will be entered into PowerChart, and you can view it in Dentrix Enterprise.

To view a patient's health assessments, with a patient selected in the Patient Chart, click the **Patient Health Assessment** button on the toolbar.

The **Patient Health Assessment** dialog box appears.



Entering Prescription Orders

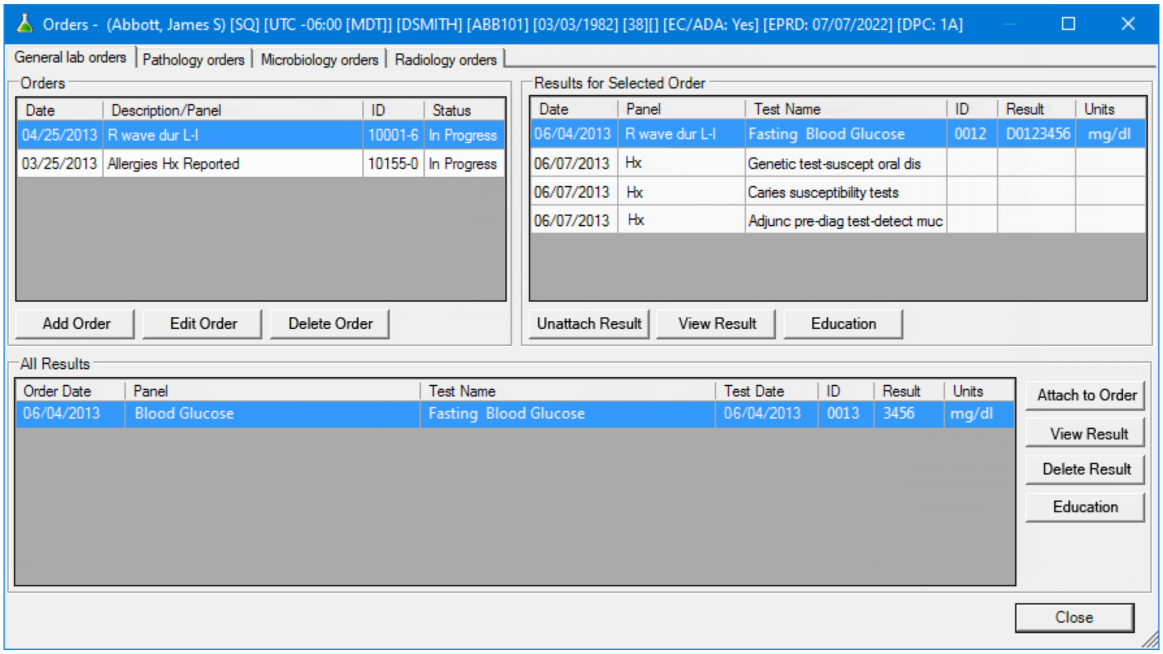
You can add a new order for a prescription in PowerChart. After the order is placed, and the medication has been verified by the pharmacy, the prescription can be seen in Dentrix Enterprise.

To open PowerChart, with a patient selected in the Patient Chart, click the **Prescriptions** button on the toolbar.

Viewing Lab Orders

You can view lab orders (for example, blood tests, biopsies, and cultures) for a patient in the Patient Chart.

To view lab orders, with a patient selected in the Patient Chart, click the **Orders** button on the toolbar. The **Orders** dialog box appears.



Accessing MiPACS Imaging Software

You can access the MiPACS imaging software from the Patient Chart to view a patient's digital images stored in that program.

To open MiPACS, with the patient selected in the Patient Chart, click the **MiPACS** button on the toolbar.

Changing Dentition in the Patient Chart

By default, the Patient Chart is set to show all teeth as permanent for patients. However, you can change the dentition for specific teeth on a patient-by-patient basis.

Important: Do not change to default setting.

To change the dentition

1. In the Patient Chart, with a patient selected, select the teeth whose dentition you need to change to primary.
2. From the **Prim/Perm** menu, click **Change Selected**.

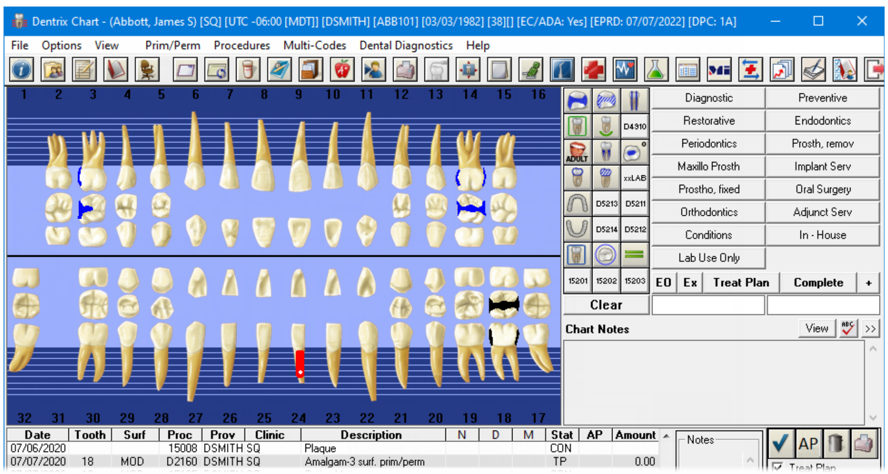
Charting Conditions

You can chart a condition, such as an open contact, caries, or a missing tooth, to help create an accurate representation of the patient's oral cavity in the graphical chart.

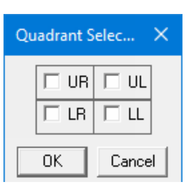
Tip: To chart all conditions as a group, before you start charting, click the **Auto-State** button (+), and then click **EO**. After you finish charting conditions, click the **Auto-State** button (-) again to turn off auto-state, or click a different status button to chart treatment with the corresponding status.

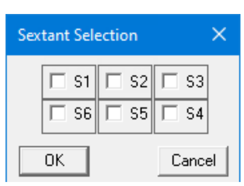
To chart a condition

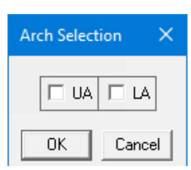
1. In the Patient Chart, with a patient selected, make sure the appointment provider's name appears on the title bar. If not, change the provider as explained in "Changing the Provider for a Charting Session" in this chapter.
2. If the condition you are entering requires a tooth number, select the appropriate tooth/teeth in the graphical chart.



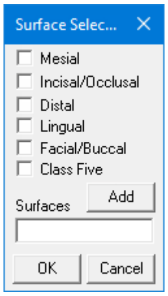
3. Click the **Conditions** procedure code category button, and then double-click a condition.
4. Do one of the following:
   - If the selected condition requires the selection of quadrants, sextants, or arches, the **Quadrant Selection**, **Sextant Selection**, or **Arch Selection** dialog box appears. Select the applicable treatment areas, and then click **OK**.







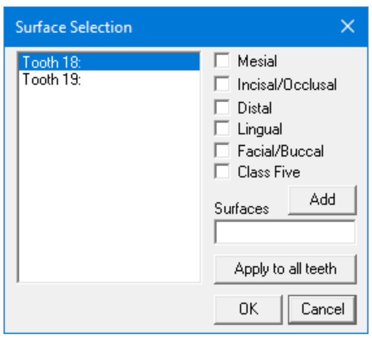
- If the selected condition requires the selection of surfaces, the **Surface Selection** dialog box appears. Do one of the following:
  - If one tooth is selected:



    a. Select the applicable treatment areas.

    b. Click **OK**.

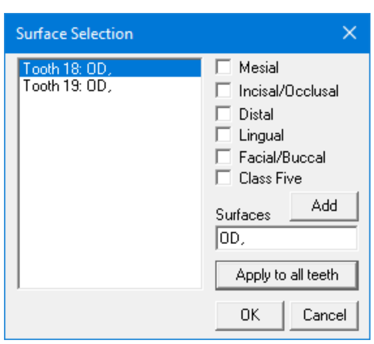
  - If multiple teeth are selected:



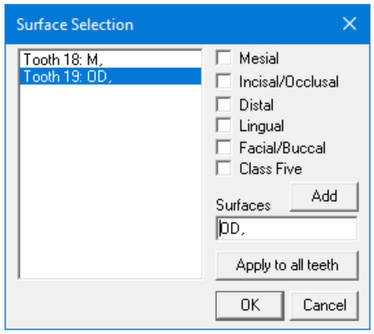
    a. With the first tooth selected in the list on the left, select the check boxes of the applicable surfaces, and then click **Add**.

    b. Do one of the following for the other teeth listed:

    - To apply the specified surfaces to all the other teeth listed, click **Apply to all teeth**. On the confirmation message that appears, click either **Yes** to apply the surfaces to all the teeth listed (you can change the surfaces of any tooth as needed before you click **OK**) or **No** to apply the surfaces to only the selected tooth (you must then add surfaces to each tooth separately before you click **OK**).



- To add surfaces to each tooth separately, select a different tooth in the list on the left, select the check boxes of the applicable surfaces, and then click **Add**. Repeat this process as needed for the other teeth listed.



Notes:

- You can also change the surfaces for any tooth in the list by selecting that tooth.
- To continue, every tooth in the list must have at least one surface applied.

c. Click **OK**.

5. Click the **EO** status button.

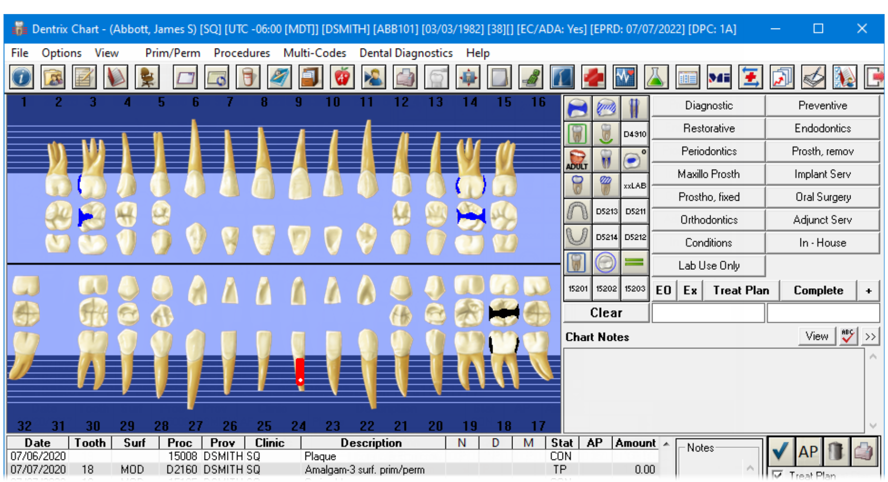
Charting Existing Treatment

You can chart existing treatment, such as a restoration, to help create an accurate representation of the patient's oral cavity in the graphical chart.

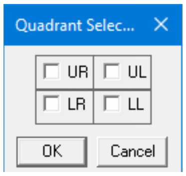
Tip: To chart all existing treatment as a group, before you start charting, click the **Auto-State** button (+), and then click **EO**. After you finish charting existing treatment, click the **Auto-State** button (-) again to turn off auto-state, or click a different status button to chart treatment with the corresponding status.

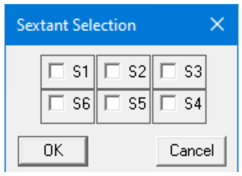
To chart an existing treatment

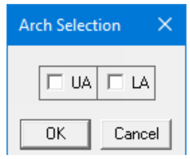
1. In the Patient Chart, with a patient selected, make sure the appointment provider's name appears on the title bar. If not, change the provider as explained in "Changing the Provider for a Charting Session" in this chapter.
2. If the existing treatment you are entering requires a tooth number, select the appropriate tooth/teeth in the graphical chart.



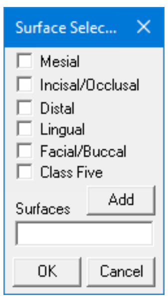
3. Specify the procedure by using a procedure button, a procedure code category button, or the **Procedures** menu.
4. Do one of the following:
   - If the selected procedure requires the selection of quadrants, sextants, or arches, the **Quadrant Selection**, **Sextant Selection**, or **Arch Selection** dialog box appears. Select the applicable treatment areas, and then click **OK**.



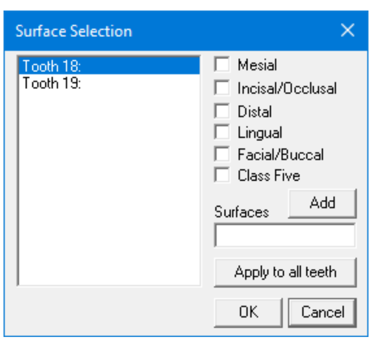




   - If the selected procedure requires the selection of surfaces, the **Surface Selection** dialog box appears. Do one of the following:
     - If one tooth is selected:



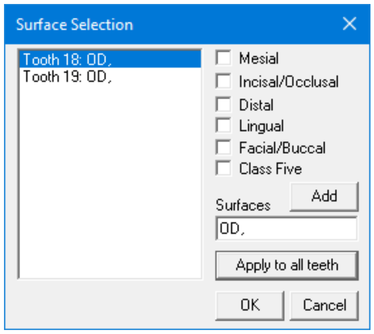
       a. Select the applicable treatment areas.
       b. Click **OK**.
     - If multiple teeth are selected:



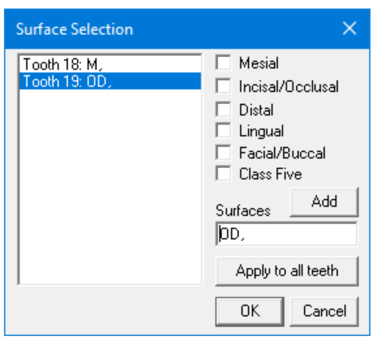
       a. With the first tooth selected in the list on the left, select the check boxes of the applicable surfaces, and then click **Add**.

b. Do one of the following for the other teeth listed:

- To apply the specified surfaces to all the other teeth listed, click **Apply to all teeth**. On the confirmation message that appears, click either **Yes** to apply the surfaces to all the teeth listed (you can change the surfaces of any tooth as needed before you click **OK**) or **No** to apply the surfaces to only the selected tooth (you must then add surfaces to each tooth separately before you click **OK**).



- To add surfaces to each tooth separately, select a different tooth in the list on the left, select the check boxes of the applicable surfaces, and then click **Add**. Repeat this process as needed for the other teeth listed.



Notes:

- You can also change the surfaces for any tooth in the list by selecting that tooth.
- To continue, every tooth in the list must have at least one surface applied.

c. Click **OK**.

5. Click the **EO** status button.

Charting Treatment Needs

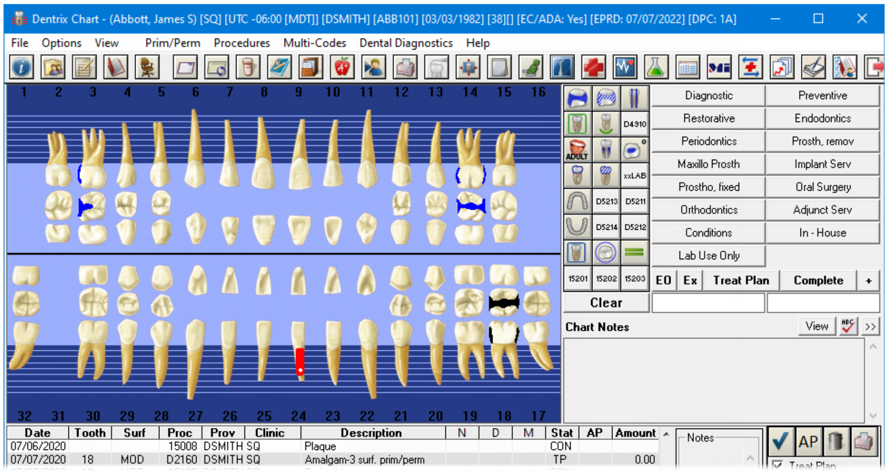
You can chart work that needs to be completed (treatment-planned).

Tip: To chart all treatment needs as a group, click the **Auto-State** button (**+**), and leave the **Treat Plan** button depressed. After you finish charting treatment needs, click the **Auto-State** button (**-**) again to turn off auto-state.

To chart a treatment need

1. In the Patient Chart, with a patient selected, make sure the appointment provider's name appears on the title bar. If not, change the provider as explained in "Changing the Provider for a Charting Session" in this chapter.

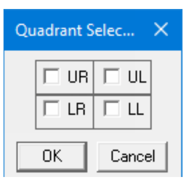
2. If the treatment need you are entering requires a tooth number, select the appropriate tooth/teeth in the graphical chart.

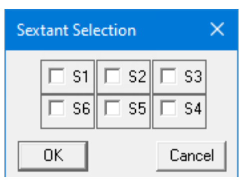


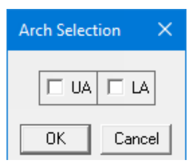
3. Specify the procedure by using a procedure button, a procedure code category button, or the **Procedures** menu.

4. Do one of the following:

   - If the selected procedure requires the selection of quadrants, sextants, or arches, the **Quadrant Selection**, **Sextant Selection**, or **Arch Selection** dialog box appears. Select the applicable treatment areas, and then click **OK**.

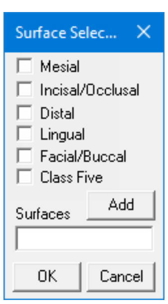






   - If the selected procedure requires the selection of surfaces, the **Surface Selection** dialog box appears. Do one of the following:

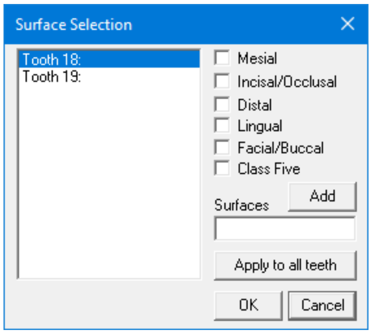
     - If one tooth is selected:



       a. Select the applicable treatment areas.

       b. Click **OK**.

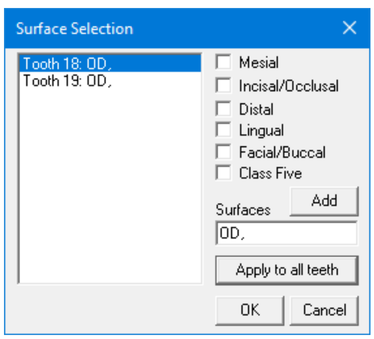
- If multiple teeth are selected:



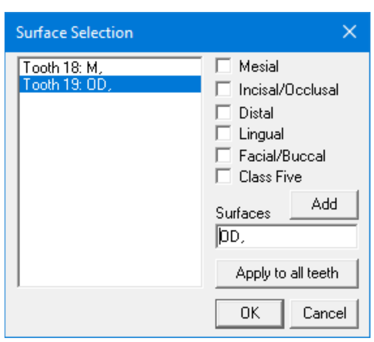
a. With the first tooth selected in the list on the left, select the check boxes of the applicable surfaces, and then click **Add**.

b. Do one of the following for the other teeth listed:

- To apply the specified surfaces to all the other teeth listed, click **Apply to all teeth**. On the confirmation message that appears, click either **Yes** to apply the surfaces to all the teeth listed (you can change the surfaces of any tooth as needed before you click **OK**) or **No** to apply the surfaces to only the selected tooth (you must then add surfaces to each tooth separately before you click **OK**).



- To add surfaces to each tooth separately, select a different tooth in the list on the left, select the check boxes of the applicable surfaces, and then click **Add**. Repeat this process as needed for the other teeth listed.



Notes:

- You can also change the surfaces for any tooth in the list by selecting that tooth.
- To continue, every tooth in the list must have at least one surface applied.

c. Click **OK**.

5. Click the **Treat Plan** status button.

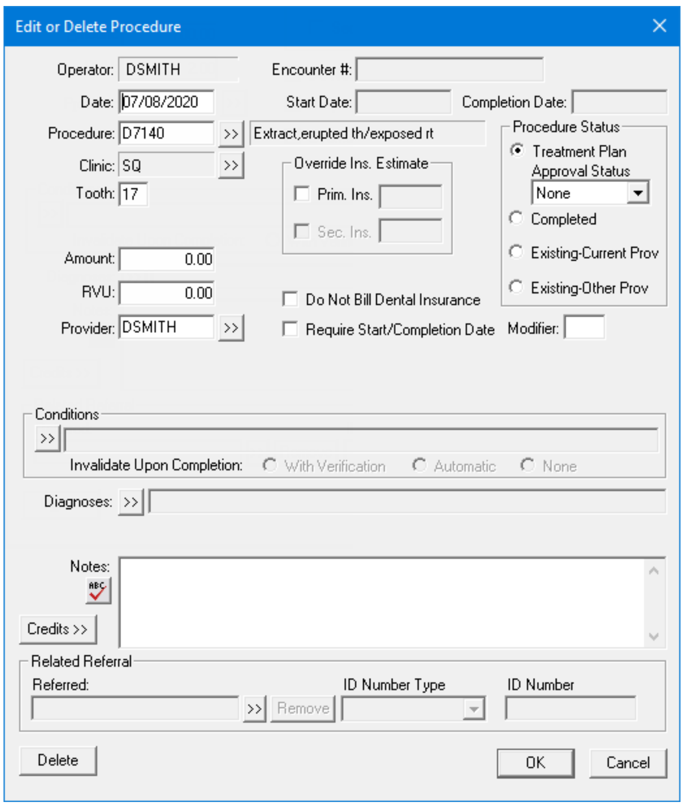
Linking Conditions and Treatment-planned Procedures

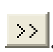
You can link multiple conditions to a treatment-planned procedure, or alternatively you can link a treatment-planned procedure to a condition. To link a condition and a treatment-planned procedure, they must both already be charted. Linking a condition and a treatment-planned procedure allows you to have that condition invalidated automatically when you complete the corresponding treatment-planned procedure.

To link a condition to a treatment-planned procedure

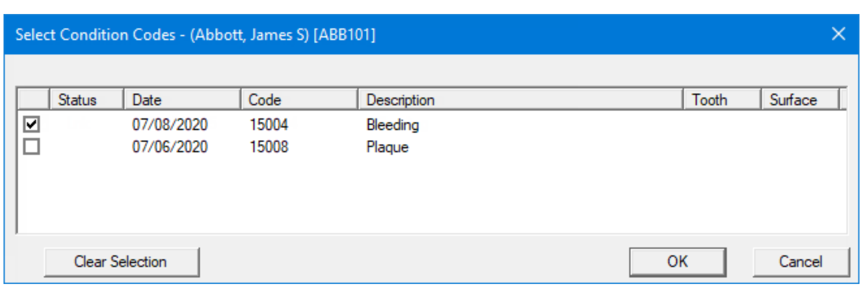
1. In the Patient Chart, with a patient selected, on the Progress Notes panel, double-click the treatment-planned procedure that you want to link a condition to.

   The **Edit or Delete Procedure** dialog box appears.



2. Click the **Conditions** search button .

   The **Select Condition Codes** dialog box appears.



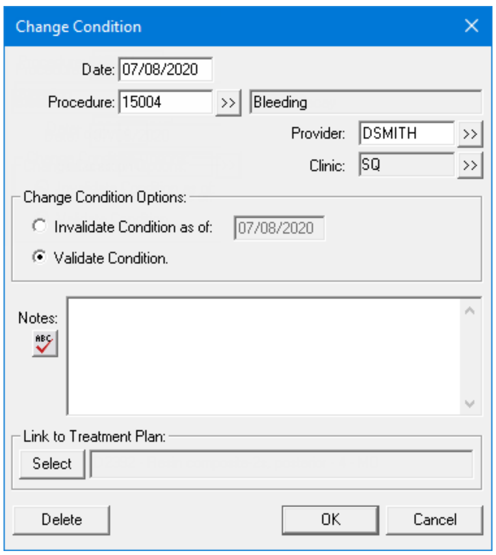
3. Select the check box of any condition that you want the procedure to be linked to.
4. Click **OK**.

5. Select an **Invalidate Upon Completion** option to specify how you want to handle the invalidation of the conditions that the procedure is linked to when you complete the procedure (if it has been treatment-planned):
   - **None** – The conditions that the procedure is linked to will not be invalidated.
   - **Automatic** – The conditions that the procedure is linked to will be invalidated automatically.
   - **With Verification** – You will choose which conditions you want to invalidate.
6. Click **OK**.

To link a treatment-planned procedure to a condition

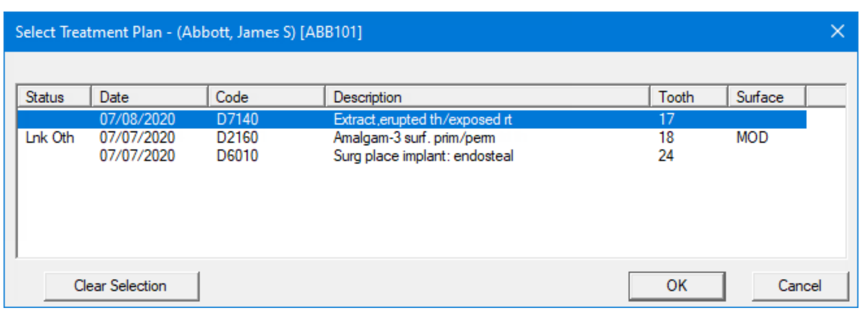
1. In the Patient Chart, with a patient selected, on the Progress Notes panel, double-click the condition that you want to link a treatment-planned procedure to.

   The **Change Condition** dialog box appears.



2. Under **Link to Treatment Plan**, click **Select**.

   The **Select Treatment Plan** dialog box appears.



3. Select the treatment-planned procedure that you want to link to the condition, and then click **OK**.
4. In the **Change Condition** dialog box, click **OK**.

Invalidating Conditions

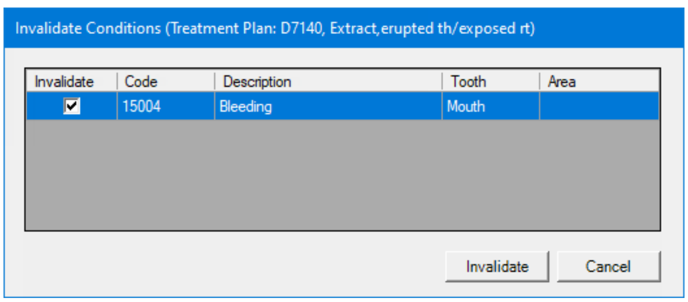
When you complete a treatment-planned procedure that has conditions linked to it, those conditions can be invalidated automatically. In contrast, conditions that are not linked to treatment-planned procedures do not get invalidated automatically when a related treatment-planned procedure is completed. However, you can manually invalidate an unlinked condition posted in the Patient Chart.

To invalidate a linked condition when completing a treatment-planned procedure

1. To complete a treatment-planned procedure, complete the appointment that has that treatment plan attached to it as explained in “Completing Appointments” in Chapter 8: Appointment Book.

   One of the following occurs, depending on the selected invalidation option for the procedure as explained in “Linking Conditions and Treatment-planned Procedures” in this chapter:

   - **None** – The conditions that the procedure is linked to are not invalidated. (Ignore the steps that follow.)
   - **Automatic** – The conditions that the procedure is linked to are invalidated automatically. (Ignore the steps that follow.)
   - **With Verification** – You choose which conditions you want to invalidate. The **Invalidate Conditions** dialog box appears. Proceed to step 2.

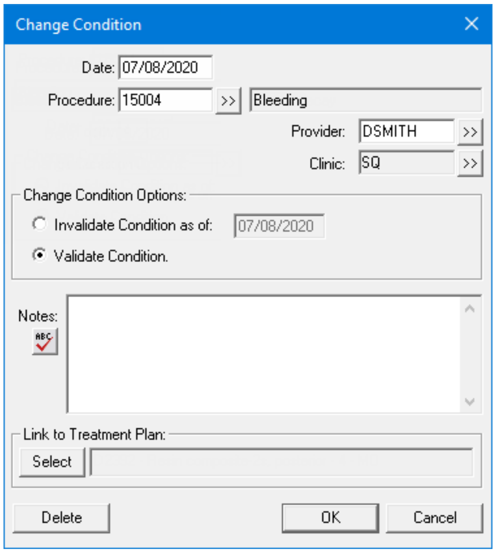


2. Leave the **Invalidate** check box of each of the conditions that you want to have invalidated selected. Clear the **Invalidate** check box of each of the conditions that you do not want to have invalidated.
3. Click **Invalidate**.

To invalidate an unlinked condition manually

1. In the Patient Chart, with a patient selected, on the Progress Notes panel, double-click a condition.

The **Change Condition** dialog box appears.



2. Under **Change Condition Options**, select **Invalidate Condition**.
3. In the **as of** field, leave the current system date entered, or type a past date to specify the correct date that the condition became invalid.
4. Enter any **Notes** to explain why this condition is being invalidated.
5. Click **OK**.

Referring Treatment to Off-site Specialists

Occasionally you may need to refer a patient to an off-site specialist. You can refer a procedure to an off-site provider from the Patient Chart. When you refer a procedure to an off-site provider, that procedure stays in your records as diagnosed, but Dentrix Enterprise does not assess any fees for it. Also, the procedure is not considered unscheduled treatment.

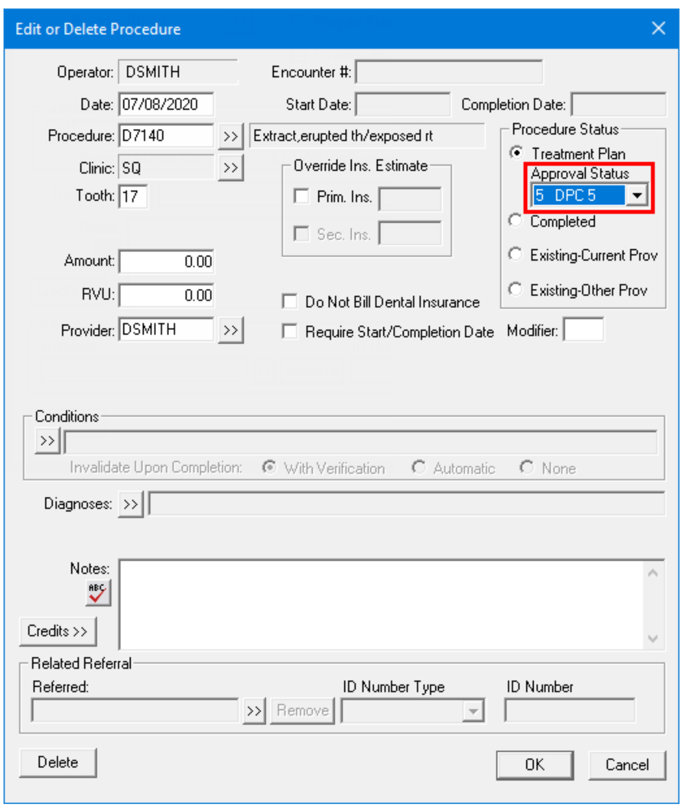
Important: Before referring treatment to an off-site provider, you must assign the appropriate Dental Priority Classification (DPC) to the treatment-planned procedure and then wait for a dental authorization review (DAR) to be performed.

To refer a procedure to an off-site provider

1. Assign a DPC 5 to the treatment-planned procedure that is to be referred to an off-site specialist by doing one of the following:
   - In a patient's Treatment Planner, change the approval status of the procedure as explained in "Changing the Approval Status of a Treatment Plan" in Chapter 12: Treatment Planner.
   - In a patient's Patient Chart, do the following:

     a. On the Progress Notes panel, double-click the procedure.

     The **Edit or Delete Procedure** dialog box appears.

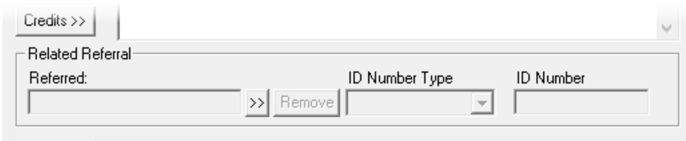


     b. Under **Procedure Status** on the right, from the **Approval Status** list, select **DPC 5**.

     c. Click **OK**.

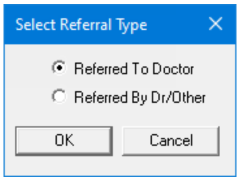
2. After receiving an approval through the DAR process, with the patient selected in the Patient Chart, on the Progress Notes panel, double-click the treatment-planned procedure.

The **Edit or Delete Procedure** dialog box appears.



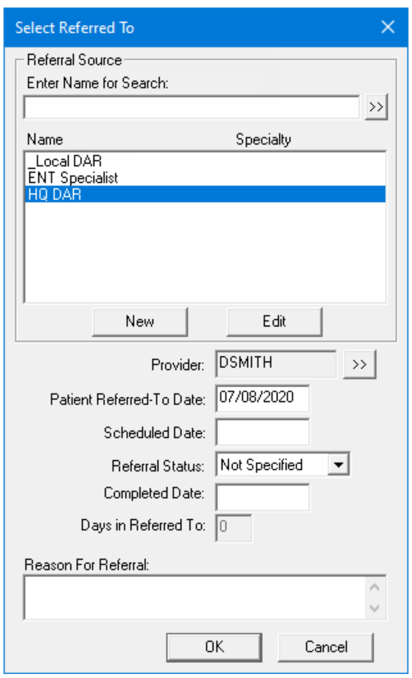
3. Under **Related Referral**, click the **Referred** search button .

   The **Select Referral Type** dialog box appears.



4. Select **Referred To Doctor**.
5. Click **OK**.

   The **Select Referred To** dialog box appears.



Note: If the list is long, you can filter it by name. In the **Enter Name** field, type all or part of the referral source name, and then click the search button .

6. Select the off-site specialist to whom you are referring this treatment.
7. Click **OK**.
8. In the **Edit or Delete Procedure** dialog box, click **OK**.

   The treatment's status changes from TP to RTP.
9. When the patient returns from the off-site specialist, after reviewing the notes received from the specialist, set the procedure complete in the patient's Chart:

   a. Select the procedure on the Progress Notes panel of the patient's Patient Chart.

b. Click the **Set Complete** button to the right of the progress notes.

10. Record the review of the specialist's notes by creating a clinical note as explained in "Entering Clinical Notes Manually" in Chapter 11: Clinical Notes.
11. Scan the specialist's documents into the patient's Document Center as explained in "Scanning Documents" in Chapter 7: Document Center. When entering the document information as explained in "Editing Document Information" in Chapter 7: Document Center, be sure to select **Dental Other/ Outside Providers** as the **Document Type**.

Referring Treatment to In-house Specialists

Occasionally you may need to refer a patient to an in-house specialist. You can refer a procedure to an in-house provider from the Patient Chart. When you refer a procedure to an in-house provider, that procedure stays in your records as diagnosed, but Dentrix Enterprise does not assess any fees for it. Also, the procedure is not considered unscheduled treatment.

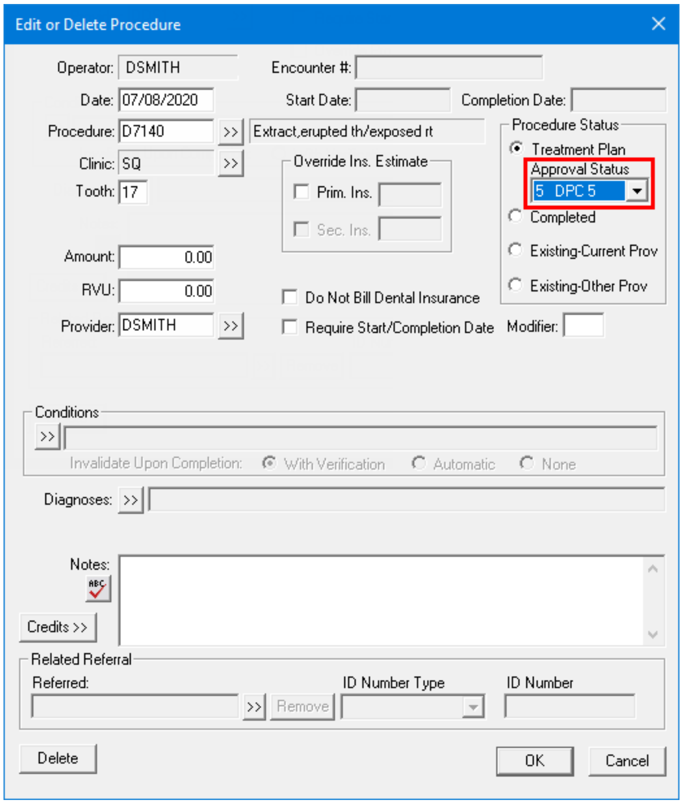
Important: Before referring treatment to an in-house provider, you must assign the appropriate Dental Priority Classification (DPC) to the treatment-planned procedure and then wait for a dental authorization review (DAR) to be performed.

To refer a procedure to an in-house provider

1. Assign a DPC 5 to the treatment-planned procedure that is to be referred to an in-house specialist by doing one of the following:
   - In a patient's Treatment Planner, change the approval status of the procedure as explained in "Changing the Approval Status of a Treatment Plan" in Chapter 12: Treatment Planner.
   - In a patient's Patient Chart, do the following:

     a. On the Progress Notes panel, double-click the procedure.

The **Edit or Delete Procedure** dialog box appears.



b. Under **Procedure Status** on the right, from the **Approval Status** list, select **DPC 5**.

c. Click **OK**.

2. After receiving an approval through the DAR process, schedule an appointment for the patient with the in-house specialist (such as an oral surgeon) as explained in “Scheduling Appointments for Treatment Requests in Chapter 8: “Appointment Book.”

3. After the in-house specialist completes the treatment, set the procedure complete by completing the appointment as explained in “Completing Appointments” in Chapter 8: “Appointment Book.”

Changing Progress Note Views

While working in the Patient Chart it may be advantageous to view only certain treatment information. For example, while explaining treatment to a patient, you might want to display just the graphical chart; or, while reviewing a patient's history, you might want to view only completed procedures and conditions on the Progress Notes panel. By providing multiple ways to view treatment information, Dentrix Enterprise makes it simple to review cases and make treatment recommendations.

Viewing the Work Chart

By default, the Patient Chart always opens with the work chart displayed. The work chart consists of the graphical chart, progress notes, procedure buttons, procedure code category buttons, and status button. While in the work chart view, you can enter conditions, chart existing and completed work, and treatment plan.

To view the work chart

With a patient selected in the Patient Chart, from the **Options** menu, click **Work Chart**.

Tip: You can resize the window, if needed. Dentrix Enterprise stores the **Patient Chart** window's dimensions upon being closed so that, when you re-open the Patient Chart, it will open as the same size.

Viewing the Full-screen Chart

The graphical chart in the Patient Chart visually depicts the condition of the patient's mouth. Treatment is drawn on the graphical chart using textbook charting symbols. In addition, treatment is color-coded to indicate the status of the treatment. For instance, completed work can be shown in blue, while recommended treatment can be shown in red. For use as a patient education tool, you can expand the graphical chart to fill the entire **Patient Chart** window.

To view the full screen chart

With a patient selected in the Patient Chart, from the **Options** menu, click **Full Screen Chart**.

Tip: You can resize the window, if needed. Dentrix Enterprise stores the **Patient Chart** window's dimensions upon being closed so that, when you re-open the Patient Chart, it will open as the same size.

Viewing the Progress Notes

You view the progress notes so that they become the focus of the Patient Chart instead of the graphical chart.

To view the progress notes

With a patient selected in the Patient Chart, from the **Options** menu, click **Progress Notes**.

The **Progress Notes** panel expands to fill nearly the entire **Patient Chart** window.

Viewing Progress Notes by Selected Teeth

If a patient has an extended treatment history, you can display only treatment related to a specific tooth or teeth in the Progress Notes panel.

To view the progress notes by selected teeth

1. With a patient selected in the Patient Chart, select the tooth or teeth for which you want to see progress notes.
2. From the **View** menu, click **View by Selected Teeth**. If no teeth are selected, this option will display progress notes for all teeth in the graphical chart.

   The progress notes view is updated, and the selected tooth/teeth are deselected.
3. To remove this view setting, from the **View** menu, click **View by Selected Teeth** (the option will have a check mark next to it if it is in use).

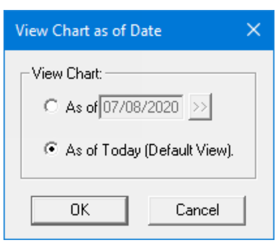
Viewing Progress Notes as of a Certain Date

You can view a patient's progress notes as of a certain date. Only treatment or conditions entered on or before the specified date are shown.

To view the progress notes as of a certain date

1. With a patient selected in the Patient Chart, from the **View** menu, click **Chart As Of Date**.

   The **View Chart as of Date** dialog box appears.

2. Select one of the following options:
   - **As of** – To view treatment and conditions on or before a certain date. Click the search button  to select a date.
   - **As of Today (Default View)** – To view all treatment and conditions regardless of the date.
3. Click **OK** to apply the change.
4. To remove this view setting, from the **View** menu, click **Chart As Of Date** (the option will have a check mark next to it if it is in use).

Viewing Progress Notes by Status

Progress notes can be listed according to a specific status option(s). For example, you can have the Progress Notes panel display only treatment-planned procedures, or you can choose to show treatment-planned and completed procedures.

To view the progress notes by status

With a patient selected in the Patient Chart, on the right side of the Progress Notes panel, select any of the following check boxes:

- **Treat Plan** – To display only treatment-planned procedures.
- **Completed** – To display only completed procedures.
- **Existing** – To display only procedures with a status of existing other
- **Conditions** – To display all conditions entered into the Patient Chart and the corresponding Dental Diagnostic codes
- **Exams** – To display a line for each Perio exam
- **Proc. Notes** – To display procedure notes
- **Clinic Notes** - To display clinical notes

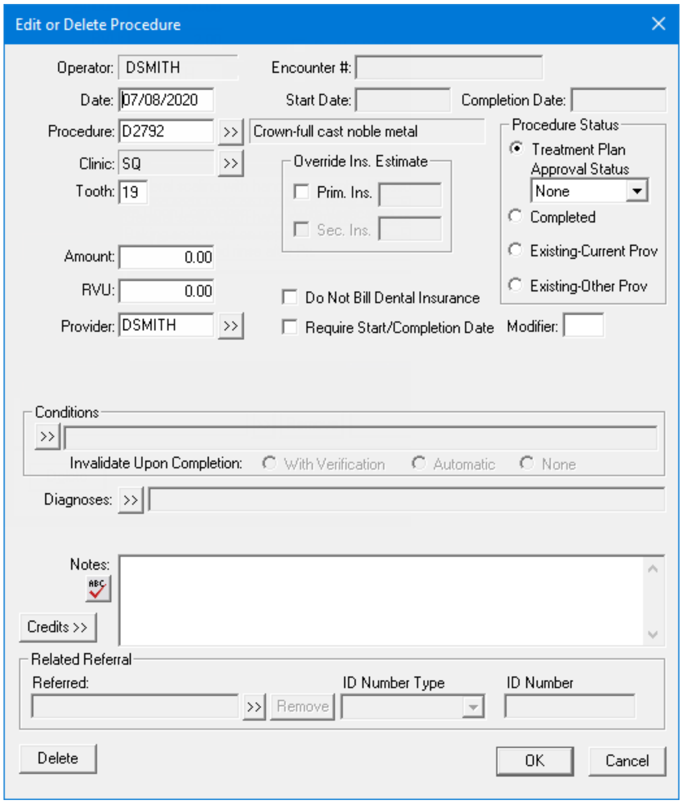
Posting Treatment to Supernumerary Teeth

Because it is not possible to view or select a supernumerary tooth in the graphical chart, it is necessary to post the procedure to the nearest tooth and then edit the posted procedure with the appropriate supernumerary tooth number.

To post treatment to a supernumerary tooth

1. In the Patient Chart, with a patient selected, select the tooth that is nearest to the supernumerary tooth.
2. To make a note of the supernumerary tooth, click the **Conditions** procedure code category button, and then double-click **Supernumerary Tooth Adjacent**.
3. Post the treatment to the tooth that is nearest to the supernumerary tooth as explained in “Charting Treatment Needs” in this chapter.
4. On the Progress Notes panel, double-click the procedure that you just posted.

The **Edit or Delete Procedure** dialog box appears.



3. Change the **Tooth** number based on the following ADA recommendations:
   - **Permanent Teeth** – Add 50 to the tooth number nearest the supernumerary tooth (for example, 1 = 51, 2 = 52, 3 = 53, and 32 = 82).
   - **Primary Teeth** – Add an "S" after the tooth letter nearest the supernumerary tooth (for example, A = AS, B = BS, C = CS, and T = TS).

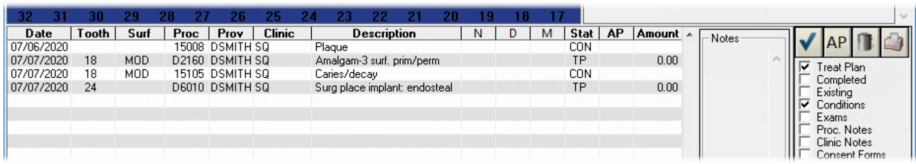
   On the message that appears, asking if you want to accept the tooth number as supernumerary, click **Yes**.
4. Click **OK**.

Editing Procedures

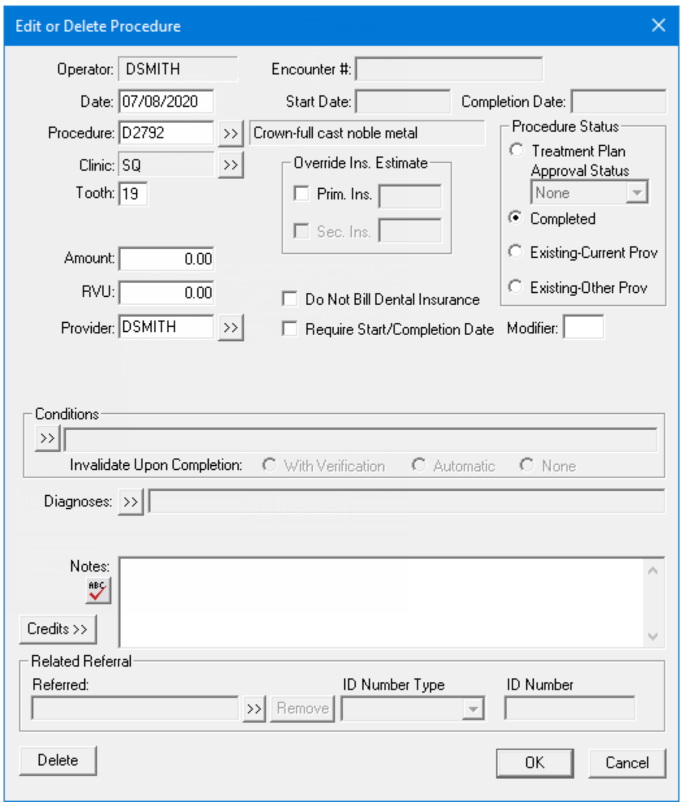
After treatment has been entered into the Patient Chart, you can make changes to the procedure, as needed, as long as the procedure is not in history or attached to a claim. For example, you may need to backdate a procedure that was posted after the actual date of service (dental encounter).

To edit treatment

1. In the Patient Chart, with a patient selected, from the Progress Notes panel, double-click the treatment item you want to change.



The **Edit or Delete Procedure** dialog box appears.



2. Make any necessary changes:
   - **Date** – Type the correct date of the procedure.
   - **Clinic** – To change the clinic, click the search button >> to select the correct clinic.
   - **Procedure** – To change the procedure code, click the search button >> to select the correct code.
   - **Treatment area** – To change the treatment area do one of the following:
     - For a tooth, type the correct **Tooth** number or letter (or supernumerary tooth number or letter).
     - For a **Surface**, **Quadrant**, **Arch**, or **Sextant**, click the corresponding search button >> to select the correct area.
   - **Amount** – Type the correct amount charged for the procedure.

- **Provider** – To change the provider attached to the procedure, click the search button >> to select the correct provider.
- **Notes** – Make any necessary changes to the note, and specify the reason for the procedure needing to be changed (for auditing purposes)

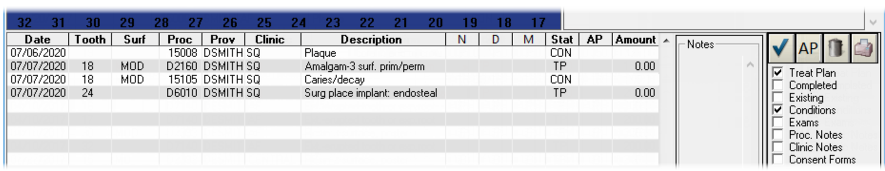
3. Click **OK**.
4. Since posted procedures are automatically added into a clinical note with date they are entered, you need to enter a narrative as to why the correction was made or the procedure was backdated. Edit or add another page to the day's clinical note for the patient's visit. For information about editing clinical notes and adding pages to clinical notes, see "Editing Clinical Notes" and "Appending Clinical Notes" in Chapter 11: Clinical Notes.

Deleting Procedures

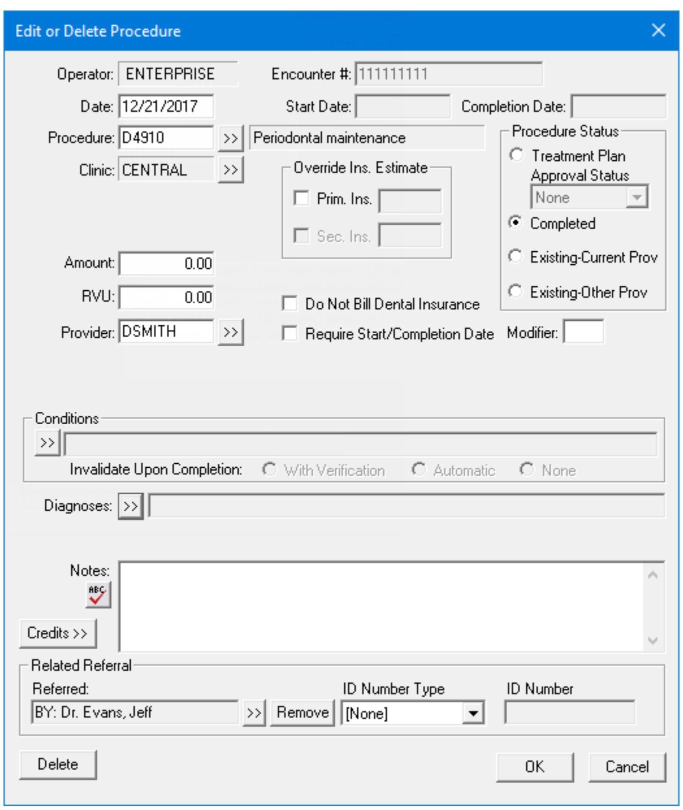
You can delete completed, treatment-planned, or existing procedures that were posted in error unless the procedure is in history or attached to a claim. You can also delete conditions.

To delete a completed, treatment-planned, or existing procedure

1. In the Patient Chart, with a patient selected, on the Progress Notes panel, double-click the completed, treatment-planned, or existing procedure you want to delete.



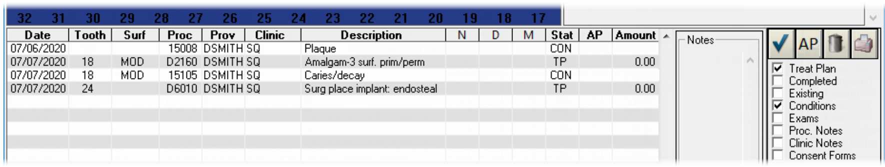
The **Edit or Delete Procedure** dialog box appears.



2. Click **Delete**.
3. On the confirmation message that appears, click **OK**.

To delete a treatment-planned or existing procedure

1. In the Patient Chart, with a patient selected, on the Progress Notes panel, click the treatment-planned or existing procedure you want to delete.



Tip: To select multiple procedures, while pressing the Ctrl key, click each procedure.

2. Click the **Delete** button .
3. On the confirmation message that appears, click **OK**.
4. Since posted procedures are automatically added into a clinical note, you need to enter a narrative as to why the deletion was made. Edit or add another page to the day's clinical note for the patient's visit. For information about editing clinical notes and adding pages to clinical notes, see "Editing Clinical Notes" and "Appending Clinical Notes" in Chapter 11: Clinical Notes.

Invalidating Procedures

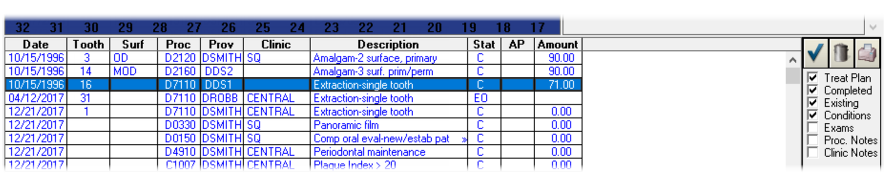
Dentrix Enterprise saves your office from repetitive data entry by posting procedures to both the Ledger and Chart at the same time. However, a different standard regarding record keeping exists for each module. The Ledger, as a financial record, uses generally accepted accounting principles (GAAP). In contrast, the Patient Chart is a clinical record of patient care.

Then, what do you do when you discover a posting error for a procedure in a month that has been closed out? The procedure has been locked to prevent deletions and changes, which is good for a financial record, and you can simply enter an adjustment in the Ledger to correct the problem. However, the clinical record needs to accurately represent the actual care given, but you can't delete or change the procedure or "adjust" the clinical record in the Chart.

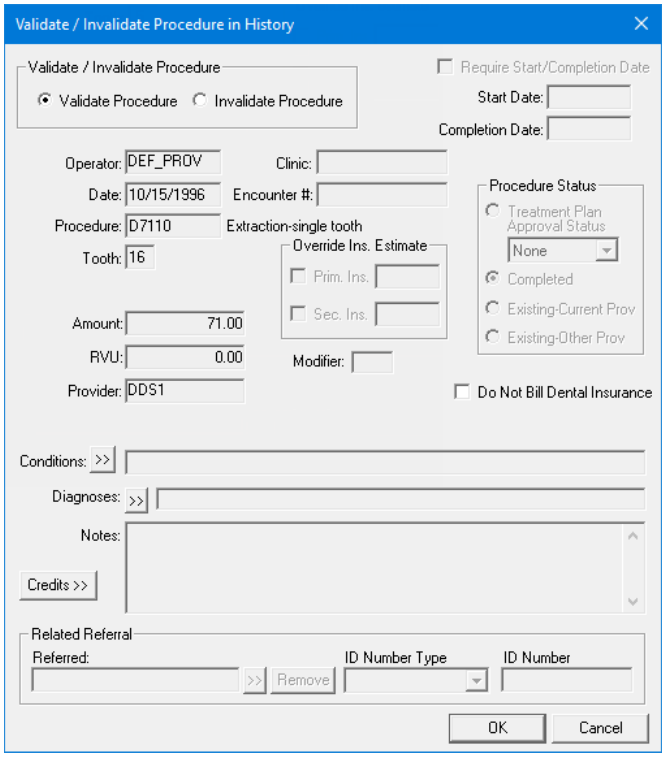
To solve this discrepancy, Dentrix Enterprise allows you to invalidate a procedure in history (in closed out months). Invalidating a procedure removes it from the Chart while leaving it in the Ledger.

To invalidate a procedure

1. In the Patient Chart, with a patient selected, on the Progress Notes panel, double-click a procedure in history.



The **Validate/Invalidate Procedure in History** dialog box appears.



2. Under **Validate/Invalidate Procedure**, click **Invalidate Procedure**.
3. Click **OK**.

   The invalidated transaction is removed from the Patient Chart but left in the Ledger as a history transaction. In the Ledger, a plus sign (+) appears to the left of the transaction description to indicate that the transaction has been invalidated.

   Important:

   - Post an offsetting adjustment equal to the amount of the procedure, as the account has already been billed for that procedure.
   - If needed, post the procedure again using the correct information. Be sure to change the date to reflect the date the procedure was originally posted, and change the charge amount to zero because the account has already been billed for the procedure.

4. Since posted procedures are automatically added into a clinical note, you need to enter a narrative as to why the correction was made. Add another page to the day's clinical note for the patient's visit. For information about adding pages to clinical notes, see "Appending Clinical Notes" in Chapter 11: Clinical Notes.

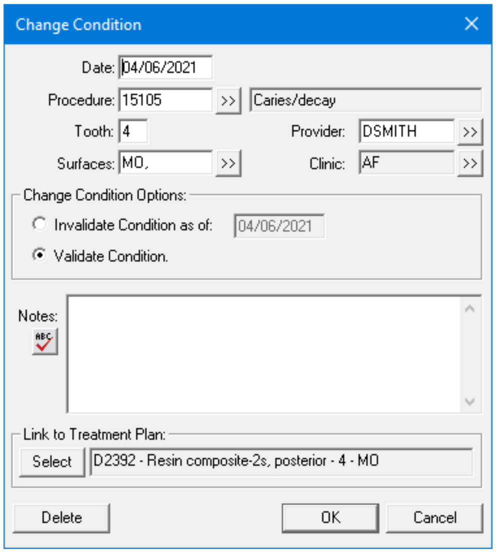
Editing Conditions

You can edit a condition that has been posted in the Patient Chart.

To edit a condition

1. In the Patient Chart, with a patient selected, on the Progress Notes panel, double-click the condition that you want to edit.

   The **Change Condition** dialog box appears.



2. Change the following details as needed:
   - **Date** – Enter the correct date when the condition was discovered (by you, the patient, or another provider).
   - **Procedure** – To select a different condition, click the search button. Only codes in the Conditions category are available for selection.
   - **Tooth** – If applicable, enter the correct tooth number or letter (or supernumerary tooth number or letter).
   - **Other treatment areas** – Do one the following if applicable:
     - For a surface, click the **Surface** search button to select the correct surface.
     - For a quadrant, click the **Quadrant** search button to select the correct quadrant.
     - For an arch, click the **Arch** search button to select the correct arch.
     - For an sextant, click the **Sextant** search button to select the correct sextant.
   - **Provider** – To select a different provider, click the search button.
   - **Clinic** – To select a different clinic, click the search button.
   - **Change Condition Options** – Invalidate or validate the condition.
   - **Notes** – Enter or modify the notes regarding the condition.
   - **Link to Treatment Plan** – Link a treatment-planned procedure to this condition, or unlink a linked treatment-planned procedure.
3. Click **OK**.

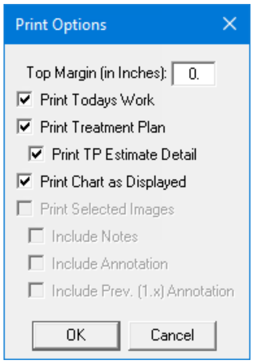
Printing a Patient's Chart

You can print a patient's chart.

To print a patient's chart

1. In the Patient Chart, with a patient selected, from the **File** menu, click **Print Dental Chart**.

   The **Print Options** dialog box appears.

2. Select the desired print options:
   - **Print Todays Work** – Select this option if you want to print completed work posted on the current system date.
   - **Print Treatment Plan** – Select this option if you want to print treatment-planned work that was posted on the current system date.

     If you want to include a list of treatment-planned work and the billed amount, patient portion, and insurance portion of each, select **Print TP Estimate Detail**.
   - **Print Chart as Displayed** – Select this option if you want the report to include the graphical chart.
3. Click **OK** to send the report to the Patient Chart printer.

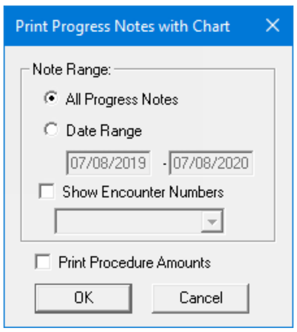
Printing Progress Notes and the Patient Chart

You can print the progress notes and graphical chart as they are currently being viewed in the Patient Chart.

To print the progress notes with the chart

1. In the Patient Chart, with a patient selected, from the **File** menu, click **Print Progress Notes With Chart**.

   The **Print Progress Notes with Chart** dialog box appears.

2. Set up the following options:
   - **Note Range** – To print all displayed progress notes, select **All Progress Notes**; or, to print notes specific to a certain date range, select **Date Range**, and then type a date range.
   - **Print Procedure Amounts** – To include amounts for procedures that appear on the report.
3. Click **OK**.

Viewing Patient Education Topics

You can provide education resources to a patient according to that patient's medical alerts/problems, medications/prescriptions, allergies, and laboratory test results. This feature uses a database of patient education topics that are available on the MedlinePlus website. The content of this website is sponsored/backed by the government.

To view a patient education topic

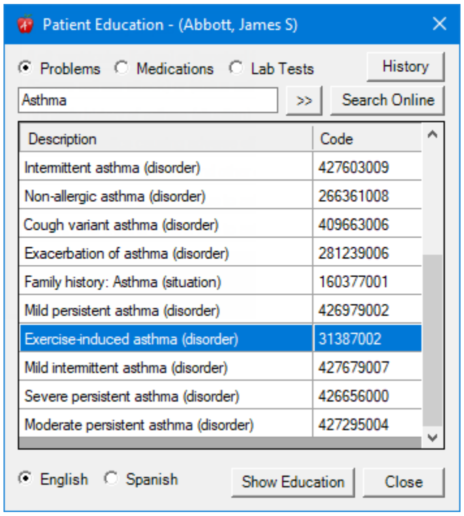
1. Do one of the following:
   - With a patient selected in a patient-specific module, such as the Patient Chart, click the **Patient Education** button. The **Patient Education** dialog box appears. Skip step 2.
   - With a prescription selected in a patient's **Patient Prescription** dialog box, click the **Patient Education** button.

     Depending on a clinic setting, one of the following occurs:
     - If there is a valid NDC associated with the selected prescription, the MedlinePlus website opens in a browser window and displays the relevant patient topics, if any. Ignore the steps that follow. However, if there are no relevant topics, a message appears and asks if you want to search the patient topic database. Proceed to the next step.
     - The MedlinePlus website opens in a browser window and displays the patient education topics, if any, that match the description of the selected prescription. The **Record Patient Education** dialog box opens but is behind the browser window. Skip to step 8.
   - With an alert/problem, a medication/prescription, or an allergy selected in a patient's **Medical Alerts** dialog box, click the **Patient Education** button.

     Depending on a clinic setting, one of the following occurs:
     - If there is a valid SNOMED-CT code associated with the selected alert/problem or allergy, or if there is a valid NDC associated with the selected prescription/medication, the MedlinePlus website opens in a browser window and displays the relevant patient topics, if any. Ignore the steps that follow. However, if there are no relevant topics, a message appears and asks if you want to search the patient topic database. Proceed to the next step.
     - The MedlinePlus website opens in a browser window and displays the patient education topics, if any, that match the description of the selected alert/problem, medication/prescription, or allergy. The **Record Patient Education** dialog box opens but is behind the browser window. Skip to step 8.
   - With a lab test result selected in a patient's **Lab Tests** dialog box under **Lab Results for Selected Lab Order** (for a selected lab order) or under **All Lab Results**, click **Education**.

     Depending on a clinic setting, one of the following occurs:
     - If there is a valid LOINC code associated with the selected lab test, the MedlinePlus website opens in a browser window and displays the relevant patient topics, if any. Ignore the steps that follow. However, if there are no relevant topics, a message appears and asks if you want to search the patient topic database. Proceed to the next step.
     - The MedlinePlus website opens in a browser window and displays the patient education topics, if any, that match the description of the selected lab test. The **Record Patient Education** dialog box opens but is behind the browser window. Skip to step 8.
2. Click **Yes**.

The **Patient Education** dialog box appears.



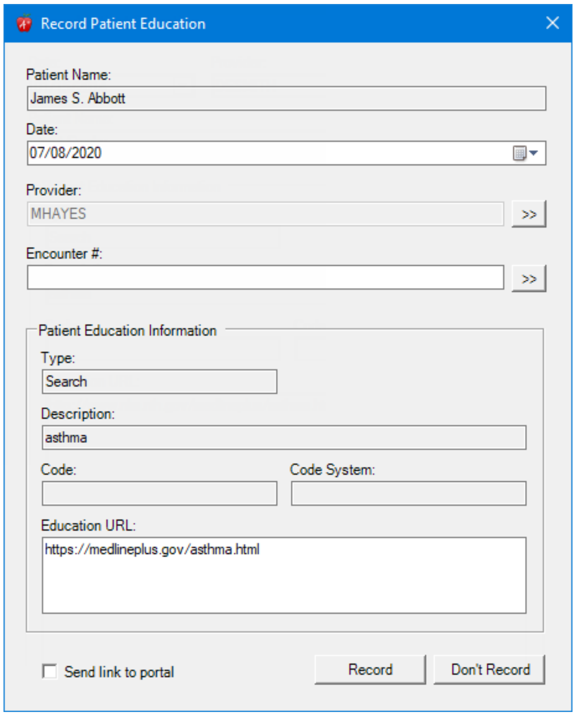
3. Select a category: **Problems**, **Medications**, or **Lab Tests**.
4. Do one of the following:
   - Type all or part of the description or code for a topic that you want to view, and then click the search button  to view a list of topics that match your search criteria. Proceed to the next step.
   - Type the words that you want to search for, and then click **Search Online** to browse topics on the MedlinePlus Connect website that match your search criteria. Ignore the steps that follow.

   Note: The search field allows for dashes (-).

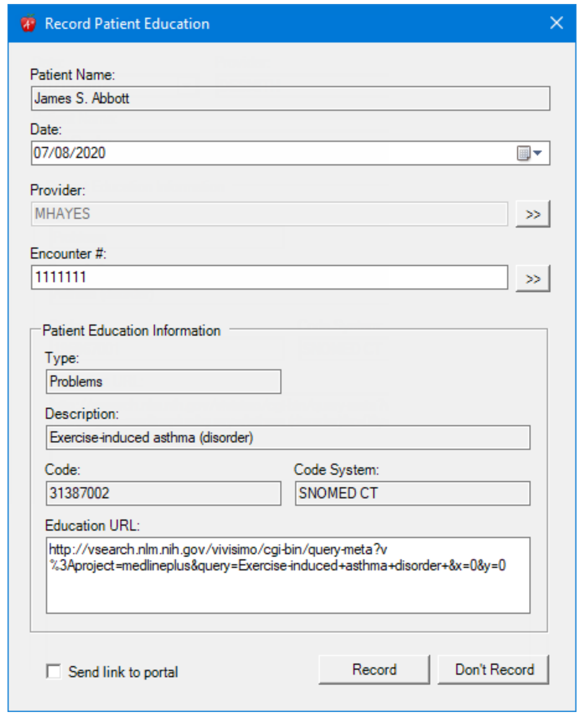
5. Select the topic that you want to view.
6. Select whether you want to view the selected topic in **English** or **Spanish**. The default selection is determined by the patient's selected language and a clinic setting.
7. Click **Show Education**.

   The MedlinePlus website opens in a browser window and displays the patient topics that match either the description or code (according to a certain clinic setting) of the selected topic.

8. In the **Record Patient Education** dialog box, change the **Date**, **Provider**, and/or **Education URL** as needed. Then, either click **Record** to record that you provided the patient with education resources, or click **Don't Record** to not record an entry in the patient's education history.

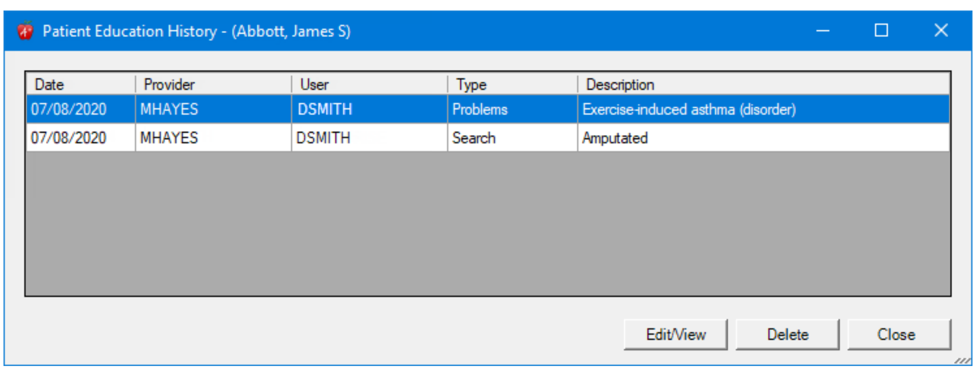


Online search



Show education (for selected topic)

Tip: To view information regarding the patient education topics that have been recorded previously for the patient, in the **Patient Education** dialog box, click **History**. The **Patient Education History** dialog box appears.



Chapter 10: Perio Chart

In the Periodontal Chart, you can record clinical attachment levels, pocket depths, gingival margins, mobility, plaque, calculus, bone loss, bleeding and suppuration points, furcation grades, and MGJ measurements.

Note: A Periodontal Screening Record (PSR) is not calculated in the Perio Chart. You can enter this information in a clinical note.

To open the Perio Chart

In the Patient Chart, with a patient selected, click the **Perio** button  on the toolbar.

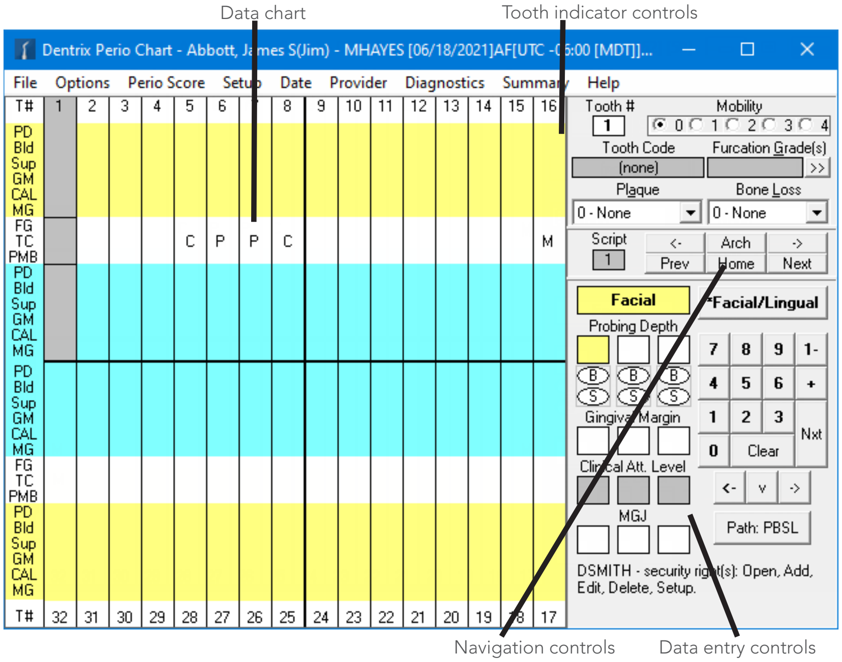
The Perio Chart opens. If the patient does not have a perio exam for today, a new exam is started.

Notes:

- The Perio Chart provider is the provider who is selected in the Patient Chart.
- If a previous perio exam exists for the patient, when the Perio Chart opens, the data chart displays the data from that exam. You can update any of the measurements as needed as you perform a new exam. The updates will be saved as a new exam for today. The previous exam is not affected and remains in history.

The Perio Chart Window

The Perio Chart window is divided into the following areas: the data chart, tooth indicator controls, navigation controls, and data entry controls.



Note: When you open the Perio Chart, the actions that you have been granted permission to perform appear in the lower-right corner. If you attempt to perform an action in the Perio Chart that is prohibited, a user with adequate security rights can override the restriction temporarily so you can complete the task.

Entering New Perio Examinations

A default path has been set up to advance the exam automatically to surfaces and teeth throughout the dentition. With the default path, you enter probing depths in the following order: #1 – 16, facial; #16 – 1, lingual; #17 – 32, facial; and then #32 – 17, lingual.

You can also chart conditions, such as bleeding, suppuration, gingival margin, mobility, furcation grade, and bone loss.

Notes:

- You can enter probing depths using the keyboard as you proceed along the default path. Alternatively, you can enter probing depths in the **Probing Depths** boxes.
- Probing depths of 4 millimeters or greater appear in red font on the perio chart.
- While recording periodontal measurements, if you deviate from the default path to perform a manual entry, you will be advanced automatically the next tooth in the path after the one that you just entered measurements for.
- Each row on the periodontal graphical chart represents one or more measurements or conditions recorded.
- Tooth codes (TC) transfer over from the Patient Chart. A tooth code appears for a tooth if a condition has been posted for that tooth. Some conditions will cause the corresponding tooth to be skipped in the recording paths.

To enter a new perio examination

1. Do one of the following:
   - If you open the Perio Chart, and the patient does not have a perio exam for today, a new exam is started automatically.

     Note: If the patient has a past exam, the data chart displays the data from that exam, and you can save time by entering only the measurements that have changed since the last exam; otherwise, the data chart is blank.
   - If you are viewing a past exam in the Perio Chart, on the **File** menu, click **New Exam**.

   Notes:
   - The Perio Chart provider is the provider who is selected in the Patient Chart.
   - To select a different script for charting the exam, on the **Options** menu, point to **Select Script**, and then click an option. The selected script will be selected by default for all subsequent exams that you start until you select a different script either from the **Options** menu or in the **Perio Entry Setup** dialog box. The script selection is saved per user.
2. Record probing depths for all the facial sites of teeth 1 through 16.

   Note: The yellow area of the tooth data chart represents the buccal/facial surfaces of teeth.
3. Record probing depths for all the lingual sites of teeth 16 through 1.

   Note: The blue area of the tooth data chart represents the lingual surfaces of teeth.
4. Record probing depths for all the facial sites of teeth 17 through 32.
5. Record probing depths for all the lingual sites of teeth 32 through 17.

6. To record periodontal conditions for any tooth, do the following:
   a. Select the facial (yellow) or lingual (blue) area of the tooth. If the correct tooth is already selected, and you need to switch from either facial to lingual or lingual to facial, click the *__Facial/Lingual__ button.

      Note: The tooth number you selected appears in the **Tooth #** box at the top of the area to the right of the data chart.

   b. Specify any of the following:
      - **B (Bleeding)** – Click a "B" oval to indicate a bleeding point on the tooth. A red oval that corresponds to the selected tooth and site appears on the data chart.
      - **S (Suppuration)** – Click an "S" oval to indicate an infection point on the tooth. A yellow oval that corresponds to the selected tooth and site appears on the data chart.
      - **Gingival Margin** – Enter the gingival margin measurements.
      - **MGJ** – Enter the mucogingival junction measurements.
      - **Mobility** – Click the desired mobility classification. The number appears in the center placement of the PMB line on the data chart.
      - **Furcation Grades** – Click the search button to select the appropriate furcation.
      - **Plaque** – From the list, select the appropriate plaque classification. A corresponding number appears in the left placement of the PMB line on the data chart.
      - **Bone Loss** – From the list, select the appropriate bone loss classification. A corresponding number appears in the right placement of the PMB line on the data chart.
7. From the **File** menu, click **Save Exam** to save the exam.

   Notes:

   - If you do not save the exam manually, when you close the Perio Chart, a message will appear and ask you to save the exam.
   - If the Perio Chart provider was changed automatically, if you close the Perio Chart after having started a new exam without saving it, a message regarding the provider being changed automatically appears.

Charting Probing Depths Greater than 9 Millimeters

You can enter pocket depths that are greater than 9 millimeters using the on-screen keyboard in the Perio Chart.

To enter a pocket depth greater than 9 millimeters

1. Select the facial (yellow) or lingual (blue) area of the tooth.
2. Click the appropriate surface box under **Probing Depths**.
3. Click the **1-** button, and then click a number button. For example, to record 12 mm, you would click **1-** and then **2**.

   Note: A measurement greater than 9 mm appears as a greater-than sign [>] on the data chart.

Recording Gingival Inflammation

You can note whether a pocket is related to a Gingival Margin (GM) that is above the Cemento-Enamel Junction (CEJ) by using the keyboard buttons.

To enter gingival inflammation

1. Select the facial (yellow) or lingual (blue) area of the tooth.
2. Click the appropriate surface box under **Gingival Margin**.
3. To enter a gingival margin that is above the CEJ as a positive number to indicate inflammation and not loss of attachment click the **+** button, and then click a number button. For example, to record 2 mm, you would click **+** and then **2**.

   Note: The positive gingival margin appears as a black box with white number on the data chart.

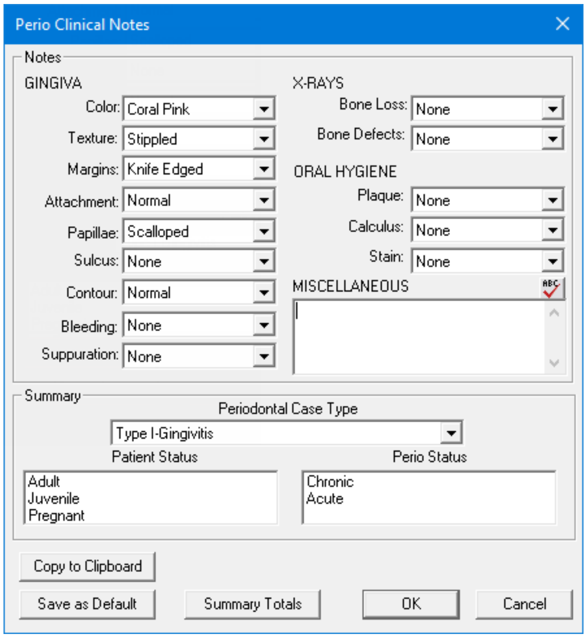
Entering Diagnostics

In addition to perio measurements, other perio data can be added to the current perio exam. This data can be used to create customized letters for insurance companies, patients, and so forth.

To add diagnostic information to the current exam

1. On the menu bar, click **Diagnostics**.

   The **Perio Clinical Notes** dialog box appears.



2. Set up the following options:
   - **GINGIVA** – Select the options appropriate to the condition of the patient's gingiva: **Color**, **Texture**, **Margins**, **Attachment**, **Papillae**, **Sulcus**, **Contour**, **Bleeding**, and **Suppuration**. Some of the lists have a "None" option.
   - **X-RAYS** – Select the options appropriate to any **Bone Loss** and **Bone Defects** indicated by an X-ray. Both of the lists have a "None" option.
   - **ORAL HYGIENE** – Select the options appropriate to the state of the patient's oral hygiene: **Plaque**, **Calculus**, and **Stain**. All of the lists have a "None" option.
   - **MISCELLANEOUS** – Type any miscellaneous information.
   - **Periodontal Case Type** – Select the appropriate type for the patient.
   - **Patient Status** – Select the appropriate patient status.
   - **Perio Status** – Select the appropriate perio status.
3. If you want to copy the information in the **Perio Clinical Notes** dialog box to the Clipboard in a text format, click **Copy to Clipboard**.
4. If you want to save the current selections as the defaults for the next time you open the **Perio Clinical Notes** dialog box for any patient, click **Save as Default**.
5. If you want to view statistics about the patient's perio condition, probing depths, and clinical attachment level, click **Summary Totals**.
6. Click **OK** to save the diagnostic information as a permanent part of the current exam.

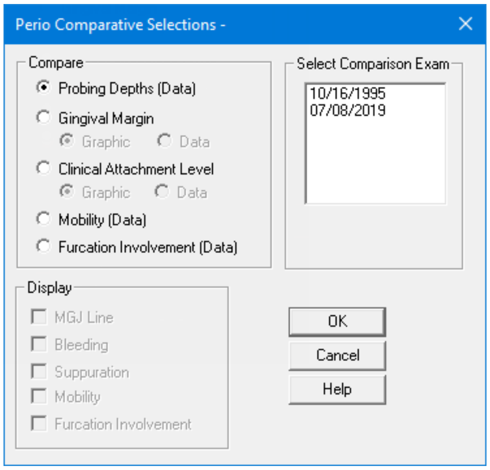
Comparing Perio Exams

To help you educate your patients regarding periodontal disease progression, you can compare up to four saved perio exams with the current exam.

To compare exams

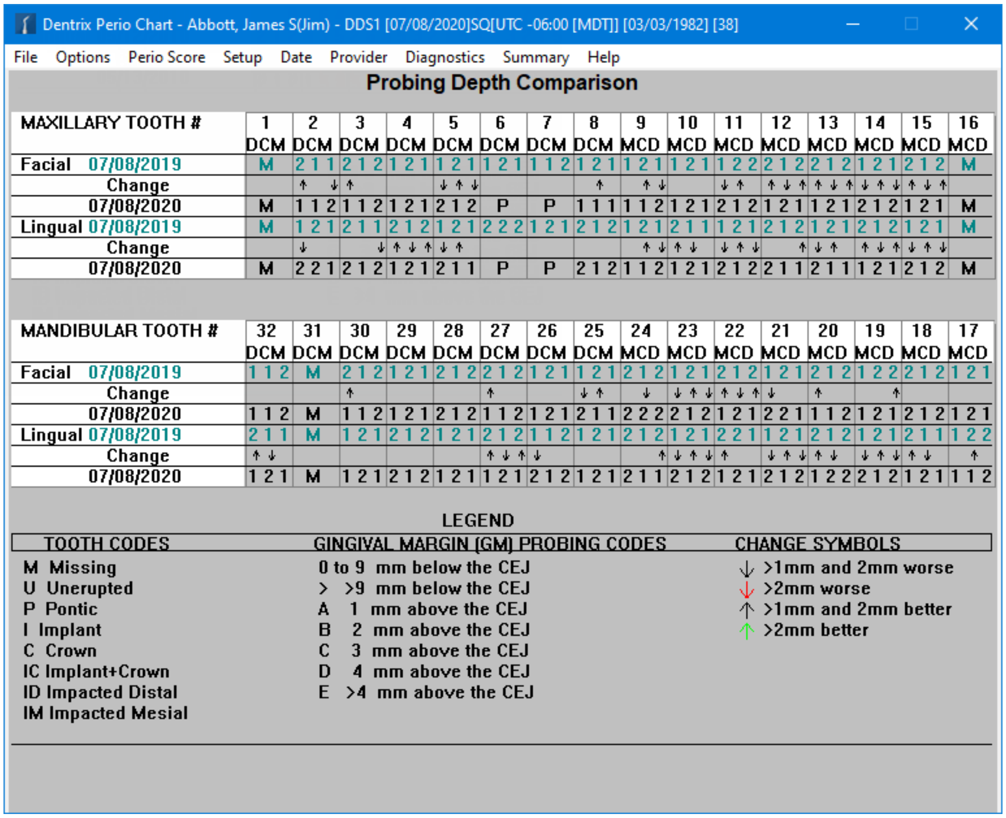
1. In the Perio Chart, from the **Options** menu, click **Exam Comparison**.

   The **Perio Comparative Selections** dialog box appears.



2. Under **Compare**, select the type of comparison that you want view:
   - **Probing Depths (Data)** – To review a data comparison of probing depth measurements.
   - **Gingival Margin** – To review a comparison of gingival margin measurements. Select whether to view a **Graphic** or **Data** representation.
   - **Clinical Attachment Level** – To review a comparison of CALs. Select whether to view a **Graphic** or **Data** representation.
   - **Mobility** – To review a data comparison of mobility measurements.
   - **Furcation Involvement** – To review a data comparison of furcation grades.
3. Under **Display**, select what you want to display: **MGJ Line**, **Bleeding**, **Suppuration**, **Mobility**, or **Furcation Involvement**. These options are not available if **Probing Depths (Data)** is selected under **Compare**.
4. Under **Select Comparison Exam**, select the exams you want to compare to the current exam.
5. Click **OK**.

The comparison appears.



Changing the Perio Exam View

From the Perio Chart, you can view perio data in several different formats:

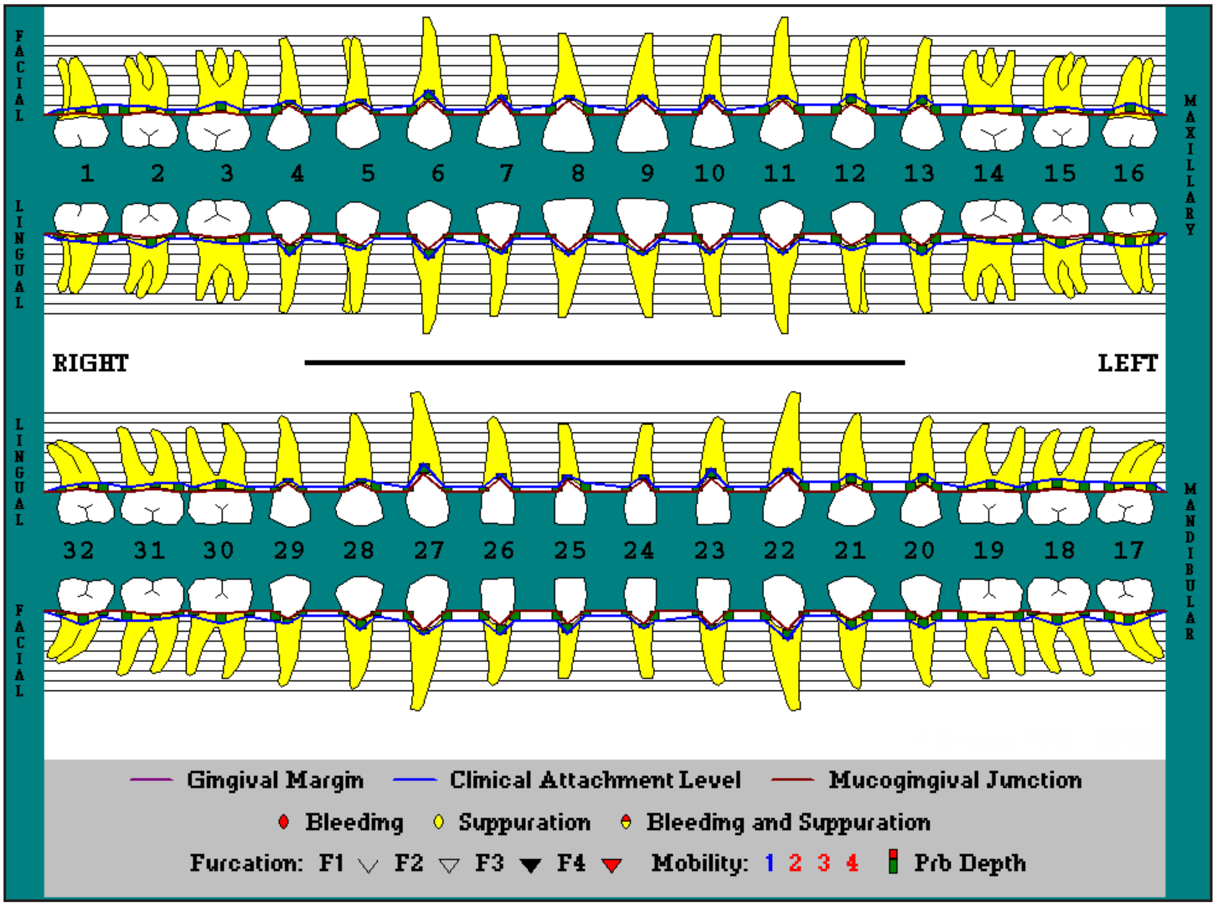
- Graphic Chart
- Combined Graphic and Data Chart
- Quadrants

Viewing the Graphic Chart

Unlike the data chart, which displays perio data numerically, the Perio Chart's graphic chart view displays numeric perio data in a graphical representation. You cannot add or change data while in the graphic chart view.

To view the graphic chart

In the Perio Chart, from the **Options** menu, click **Graphic Chart**.

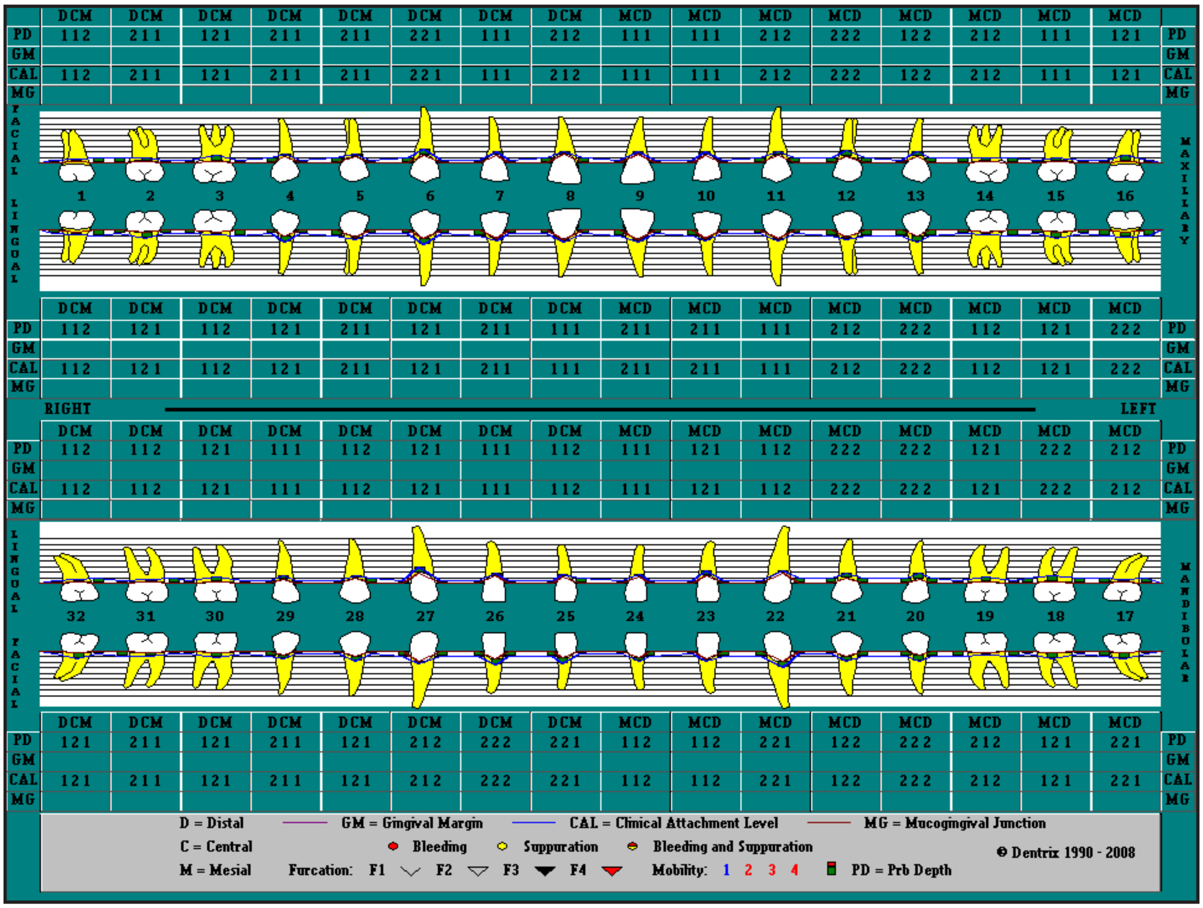


Viewing the Combined Graphic and Data Chart

In the Perio Chart, you can view a combination of the data chart and graphic chart. Numerical data appears above the graphic portion of the chart. You cannot add or change data while in the data and graphic chart view.

To view the combined graphic and date chart

In the Perio Chart, from the **Options** menu, click **Combined Graphic & Data Chart**.



Viewing Quadrants

You can enlarge a quadrant to view that area close up.

To zoom in on a quadrant

1. While viewing the data chart or graphic chart, click in the quadrant you want to view.
2. From the **Options** menu, click **Quadrant Zoom**.
3. If you want to zoom back out to see all quadrants or to select a different quadrant to zoom in on, while in the quadrant zoom mode, right-click anywhere in the window to zoom out so that all quadrants are being viewed in the graphic chart (the pointer changes to a magnifying glass), and then click the desired quadrant.
4. When you are finished using the quadrant zoom feature, from the **Options** menu, click **Quadrant Zoom** again to get out of the quadrant zoom mode.

Chapter 11: Clinical Notes

Keeping accurate and thorough documentation of each procedure performed in the dental office is an essential part of clinical dentistry. In Dentrix Enterprise, you can enter a clinical note to store information about a patient's exam and treatment that are not specific to a procedure.

Notes:

- A dental clinical note will be added automatically to the corresponding patient's medical record (in PowerChart) when that note is signed. Medical notes are not added automatically to patients' dental records.
- There may be times when a clinical note is entered without a code being posted. For example, if an appointment is not needed for a patient's treatment request, create a clinical note using the **No Face to Face** template, and enter the reason for the patient not needing an appointment in that clinical note.

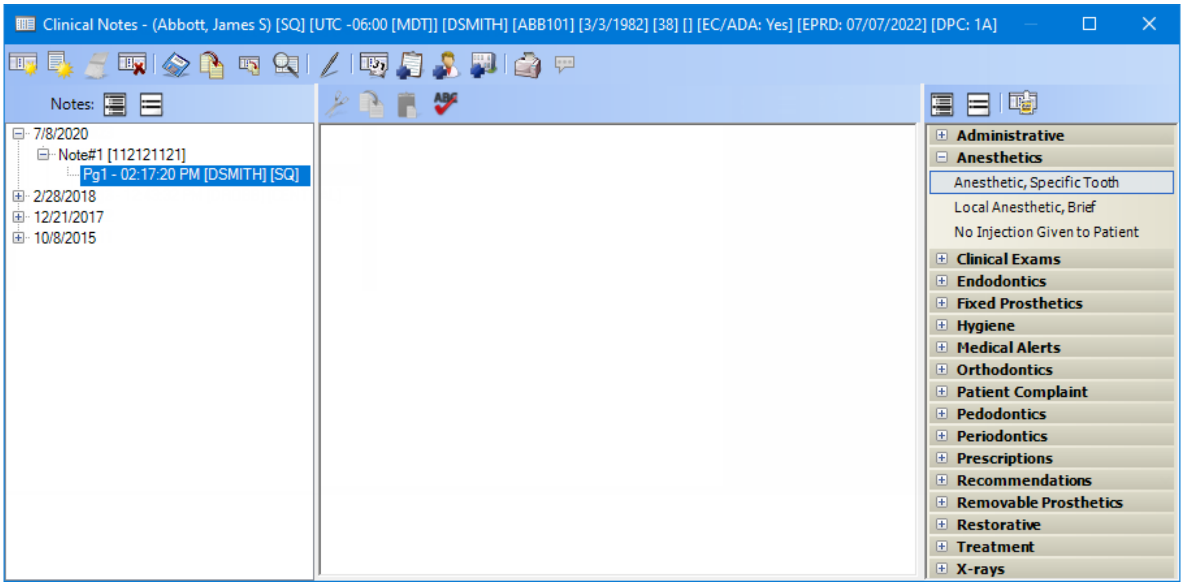
Viewing Clinical Notes

You will access the Clinical Notes from the Appointment Book or Patient Chart.

To view clinical notes

With a patient's appointment selected in the Appointment Book, click the **Clinical Notes** button  on the toolbar.

The **Clinical Notes** window opens.



To see all the pages of all clinical notes, click the **Expand All** button .

To see the pages of a specific clinical note, click the plus sign (+) next to a date and then a note. When you select a page, you should see all of the posted procedures.

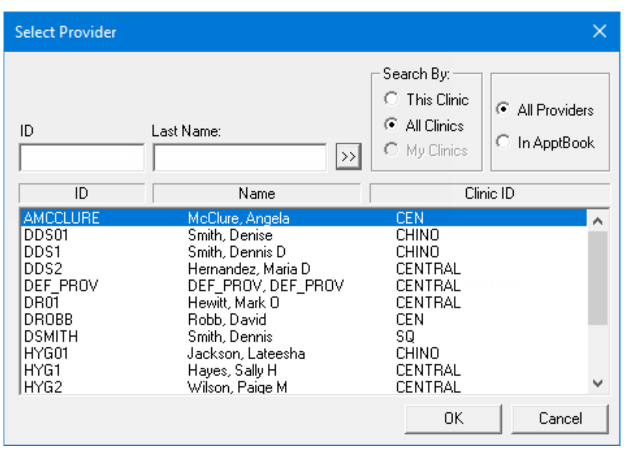
Changing the Provider

If the correct provider is not attached to the page of a clinical note, you can change the provider.

To change the provider for a note

1. With a clinical note page selected, click the **Change Provider for Selected Note** button  on the toolbar.

   The **Select Provider** dialog box appears.

2. Select a provider, and then click **OK**.

Entering Clinical Notes Using Templates

You can use templates to quickly create and add to clinical notes.

To enter a clinical note using a template

1. Do one of the following:

   - To add a clinical note, click the **New Clinical Note** button . The **Change Date and Time** dialog box appears. Leave the current date and system time entered, or type a different date and time. Then, click **OK**.

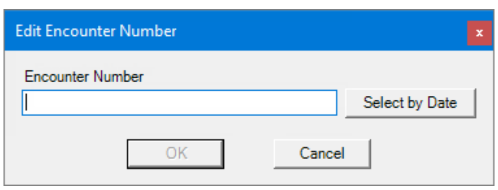
     Important: The date of the clinical note should be the date of service (dental encounter).

   - To add a page to an existing clinical note, with that note selected, click the **New Clinical Note Page** button . The **Change Time** dialog box appears. Leave the current system time entered, or type a different time. Then, click **OK**.

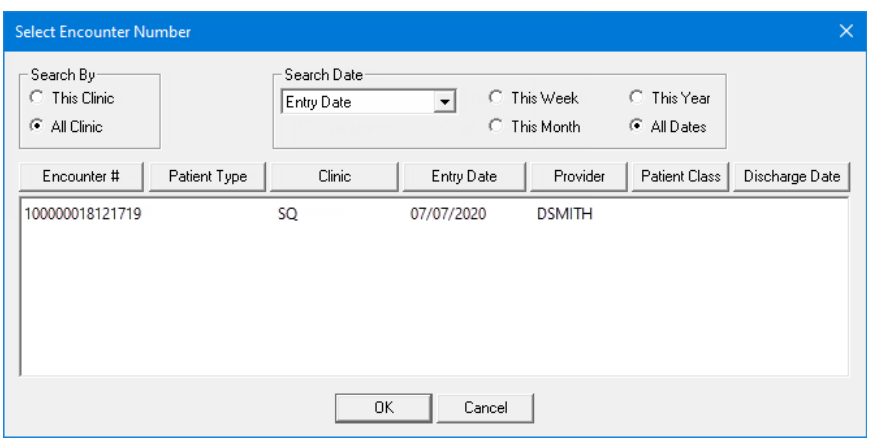
   Note: If a clinical note page is not selected when you choose a template, a new clinical note will be added. So, to add a template to an existing note, make sure the correct page of that clinical note is selected.

2. If you are adding a clinical note without a corresponding scheduled appointment, you must attach an encounter number to the clinical note. If the **Edit Encounter Number** dialog box does not appear automatically, to attach an encounter number to the clinical note, do the following:

   a. Click the **Change Encounter For Selected Note** button .

   b. Click **Select by Date**.

   c. Search for and select the correct encounter number, and then click **OK**.

   Note: You should select the open encounter (the encounter without a discharge date) that corresponds with the patient's status (either outpatient for an institutional encounter or inpatient for an inpatient setting). Selecting the correct encounter in Dentrix Enterprise ensures that documentation in the EHRS is associated with the correct encounter.

   d. Click **OK**.

3. In the template pane (on the right), expand a category to view the list of available templates for that category by clicking the plus sign (+) next to the category name, and then double-click the desired template.
4. Respond to the prompts associated with the template, if applicable.

   The template text and any responses you entered appear in the note field (in the middle).

   Note: You can edit the note or add additional information as needed.

5. Click the **Save Clinical Note** button .

Entering Clinical Notes Manually

You can create a clinical note with text that you enter manually.

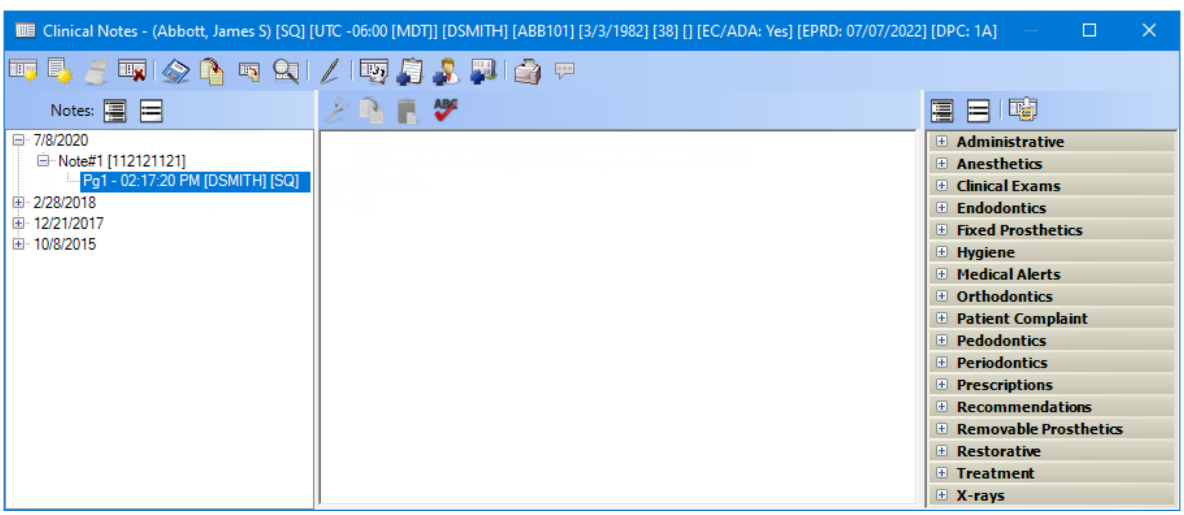
To enter a clinical note

1. Do one of the following:

   - To add a clinical note, click the **New Clinical Note** button . The **Change Date and Time** dialog box appears. Leave the current date and system time entered, or type a different date and time. Then, click **OK**.

     Important: The date of the clinical note should be the date of service (dental encounter).

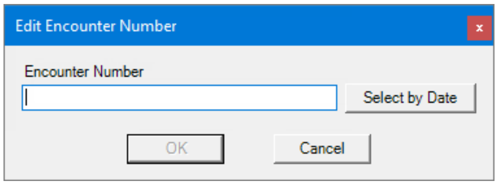
   - To add a page to an existing clinical note, with that note selected, click the **New Clinical Note Page** button . The **Change Time** dialog box appears. Leave the current system time entered, or type a different time. Then, click **OK**.



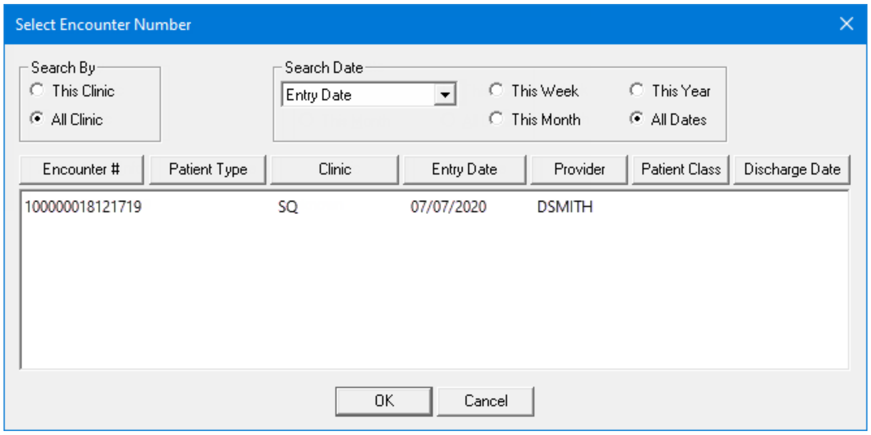
2. If you are adding a clinical note without a corresponding scheduled appointment, you must attach an encounter number to the clinical note. If the **Edit Encounter Number** dialog box does not appear automatically, to attach an encounter number to the clinical note, do the following:

   a. Click the **Change Encounter For Selected Note** button .

The **Edit Encounter Number** dialog box appears.



b. Click **Select by Date**.



c. Search for and select the correct encounter number, and then click **OK**.

Note: You should select the open encounter (the encounter without a discharge date) that corresponds with the patient's status (either outpatient for an institutional encounter or inpatient for an inpatient setting). Selecting the correct encounter in Dentrix Enterprise ensures that documentation in the EHRS is associated with the correct encounter.

d. Click **OK**.

3. Type the text of the note in the field in the middle of the window.

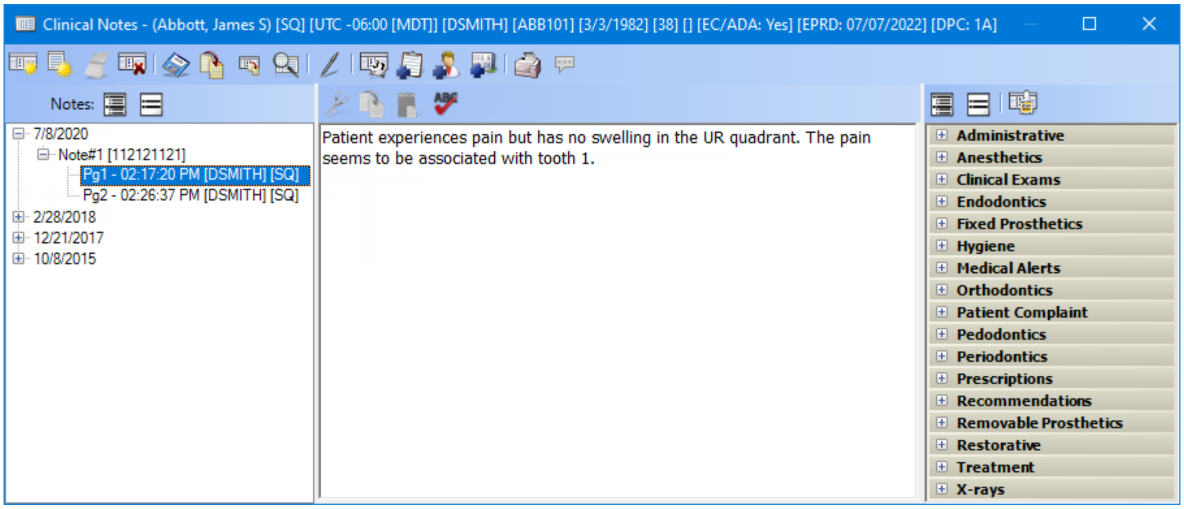
4. Click the **Save Clinical Note** button .

Editing Clinical Notes

You can edit a clinical note that has note been signed.

To edit a clinical note

1. With a clinical note's page selected, edit existing text, type other text manually, or insert text by using a template.



2. Click the **Save Clinical Note** button .

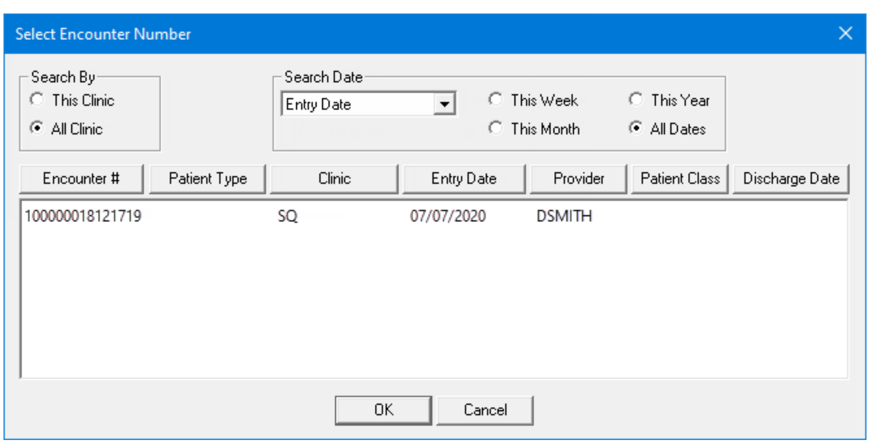
Signing Clinical Notes

Once a clinical note has been completed, sign it.

Tip: You can also sign clinical notes from the Signature Manager (which you can access from the Office Manager).

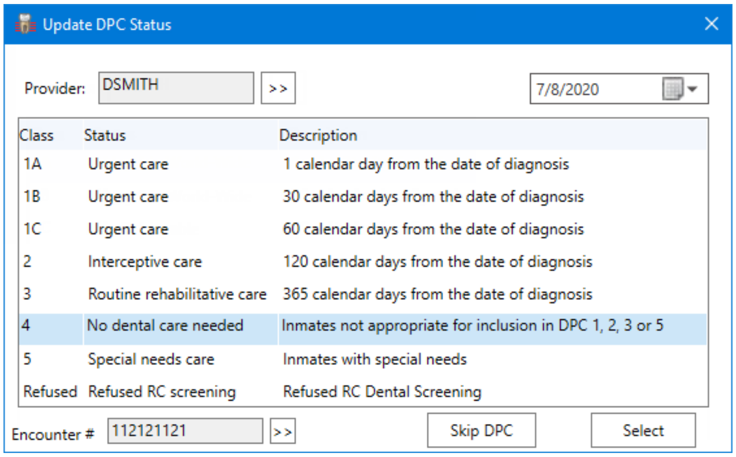
To sign a clinical note

1. With a clinical note's page selected, click the **Sign Clinical Note** button .
2. If an encounter number is not already attached to the clinical note, the **Select Encounter Number** dialog box appears. Search for and select the correct encounter number, and then click **OK**.



Note: You should select the open encounter (the encounter without a discharge date) that corresponds with the patient's status (either outpatient for an institutional encounter or inpatient for an inpatient setting). Selecting the correct encounter in Dentrix Enterprise ensures that documentation in the EHRS is associated with the correct encounter.

The **Update DPC Status** dialog box appears.



3. Do one of the following:
   - **Update the status** – Verify that the correct **Provider** is selected. If it is not, click the search button >> to select the correct provider. Next, select the correct status based on the patient's treatment plans. Then, click **Select**.
   - **Do not update the status** – If the patient's DPC has already been set for the visit, click **Skip DPC**.

Notes:

- If you updated the DPC, a "Signed on [date]" stamp is added to the end of the clinical note.
- If you skipped updating the DPC, a "[User ID] selected Skip DPC button for DPC update" stamp is added to the end of the clinical note.
- If you select a clinical note that has been signed, the **Sign Clinical Note** button changes to the **Signature** button.
- The background of a signed clinical note's page becomes gray to indicate that it is signed and locked.

Appending Clinical Notes

You cannot edit a clinical note that has been signed. However, if errors or omissions are discovered after a clinical note has been locked, it must be appended in order to make any corrections or additions. You can add a page to a signed clinical note to append it.

To append a clinical note

1. With a note selected, click the **New Clinical Note Page** button. The **Change Time** dialog box appears. Leave the current system time entered, or type a different time. Then, click **OK**.
2. Create the clinical note as explained in "Entering Clinical Notes Using Templates" in this chapter.
3. Click the **Save Clinical Note** button.
4. Sign the clinical note page as explained in "Signing Clinical Notes" in this chapter.

Using the Signature Manager

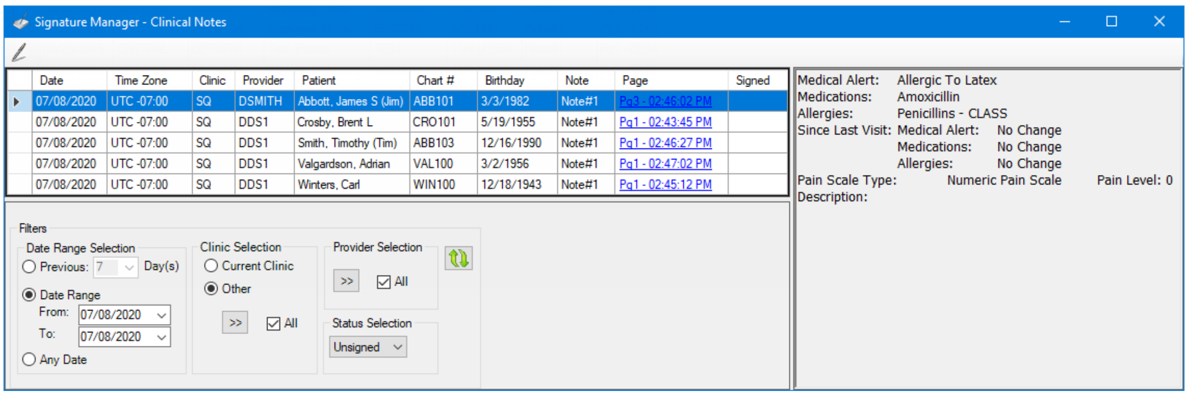
You can review and sign clinical notes from the Signature Manager.

Note: You cannot make updates or addendums to clinical notes from the Signature Manager. You must do so from the Clinical Notes for the corresponding patient.

To view clinical notes in the Signature Manager

1. While logged in to Dentrix Enterprise as the user who needs to sign clinical notes, in the Office Manager, click the **Signature Manager** button.

   The **Signature Manager** dialog box appears.



2. Set up the following **Filters** as needed:
   - **Date Range Selection** – Select one of the following options:
     - **Previous** – To view clinical notes for the specified number of days prior to today's date. Enter the number of days.
     - **Date Range** – To view clinical notes within the specified date range. Select the starting and ending dates of the range.
     - **Any Date** – To view clinical notes for any date.
   - **Clinic Selection** – Select one of the following options:
     - **Current Clinic** – To view clinical notes for the clinic that you are currently logged in to.
     - **Other** – To view clinical notes for specific clinics or all clinics. Either click the search button >> to select the clinics whose clinical notes you want to view, or select the **All** check box to include all clinics' clinical notes.
   - **Provider Selection** – Click the search button >> to select the providers whose clinical notes you want to view, or select the **All** check box to include all providers' clinical notes.
   - **Status Selection** – Select whether you want to view all, unsigned, or signed clinical notes.
3. Click the **Refresh** button to apply the specified filters.

   Only the clinical notes that match the specified criteria appear in the list.
4. For each clinical note that you need to sign, do the following:

   a. Select the clinical note to review it.

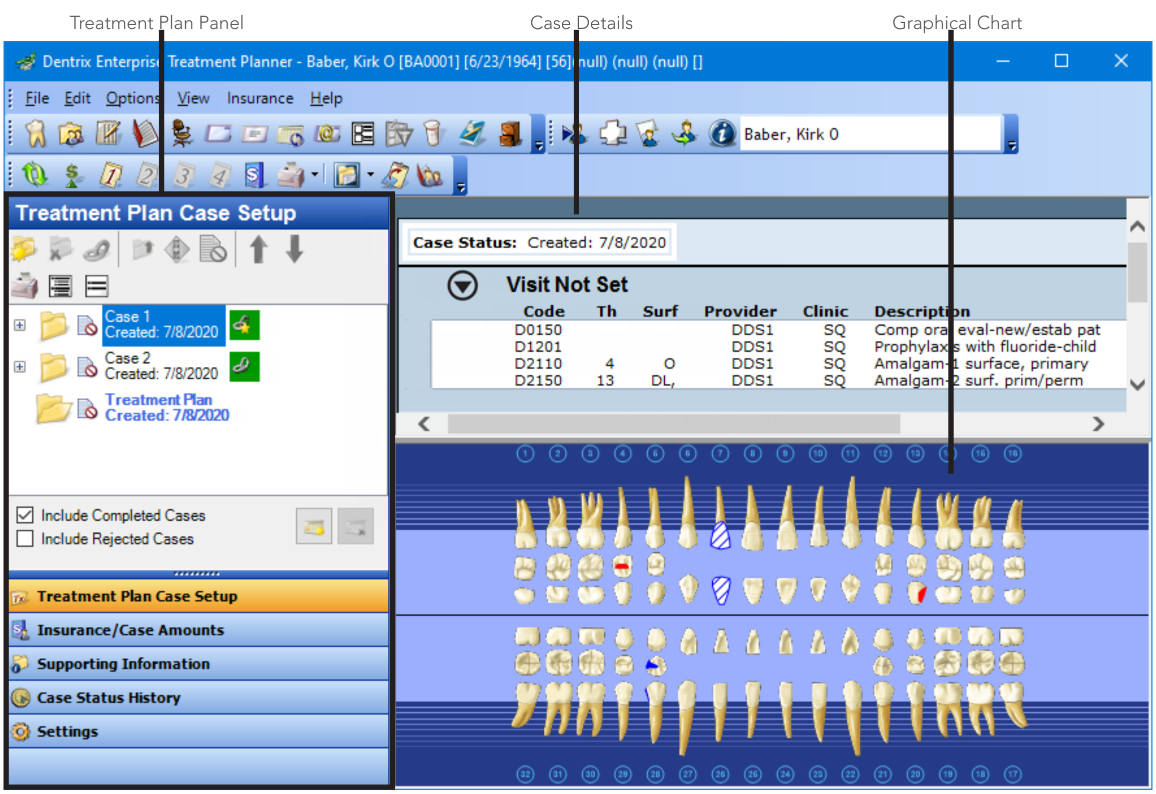
   b. Click the **Sign** button to sign the clinical note as explained in "Signing Clinical Notes" in this chapter.

Chapter 12: Treatment Planner

In the Dentrix Enterprise Treatment Planner, you can organize treatment based on a patient's Dental Priority Classification (DPC). Also, you can prioritize treatment and set the Approval Code. Dentrix Enterprise automatically adds all procedures that are treatment-planned from the Patient Chart into the default treatment plan case folder.

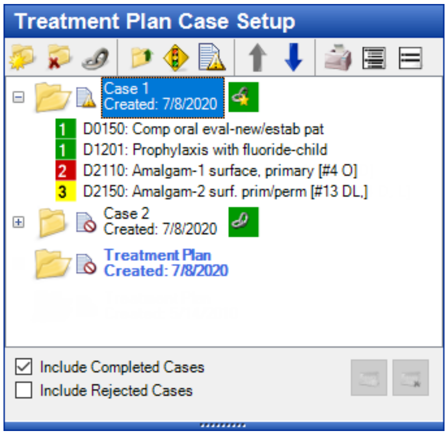
To open the Treatment Planner, with a patient selected in the Patient Chart, click the **Treatment Planner** button  on the toolbar.

The **Treatment Planner** window consists of a menu bar, toolbars, the Treatment Plan panel, the case details, and the graphical chart or progress notes.



Viewing Treatment Plans

The **Treatment Plan Case Setup** section on the Treatment Plan panel displays the treatment plan cases that have been created for a patient.

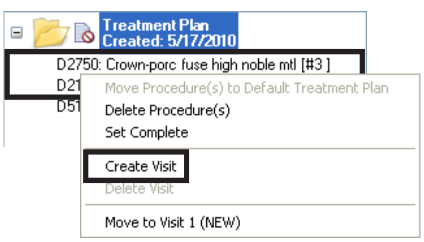


Prioritizing Treatment Plans

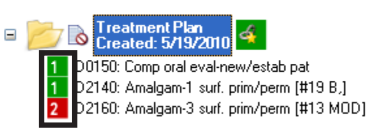
When more than one visit is required to complete a treatment plan case, you can organize the procedures in that case into visits, so you know which procedures will be done in each visit.

To order procedures by visit

1. In the Treatment Planner, on the Treatment Plan panel, from the **Treatment Plan Case Setup** section, expand the appropriate case by clicking the plus sign (+).
2. Select the procedures that will be completed in one visit (to select multiple, while pressing the Ctrl key, click each procedure). Next, right-click one of the selected procedures, and then click **Create Visit**.

   Repeat this step for all subsequent visits of the treatment plan. As visits are created, the number of the visit increases (1, 2, 3, and so forth). The specified visit numbers appear next to the procedures.

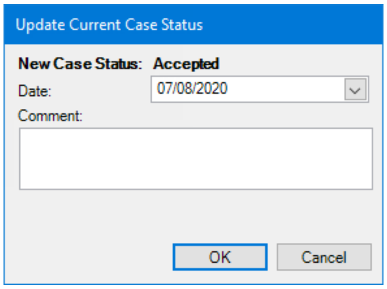
   Note: The visit order also appears for your reference when selecting a **Tx** appointment reason from the **Appointment Information** dialog box.

3. After you have prioritized treatment in the case, you must change the status of the case to "Accepted." Any additional treatment will go into a new case folder. To accept the case, do the following:

   a. Select the case folder.

   b. Click the **Update Case Status** button , and then click **Accepted** on the button menu.

The **Update Current Case Status** dialog box appears.



c. Leave today's date entered, or select the correct date that the case was accepted.

d. Enter any relevant notes.

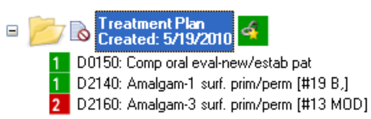
e. Click **OK**.

Changing Treatment Plan Approval Statuses

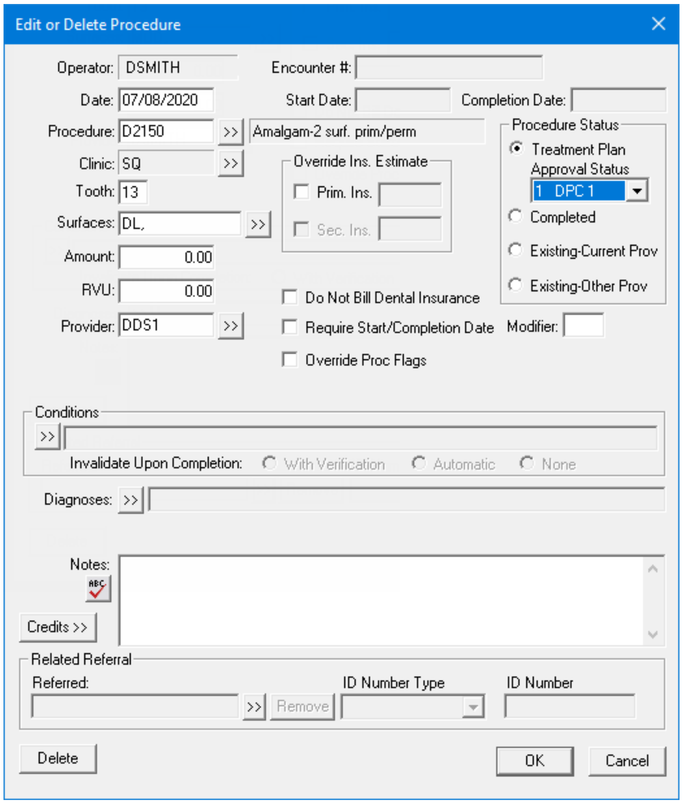
After prioritizing a treatment plan, the dentist can assign a DPC code to each procedure of that plan. This information will be transferred back to the Treatment Request Manager and the Unscheduled Treatment Plan list of the Scheduling Assistant.

To change the approval status of an individual procedure

1. In a treatment plan case folder, double-click a procedure.



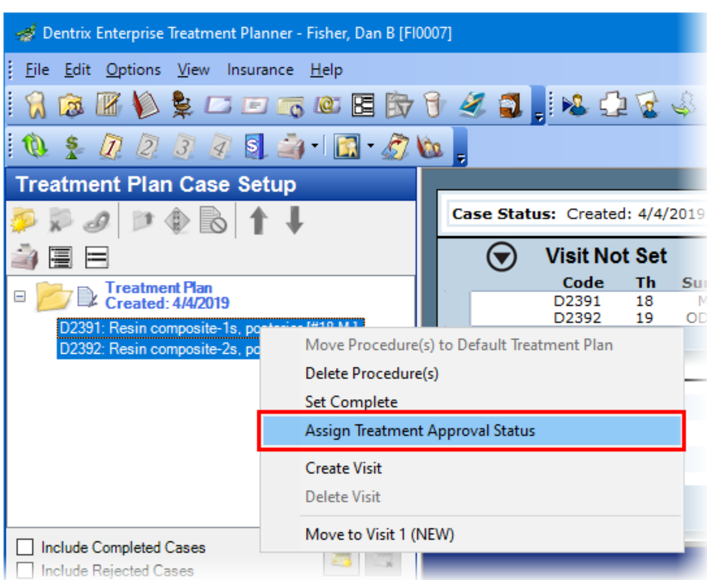
The **Edit or Delete Procedure** dialog box appears.



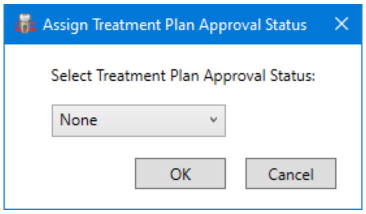
2. Under **Procedure Status** on the right, from the **Approval Status** list, select a DPC code.
3. Click **OK**.

To change the approval status of multiple procedures

1. In a treatment plan case folder, select procedures, right-click one of the selected procedures, and then click **Assign Treatment Approval Status**.



The **Assign Treatment Approval Status** dialog box appears.



2. From the **Select Treatment Approval Status** list, select the DPC code that you want to apply to all the selected procedures.
3. Click **OK**.

Note: If any of the selected procedures already has an approval status, and it is different from the status that you selected in the **Assign Treatment Approval Status** dialog box, the approval status will be changed for those procedures.

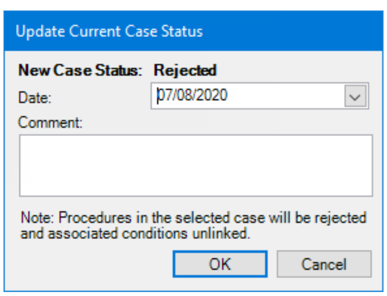
Rejecting Treatment Plans

If a patient refuses all or certain treatment, you can reject those procedures in the Treatment Planner. Rejected treatment is removed from the odontogram.

To reject all treatment in a case

1. Select a treatment plan case folder.
2. Click the **Update Case Status** button , and then click **Rejected** on the button menu.

   The **Update Current Case Status** dialog box appears.The **Update Current Case Status** dialog box appears.



   Note: If any procedures have linked conditions, a note appears at the bottom of the dialog box to inform you that the associated conditions will be unlinked from the rejected procedures.

3. Leave today's date entered, or select the correct date that the case was rejected.
4. Enter the reason that the treatment was refused.
5. Click **OK**.

To reject partial treatment

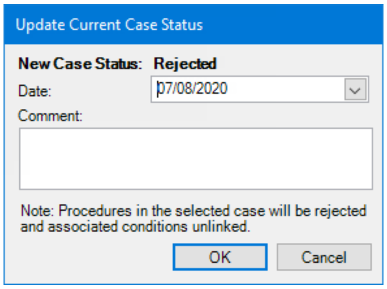
1. Create a new treatment plan case folder as explained in "Creating Treatment Plan Cases" in this chapter.

   Note: If you need to rename the folder, you can do so by right-clicking it and clicking **Rename Case**.

2. Drag the rejected procedures into the new folder.

3. Click the **Update Case Status** button , and then click **Rejected** on the button menu.

   The **Update Current Case Status** dialog box appears.



4. Leave today's date entered, or select the correct date that the case was rejected.
5. Enter the reason that the treatment was refused.
6. Click **OK**.

To reject irrelevant treatment

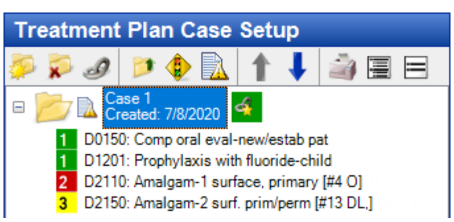
If, for example, an RCT was treatment planned for a tooth, but that tooth was subsequently extracted, create a new case folder, put that extraction procedure in it, and then reject the new case.

Creating Treatment Plan Cases

To maximize the patient experience, you want make treatment planning customized and personal, but you also want to maintain efficiency. When you post treatment-planned procedures in the Ledger or the Patient Chart, Dentrix automatically places those procedures into a default treatment plan case in the Treatment Planner. However, you can create additional treatment plan cases to group and organize procedures. This allows you to track the status of or prioritize various courses of treatment.

To create a new case

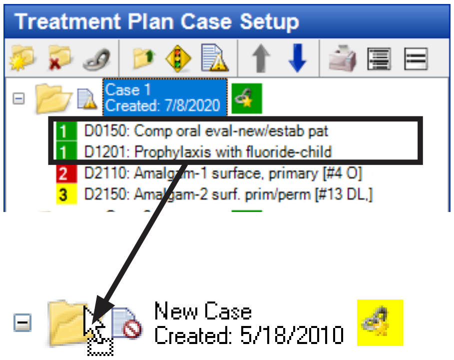
1. In the Treatment Planner, on the Treatment Plan panel, from the **Treatment Plan Case Setup** section, click the **New Case** button .



   The new case appears in the case list.

2. Type a name for the case, and then press Tab or Enter to apply the name.

3. All treatment-planned procedures are automatically added to the default case ("Treatment Plan" is the name if it has not been renamed). Select the desired procedures in the default case (to select multiple procedures, while holding down the Ctrl key, click the procedures), and then drag the selected procedures to the new case.



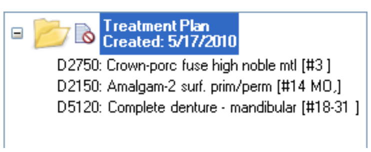
Tip: If all the procedures in the default treatment plan case will be put into the same case, you can rename the default case to avoid having to create a new case and move the procedures into the new case.

Deleting Treatment

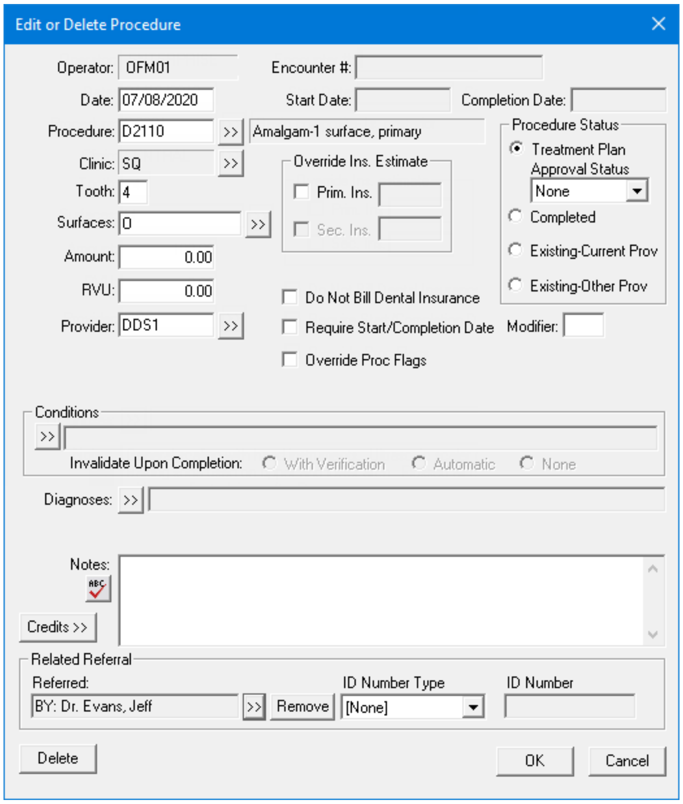
You can delete existing treatment-planned procedures that are not in history. For example, if a panorex was treatment planned a year ago and is no longer necessary, you can delete that procedure.

To delete a treatment-planned procedure

1. In the Treatment Planner, on the Treatment Plan panel, from the **Treatment Plan Case Setup** section, expand the appropriate case by clicking the plus sign (+), and then double-click a procedure.



The **Edit or Delete Procedure** dialog box appears.



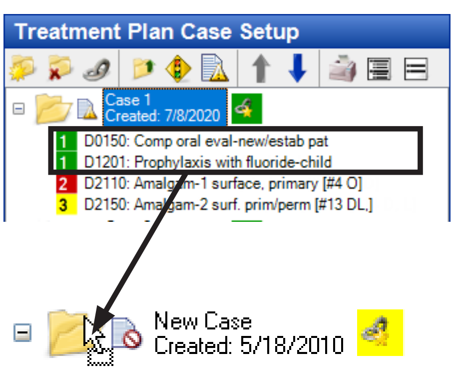
2. Click **Delete**.
3. On the confirmation message that appears, click **OK**.

   The treatment-planned procedure is removed from the Treatment Planner, Patient Chart, and Ledger-Treatment Plan.

Tip: To delete multiple procedures at the same time, in the **Treatment Plan Case Setup** section, while pressing the Ctrl key, click the procedures you want to delete. Next, right-click one of the selected procedures, and then click **Delete Procedure(s)**. Then, on the confirmation message that appears, click **Yes**.

Moving Treatment Between Cases

To move treatment between cases, select the desired procedures in one case (to select multiple procedures, while holding down the Ctrl key, click the procedures), and then drag the selected procedures to another case.



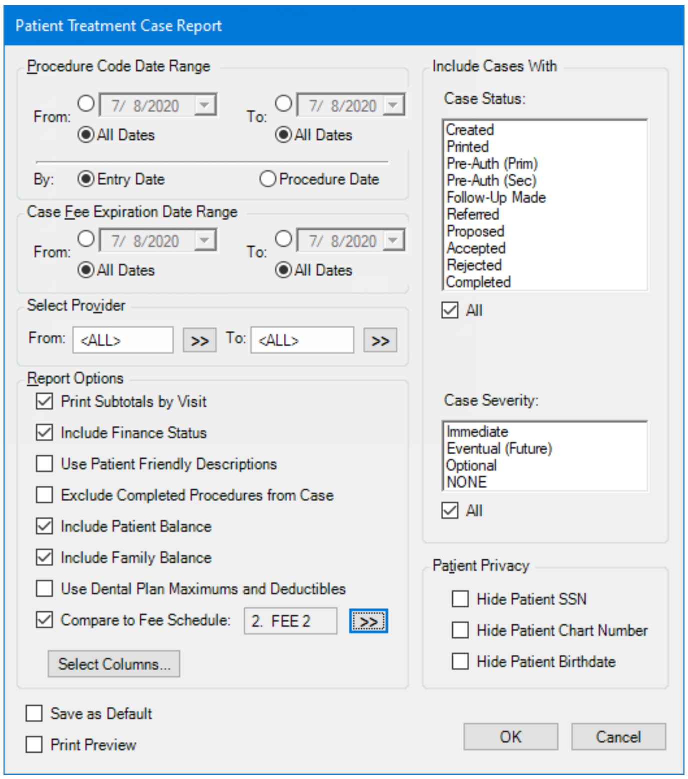
Printing the Patient Treatment Case Report

You can print the Patient Treatment Case Report for the current patient and customize the data that appears on the report.

To generate the Patient Treatment Case Report

1. In the Treatment Planner, on the Treatment Plan panel, click the **Print** button, and then click **Patient Treatment Case Report** on the button menu.

   The **Patient Treatment Case Report** dialog box appears.



3. Set up any of the following options:
   - **Procedure Code Date Range** – Enter a date or date range of treatment-planned procedures posted in the range to include. To include all dates, select **All Dates** for **From** and **To**.
   - **Case Fee Expiration Date Range** – Enter a date or date range of cases with an expiration date within that range to include. To include all dates, select **All Dates** for **From** and **To**.
   - **Select Provider** – To select a provider or range of providers for the patient's treatment-planned procedures to include, click the **From** and **To** search buttons, and select the providers. To include all providers, leave **From** "<ALL>" **To** "<ALL>" entered.
   - **Report Options**:
     - Select the options that correspond to the information you want to include.
     - To include a comparison of the current fee schedule to a selected fee schedule, select the **Compare to Fee Schedule** search button, and select a fee schedule.

- **Include Cases With** – Select the case statuses that you want to include, or select **All** to include all statuses. Also, select the case severities that you want to include, or select **All** to include all severity levels.
- **Patient Privacy** – Select the options that correspond to the patient information you want to exclude.

Tips:

- To save the current report settings as a set for the next time you run this report, select **Save as Default**.
- To preview the report before printing it, select **Print Preview**.

4. Click **OK**.

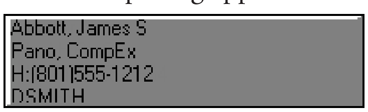
Chapter 13: End of Day

At the end of the day, do the following:

1. Verify that all appointments are set complete in the Appointment Book.
2. Verify that all procedures are completed by generating a day sheet.
3. Sign any unsigned clinical notes from the Signature Manager.
4. Verify that there are not any patient credit balances by generating an aging report.

Verifying Completed Appointments

While viewing today in the Appointment Book, all appointments should be grayed out. For information about completing appointments, see “Completing Appointments” in Chapter 8: Appointment Book.



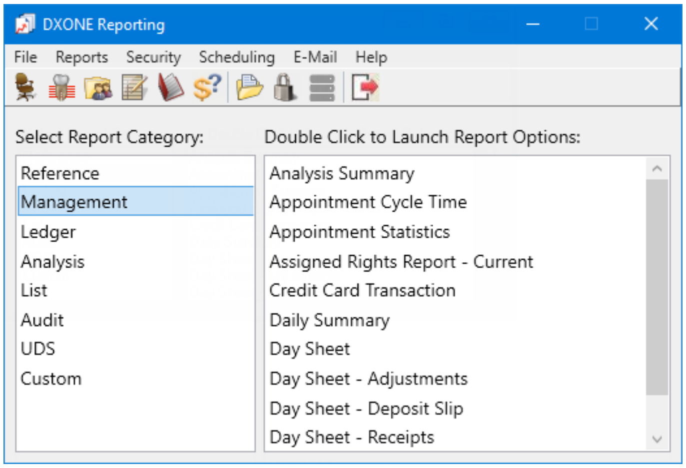
Generating a Day Sheet

To make sure that each patient who was seen today has had a procedure posted and that a visit co-pay and/or dental lab fee has been charged.

To generate a day sheet

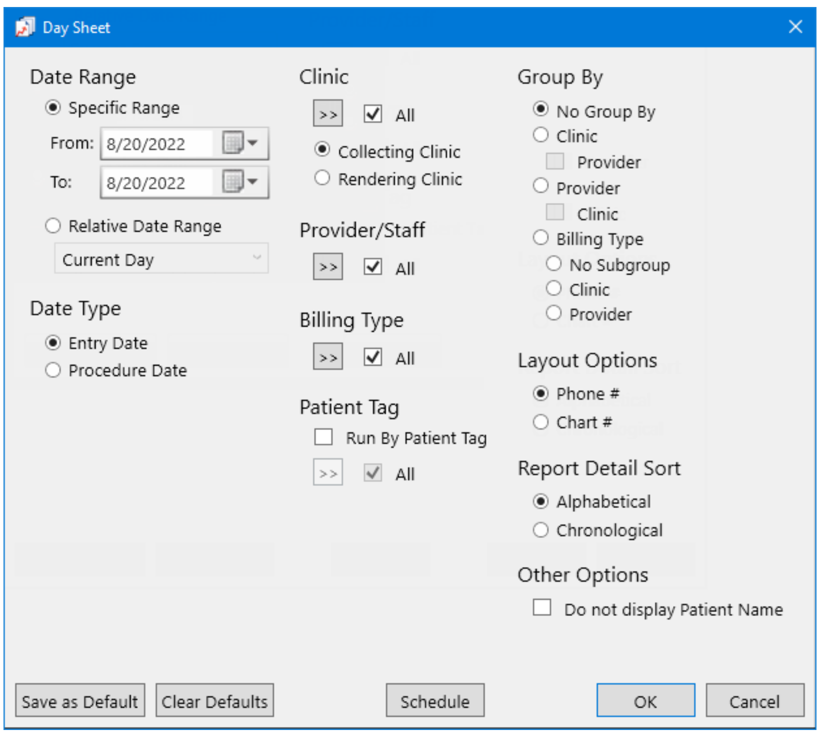
1. In the Office Manager, click the **DXOne Reports** button  on the toolbar.

The **DXONE Reporting** dialog box appears.



2. From the **Select Report Category** list box, select **Management**.
3. In the **Double Click to Launch Report Options** list box, double-click **Day Sheet**.

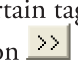
   The **Day Sheet** dialog box appears.



4. Set up the following options:
   - **Date Range** – Do one of the following:
     - Leave **Specific Range** selected and today's date entered in the **From** and **To** fields.
     - Select **Relative Date Range**, and then select **Current Day** from the list.

   Note: For a credit or charge to be included on the report, it must have a date within the date range or relative date range, based on the **Date Type**.

- **Date Type** – Select whether to run the report by **Entry Date** or **Procedure Date**. Entry date indicates the date of a transaction that was entered into the database. Procedure date indicates the date of a transaction that was manually changed. Most of the time, procedures will have the same entry and procedure date. They will only differ when you backdate a procedure. Applied credits use the allocate date instead of entry or procedure date.
- **Clinic** – Click the search button  to select the clinics you want to include on the report, or leave **All** selected to include all clinics. Select whether to run the report by **Collecting Clinic** or **Rendering Clinic**.
    - When specific clinics are selected for the **Collecting Clinic**, the report will include the following:
        - Credits where the collecting clinic is specified
        - Charges where the rendering clinic is specified
    - When specific clinics are selected for the **Rendering Clinic**, the report will include the following:
        - Suspended credits where the collecting clinic is specified
        - Applied credits where the rendering clinic is specified
        - Charges where the rendering clinic is specified
- **Provider/Staff** – Click the search button  to select the providers/staff members you want to include on the report, or leave **All** selected to include all providers and staff members.

  The following stipulations apply when selecting a provider:
    - The report will only include transactions associated with the rendering provider(s) specified.
    - If any providers are specified, the report will not include any suspended credits regardless of the group by option specified.
- **Billing Type** – Click the search button  to select the billing types for the patients you want to include on the report, or leave **All** selected to include all billing types.
- **Patient Tag** – To have the report include patients with certain tags assigned to them, select the **Run By Patient Tag** check box; and then click the search button  to select the desired patient tags, or leave **All** selected to include all patient tags. To not filter the report by patient tag, clear the **Run By Patient Tag** check box.
- **Group By** – Select one of the following options:
    - **No Group By** – For no grouping. Only the grand totals appear on the report. The totals are not broken down by clinic or provider.
    - **Clinic** – To group the report by clinic. The totals are broken down by clinic, and the report displays grand totals.

      Do one of the following:
        - To <u>not</u> group the report by provider within each clinic grouping, clear the **Provider** check box. The report displays a charge with its associated rendering clinic. The report displays a suspended credit with its associated collecting clinic. The report displays an applied credit with either the rendering clinic of the charge that it's applied to or its collecting clinic.
        - To group the report by provider within each clinic grouping, select the **Provider** check box. For each provider, the report displays totals that are related to the outer clinic grouping. The report displays a charge with its associated rendering provider. The report displays a suspended credit under a "SUSPENDED CREDITS" grouping. The report displays an applied credit with the rendering provider of the charge that it's applied to.

- **Provider** – To group the report by provider. Totals are broken down by provider, and the report displays grand totals.

  Do one of the following:

  - To not group the report by clinic within each provider grouping, clear the **Clinic** check box. The report displays a charge with its associated rendering provider. The report displays an applied credit with the rendering provider of the charge that it's applied to. With this grouping option, the report does not display suspended credits because suspended credits are not associated with a provider.
  - To group the report by clinic within each provider grouping, select the **Clinic** check box. For each clinic, the report displays totals that are related to the outer provider grouping. The report displays a charge with its associated rendering clinic. The report displays an applied credit with either the rendering clinic of the charge that it's applied to or its collecting clinic. With this grouping option, the report does not display suspended credits because suspended credits are not associated with a provider.

- **Billing Type** – To group the report by billing type. Totals are broken down by billing type, and the report displays grand totals.

  Do one of the following:

  - To group the report by billing type without a secondary grouping, select the **No Subgroup** option.
  - To group the report by clinic within each billing type grouping, select the **Clinic** option. For each clinic, the report displays totals that are related to the outer billing type grouping. The report displays a charge with its associated rendering clinic. The report displays an applied credit with either the rendering clinic of the charge that it's applied to or its collecting clinic. With this grouping option, the report does not display suspended credits because suspended credits are not associated with a provider.
  - To group the report by provider within each billing type grouping, select the **Provider** option. For each provider, the report displays totals that are related to the outer billing type grouping. The report displays a charge with its associated rendering provider. The report displays an applied credit with the rendering provider of the charge that it's applied to.

    If all providers are selected for **Provider/Staff**, the report displays a suspended credit under a "SUSPENDED CREDITS" grouping. If specific providers (instead of all providers) are selected for Provider/Staff, the report does not include a "SUSPENDED CREDITS" grouping.

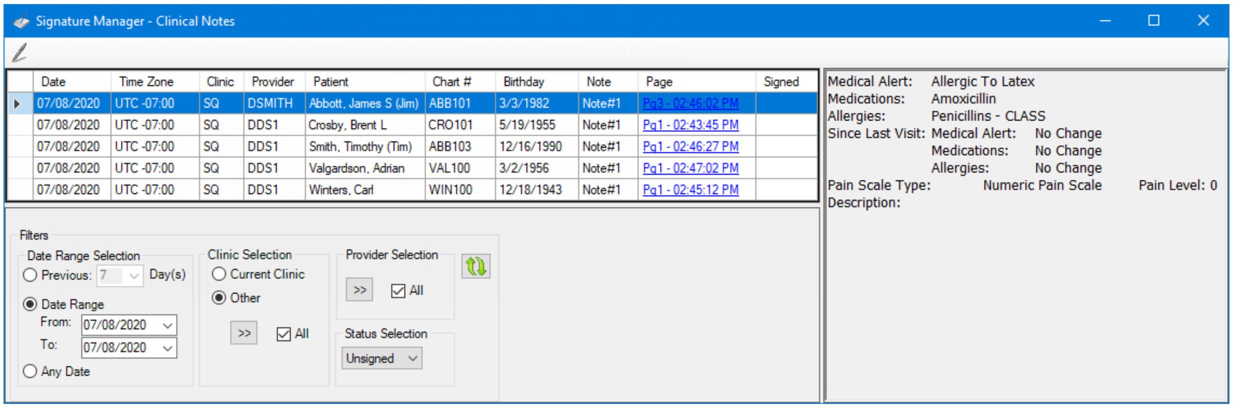
  If specific providers (instead of all providers) are selected for **Provider/Staff**, the totals and grand totals do not include suspended credits, other applied credits, or other applied credit initial balances.

- **Layout Options** – Click **Phone #** to display the patient's phone number next to the procedure, or **Chart #** to display the patient's chart number next to the procedure.
- **Report Detail Sort** – Select either **Alphabetical** to sort the transactions alphabetically by the last names of patients or **Chronological** to sort the transactions by date according to the **Date Type**.

5. Click **Save as Default** to save the current settings for the next time you run the report.
6. Click **Clear Defaults** to revert the dialog box options to the original defaults.
7. Click **Schedule** to open the **Schedule Report** dialog box and schedule the report to be emailed.
8. Click **OK** to preview the report.

Signing Clinical Notes

You can identify and sign any unsigned clinical notes in the Signature Manager. For information about reviewing and signing clinical notes, see " Using the Signature Manager" in Chapter 11: Clinical Notes.



Generating the Aging/Credit Balance Report

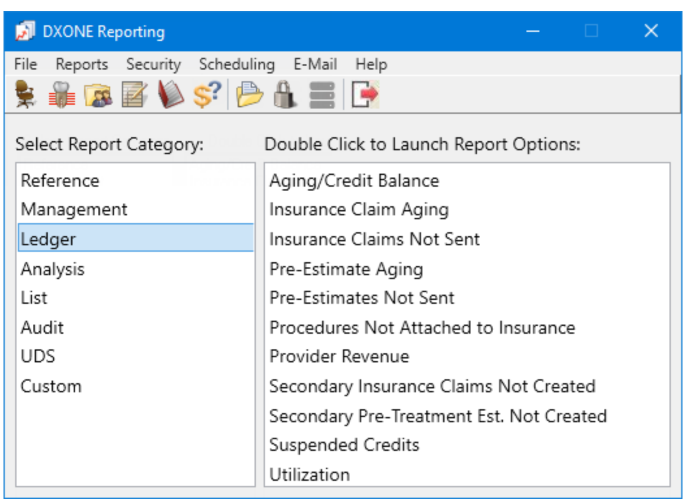
As visit co-pays and dental lab fees are posted, Dentrix Enterprise will automatically adjust off the balance in the Ledger. If an error is made in posting either of those adjustments, and it was subsequently deleted, Dentrix Enterprise will not automatically remove the adjustment. The adjustment will have to be deleted manually.

To verify that all patient balances have been adjusted off, generate the Aging/Credit Balance Report.

To generate an aging report

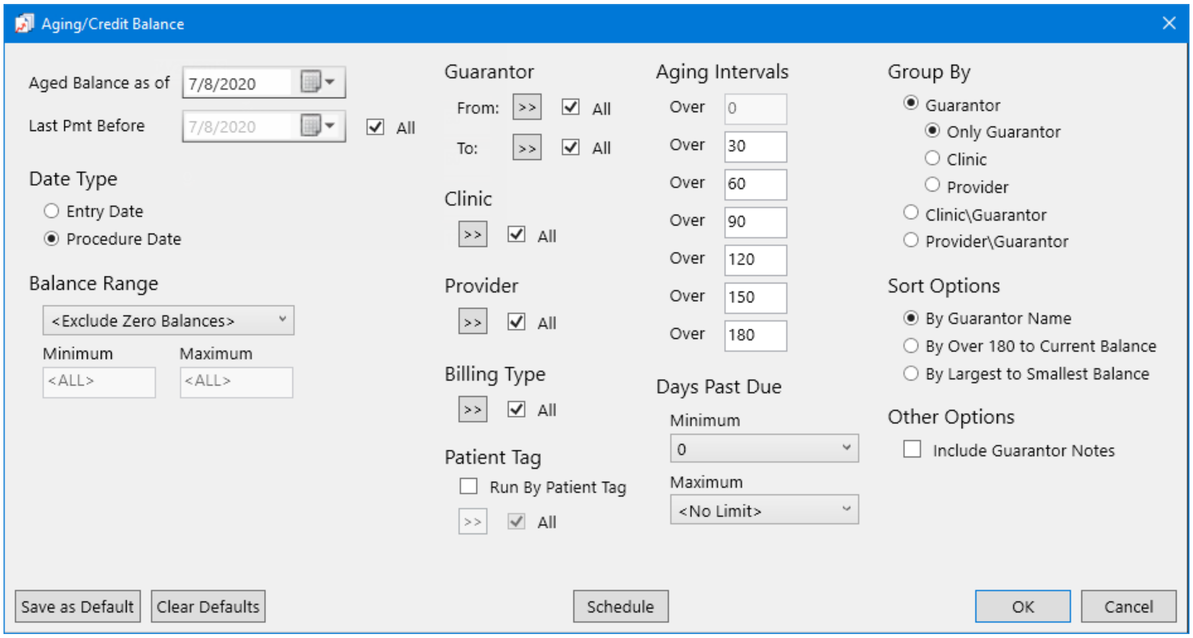
1. In the Office Manager, click the **DXOne Reports** button  on the toolbar.

   The **DXONE Reporting** dialog box appears.

2. From the **Select Report Category** list box, select **Ledger**.
3. In the **Double Click to Launch Report Options** list box, double-click **Aging/Credit Balance**.

The **Aging/Credit Balance** dialog box appears.



4. Set up the following options:
   - **Aged Balance as of** – Enter the **Aged Balance as of** date, which is the date from which to age the balances. Remember the following when typing a date:
     - The credit or charge must have a date prior to or equal to the date entered.
     - Credits that have been applied to charges use the applied date to determine if the date is less than or equal to the aged balance date.
     - All charges and suspended credits use the entry date or procedure date (whichever is specified) to determine if the date is less than or equal to the aged balance date.
   - **Last Pmt Before** – The **Last Pmt Before** date can be used to exclude accounts that have made a payment recently. For example, if the date is for the prior month, any accounts that have a guarantor payment for that prior month will be excluded from the aging report. Insurance payments are ignored.
     - Clear **ALL** and enter a date to include accounts that have made payments before the specified date. Also, if **ALL** is not selected, a guarantor will only show on the report when his/her last payment (guarantor payment) was made prior to the date entered.
     - Leave **ALL** selected to include all accounts, regardless of the date of the last payment.
   - **Date Type** – Select whether to run the report by **Entry Date** or **Procedure Date**. Entry date indicates the date of a transaction that was entered into the database. Procedure date indicates the date of a transaction that was manually changed. Most of the time, procedures will have the same entry and procedure date. They will only differ when you backdate a procedure. Applied credits use the allocate date instead of entry or procedure date.
   - **Balance Range** – Select **Exclude Zero Balances** to include all credit or debit balances on the report.
   - **Guarantor** – Click the **From** and/or **To** search buttons  to select the range of guarantors you want to include on the report (the range can be open-ended), or leave both **All** check boxes selected to include all guarantors.

- **Clinic** – Click the search button to select the clinic that you are verifying balances in. With a specific clinic selected, the report will include the following:
  - Suspended credits where the collecting clinic is specified
  - Charges where the rendering clinic is specified
  - Applied credits assume the charges are for the rendering clinic. Therefore, if a charge doesn't show because of the clinics specified, and the applied date is on or before the aged balance date specified, the applied amount will not show and is not considered suspended.
- **Provider** – Click the search button to select the providers you want to include on the report, or leave **All** selected to include all providers. When specific providers are selected, the report will include/exclude the following:
  - Include transactions associated with the rendering provider(s) specified.
  - Not include any suspended credits, regardless of the **Group By** option specified.
  - If a charge doesn't show because of the providers specified, and the applied date is on or before the aged balance date specified, the applied amount will not appear.
- **Billing Type** – Click the search button to select the billing types for patients you want to include on the report, or leave **All** selected to include all billing types.
- **Patient Tag** – To have the report include patients with certain tags assigned to them, select the **Run By Patient Tag** check box; and then click the search button to select the desired patient tags, or leave **All** selected to include all patient tags. To not filter the report by patient tag, clear the **Run By Patient Tag** check box.
- **Aging Intervals** – Enter the aging intervals, in days, as you want them to appear on the report. Each guarantors balance will be aged by the ranges specified in each of the six interval buckets. Clinic and provider groupings are also aged using these same buckets.
- **Days Past Due** – Select the **Minimum** days past due: 0, 30, 60, 90, 120, 150, or 180. For example, if you only want accounts with a balance over 60 days, select "60." Select the **Maximum** days past due: <No Limit>, 30, 60, 90, 120, 150, or 180. For example, if you do not want to include any accounts with an aged balance over 90 days, select "90."
- **Group By** – You have the following options:
  - **Guarantor** – Click this option to group the report by guarantors.
  - **Only Guarantors** – Click this option to list balances by guarantor name.
    - Click **Clinic** or **Provider** to group the report first by guarantor name and then by clinic for each guarantor. Clinics listed are based on the charges for the rendering clinic and suspended credits for the collecting clinic.
    - Click **Provider** to group the report first by guarantor name and then by provider for each guarantor. Providers listed are based on the charges provider. Suspended credits are included on the report but are only shown under the guarantor grouping.
  - **Clinic/Guarantor** – Click this option to group the report first by clinic and then by guarantor name. Clinics listed are based on the charges for the rendering clinic and suspended credits for the collecting clinic.
  - **Provider/Guarantor** – Click this option to group reports first by provider and then by guarantor name. Providers listed are based on the charges provider. Suspended credits are not included with this grouping.

- **Sort Options** – You have the following options:
  - **By Guarantor Name** – Click this option to sort the report first by the grouping specified and then alphabetically by guarantor name.
  - **By Over 180 to Current Balance** – Click this option to sort the report first by the grouping specified (whatever is entered as the last aging interval) and then by the oldest to newest balance.
  - **By Largest to Smallest Balance** – Click this option to sort the report first by the grouping specified and then by the largest to smallest balance.
- **Other Options**:
  - **Include Guarantor Notes** – Select this check box if you want to include the patient's guarantor note. With this check box selected, any guarantors with a note will print below the guarantor information. This check box is only available when the **Group By** option is set to **Guarantor** (with any sub-grouping).

5. Click **Save as Default** to save the current settings for the next time you run the report.
6. Click **Clear Defaults** to revert the dialog box options to the original defaults.
7. Click **Schedule** to open the **Schedule Report** dialog box and schedule the report to be emailed.
8. Click **OK** to preview the report.
9. If any balances are listed, post adjustments to those accounts to make their balances be zero.
10. Re-run the report to make sure that there are no accounts listed.

Chapter 14: Continuing Care

You can use the Continuing Care module to track the following:

- Perio maintenance for patients
- Patients who have a Plaque Index (PI) score over 20
- Lab cases for prosthetics
- Biopsy cases

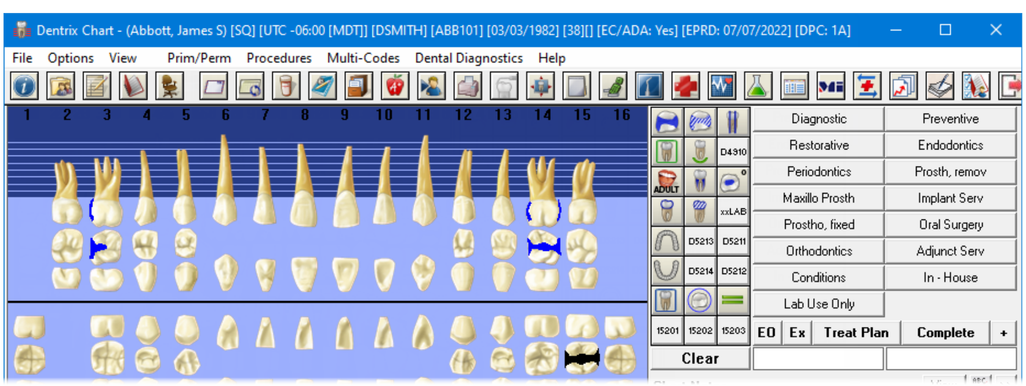
You will generate Continuing Care lists only for lab cases.

Tracking Perio Maintenance

You will post a D4910 to track a periodontal maintenance for a patient. If needed, you can also change the interval for that continuing care type for a patient.

To record periodontal maintenance

1. In the Patient Chart, with a patient selected, make sure the appointment provider's name appears on the title bar. If not, change the provider as explained in "Changing the Provider for a Charting Session" in this chapter.

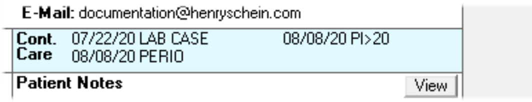


2. Click the **Periodontics** procedure code category button, and then double-click **D4910 Periodontal maintenance**.
3. Click the **Comp** status button.

   The procedure appears in the progress notes, and the associated continuing care type, PERIO, is attached to the patient's record.

To view and modify a patient's continuing care

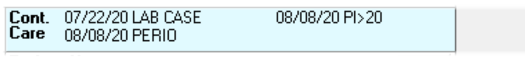
The continuing care types attached to a patient's record appear in the **Cont. Care** block of the Family File.



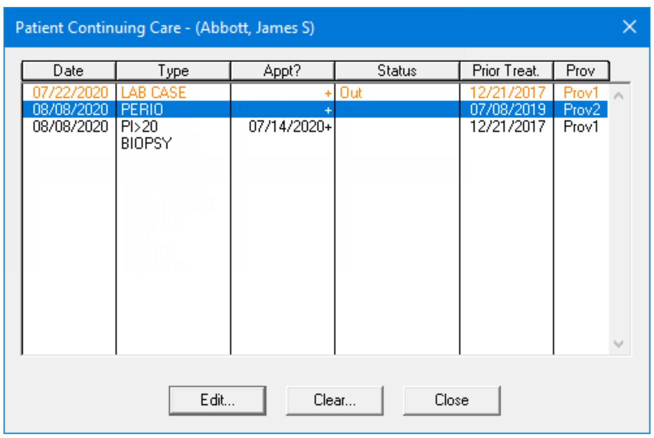
If you need to change when the patient is eligible for a follow-up visit for a specific continuing care type, such as PERIO, you can change the interval of that continuing care type.

To edit a patient's continuing care

1. With a patient selected in the Family File, double-click the **Cont. Care** block.

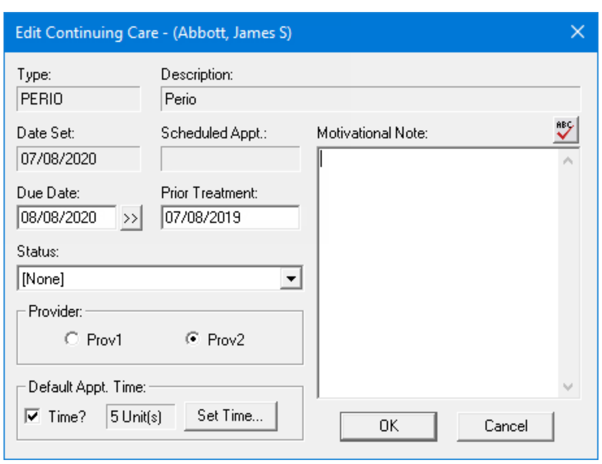


The **Patient Continuing Care** dialog box appears.



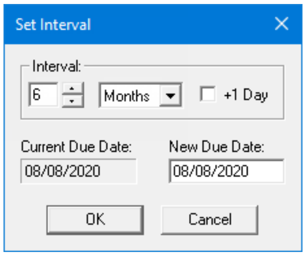
2. Select the continuing care type that you want to edit.
3. Click **Edit**.

The **Edit Continuing Care** dialog box appears.



4. To set the interval for the patient's continuing care, click the **Due Date** search button >>.

The **Set Interval** dialog box appears.



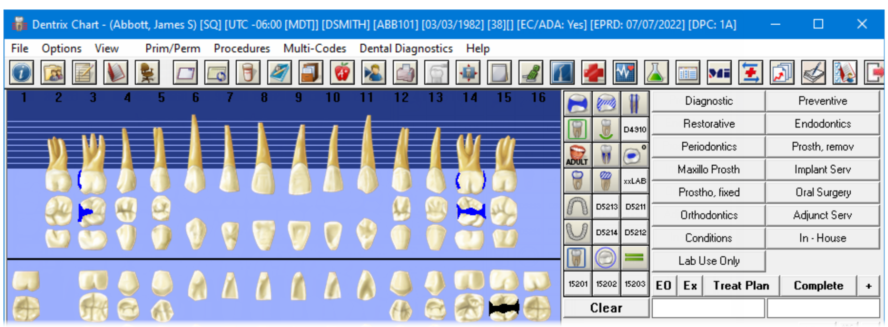
5. Change the **Interval** to reflect the amount of time that elapses between the patient's continuing care visits. Select **+1 Day** to extend the interval an extra day to prevent insurance billing problems for patients with strict interval requirements.
6. Click **OK**.
7. In the **Edit Continuing Care** dialog box, click **OK**.

Tracking Plaque Index > 20

You will post the in-house code C1020 to track Plaque Index >20 for a patient. Show how the continuing care module will track this patient.

To enter a plaque index over 20

1. In the Patient Chart, with a patient selected, make sure the appointment provider's name appears on the title bar. If not, change the provider as explained in "Changing the Provider for a Charting Session" in this chapter.

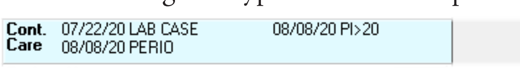


2. Click the **In-House** procedure code category button, and then double-click **C1020 Plaque Index > 20**.
3. Click the **Comp** status button.

   The procedure appears in the progress notes, and the associated continuing care type, **PI>20**, is attached to the patient's record.

To view a patient's continuing care

The continuing care types attached to a patient's record appear in the **Cont. Care** block of the Family File.



Tracking Lab Cases

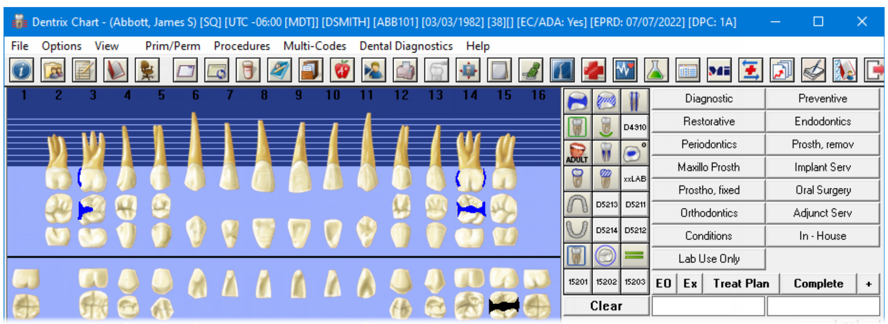
You can use the Continuing Care module to track a patient's lab case.

Lab Out

To start the tracking of a lab case, post the correct procedure, and then verify that the correct continuing care type is attached to the patient's record and that the type has the correct status.

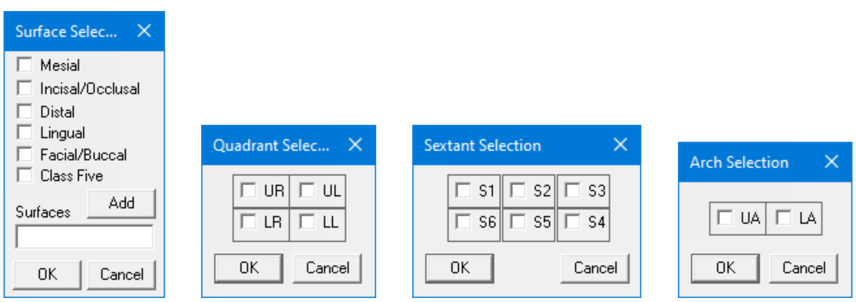
To post a lab case procedure

1. In the Patient Chart, with a patient selected, make sure the appointment provider's name appears on the title bar. If not, change the provider as explained in "Changing the Provider for a Charting Session" in this chapter.
2. If the treatment need you are entering requires a tooth number, select the appropriate tooth/teeth in the graphical chart.



3. Specify a prosthetic procedure, such as D7110, by using a procedure button, a procedure code category button, or the **Procedures** menu.

   If the selected procedure requires additional treatment information (surfaces, quadrants, sextants, or arches), the **Surface Selection**, **Quadrant Selection**, **Sextant Selection**, or **Arch Selection** dialog box appears.



4. Select the applicable treatment areas, and then click **OK**.

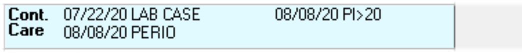
   Note: For surface selections, if multiple teeth have been selected, the treatment areas you specify will be applied to all those teeth.

5. Click the **Comp** status button.

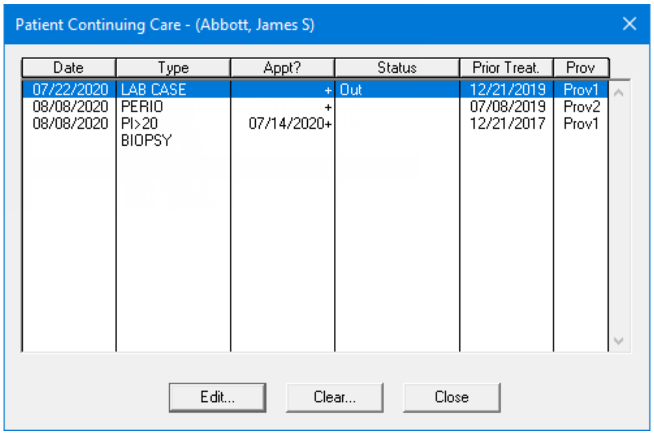
   The procedure appears in the progress notes, and the associated continuing care type, **LAB CASE**, is attached to the patient's record.

To verify the initial status of a lab case

1. With a patient selected in the Family File, double-click the **Cont. Care** block.

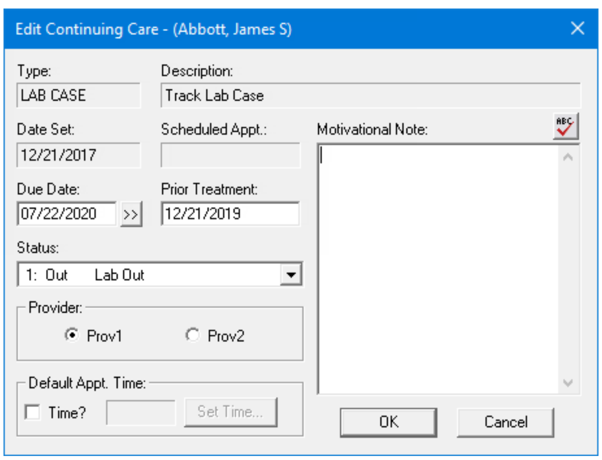


The **Patient Continuing Care** dialog box appears.



2. Select the **LAB CASE** continuing care type.
3. Click **Edit**.

The **Edit Continuing Care** dialog box appears.



The selected **Status** should be **Lab Out**.

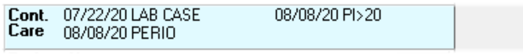
4. Click **OK**.
5. In the **Patient Continuing Care** dialog box, click **Close**.

Lab In

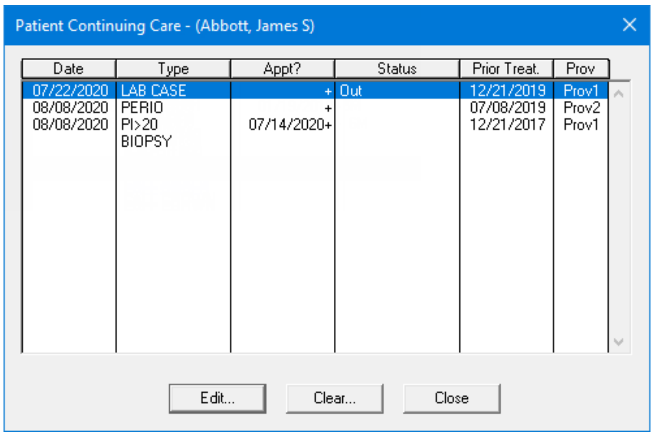
When a lab case is received back from the lab, change the status of the patient's Lab continuing care type, and then schedule the patient for an appointment.

To change the status of a lab case

1. With a patient selected in the Family File, double-click the **Cont. Care** block.

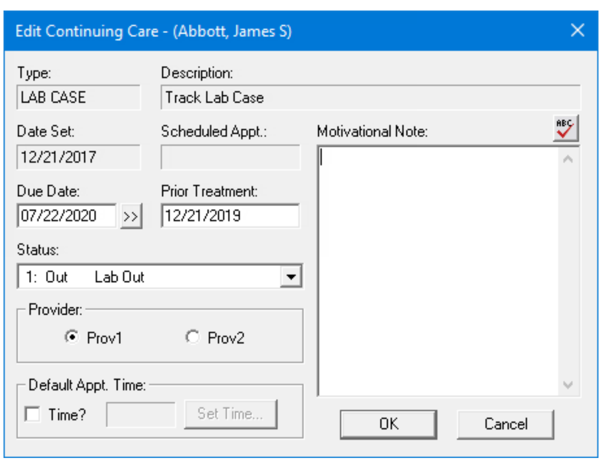


The **Patient Continuing Care** dialog box appears.



2. Select the **LAB CASE** continuing care type.
3. Click **Edit**.

The **Edit Continuing Care** dialog box appears.



4. Change the **Status** to **Lab In**.
5. Click **OK**.
6. In the **Patient Continuing Care** dialog box, click **Close**.

7. Review the patient's prosthetic procedure in the Patient Chart to see if an additional lab fee needs to be posted. Do not edit the original fee.

   To post an additional lab fee, do the following:

   a. In the Patient Chart, with the patient selected, make sure the treating provider's name appears on the title bar. If not, change the provider as explained in "Changing the Provider for a Charting Session" in this chapter.
   b. Click the **Lab Use Only** procedure code category button, and then double-click the additional lab procedure.
   c. Click the **Comp** status button.
   d. Locate the clinical note that was created when you posted the additional lab procedure. For information about viewing clinical notes, see "Viewing Clinical Notes" in Chapter 11: Clinical Notes.

      Note: The provider will have to sign the clinical note.

   e. If the provider for the clinical note is not the treating dentist, change the provider as explained in "Changing the Provider" in Chapter 11: Clinical Notes.
8. Schedule the patient's appointment for the lab case from the Scheduling Assistant as explained in "Scheduling Appointments from the Scheduling Assistant" in Chapter 3: Scheduling Assistant.

   Note: You do not attach a treatment request to a follow-up appointment for a prosthesis.

Lab Delivered

When the prosthetic appliance is delivered, clear the Lab Case continuing care type from the patient's record.

Important: You can view all outstanding lab cases from the Scheduling Assistant module. Make sure to delete all delivered cases from the list to keep it accurate.

To stop tracking a lab case

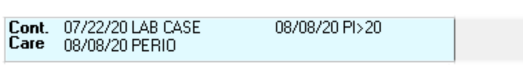
1. In the Scheduling Assistant, filter the list to view only the patients with the Lab Case continuing care type attached to their records as explained in "Customizing the Continuing Care Filter Settings" in Chapter 3: Scheduling Assistant
2. Click the patient's name (which is a hyperlink).

   The patient's **More Information** window opens.

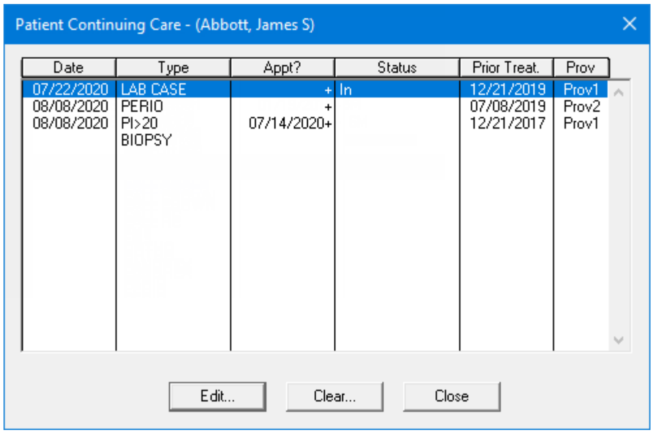
3. Click the **Family File** button .

   The patient's Family File opens.

4. Double-click the **Cont. Care** block.



The **Patient Continuing Care** dialog box appears.



5. Select the **LAB CASE** continuing care type.
6. Click **Clear**.
7. On the confirmation message that appears, click **Yes**.

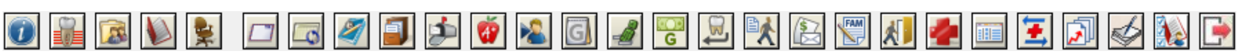
Chapter 15: Ledger

The Dentrix Enterprise Ledger contains all the procedures posted from the Appointment Book or Patient Chart. For the most part, you will use the Ledger only to view procedures. If a procedure has been entered in error, the provider can edit or delete it from the Patient Chart. However, it will be necessary to edit or delete the adjustment associated with the edited or deleted procedure in the Ledger.

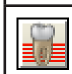
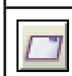
For information about editing and deleting procedures, see "Editing Procedures," "Deleting Procedures," and "Invalidating Procedures" in Chapter 9: Patient Chart.

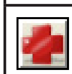
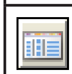
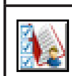
Ledger Toolbar

The toolbar contains several buttons that you can click to access certain areas or features of Dentrix Enterprise.



The function of each button on the toolbar is explained in the following table.

Button	Name	Description
	More Information	Opens the selected patient's **More Information** window.
	Patient Chart	Opens the selected patient's Patient Chart.
	Family File	Opens the selected patient's Family File.
	Appointment Book	Opens the Appointment Book module.
	Office Manager	Opens the Office Manager module.
	Quick Letters	Opens the **Quick Letters** dialog box.
	Continuing Care	Opens the selected patient's Continuing Care list.
	Prescriptions	Opens PowerChart.
	Office Journal	Opens the selected patient's Office Journal.

Button	Name	Description
	Document Center	Opens the selected patient's Document Center.
	Message Center	Opens the Cerner Message Center.
	Patient Education	Opens the **Patient Education** dialog box.
	Select Patient	Opens the **Select Patient** dialog box to select a patient.
	Guarantor Notes	Opens the selected patient's **Guarantor Notes** dialog box.
	Treatment Planner	Opens the selected patient's Treatment Planner.
	Enter Payment	Opens the **Enter Payment** dialog box to enter a patient payment.
	Enter Procedure	Opens the **Enter Procedure(s)** dialog box.
	Print Walkout	Prints a walkout statement.
	Print Statement	Prints a billing statement.
	Print Family Ledger	Prints a family ledger report.
	Fast Checkout	Performs a fast check out.
	Medical Alerts	Opens the selected patient's **Medical Alerts** window.
	Clinical Notes	Opens the selected patient's **Clinical Notes** window.
	Patient Health Exchange	Opens the selected patient's **Patient Health Exchange** dialog box.
	DXOne Reports	Click to open DXOne Reporting to generate and manage reports.
	Signature Manager	Click to open the **Signature Manager** dialog box to sign multiple clinical notes at one time.
	Scheduling Assistant	Click to open the **Scheduling Assistant** window, which can help enhance your scheduling workflow.

Viewing the Transaction Log

The transaction log is a written record of all transactions posted to a patient's account. For each transaction, the date, patient name, tooth number and surface (when applicable), procedure code or type, a description, amount, provider, and clinic are shown.

Date	Name	Surface	Tooth	Check #	Code	*	Description	N	R	D	M	S/P	Amount	Provider	Clinic	Ins	AP	Balance
12/21/2017	William Johnson				D1110		Prophylaxis-adult	♪					0.00	DSMITH	AF	No	1	0.00
12/21/2017	William Johnson	M	2		D2140		Amalgam-1 surf. prim/perm						0.00	DSMITH	AF	No	1	0.00
12/21/2017	William Johnson				D4355		Full mouth debridemnt,eval/di...						0.00	DSMITH	AF	No		0.00
12/21/2017	William Johnson				D0210		Intraoral-complete series (bw)	♪					0.00	DSMITH	AF	No		0.00
12/21/2017	William Johnson				D0150		Comp oral eval-new/estab pat	♪					5.00	DSMITH	AF	No		5.00
12/21/2017	William Johnson				Adjust...		Write-Off						-5.00	DSMITH	AF			0.00

You can sort the transaction log by clicking any of the column headers, such as the following:

- **Date** – The date of the transaction or procedure.
- **Entry Date** – The date that the transaction or procedure was entered. This may be different than the **Date**; for example, if you backdated the transaction or procedure.
- **Tooth (Tooth Number)** – The tooth associated with the procedure.
- **Code (Procedure/Transaction Code)** – The associated procedure code or financial transaction type (payment, adjustment, or so forth).
- * **(Transaction Flags)** – In this column, any of the following symbols may appear:

  * – An asterisk indicates that the transaction has been moved to history. History transactions cannot be edited or deleted.

  + – A plus sign indicates that the procedure has been invalidated. Invalidated procedures still show on the Ledger but no longer appear in the Patient Chart.

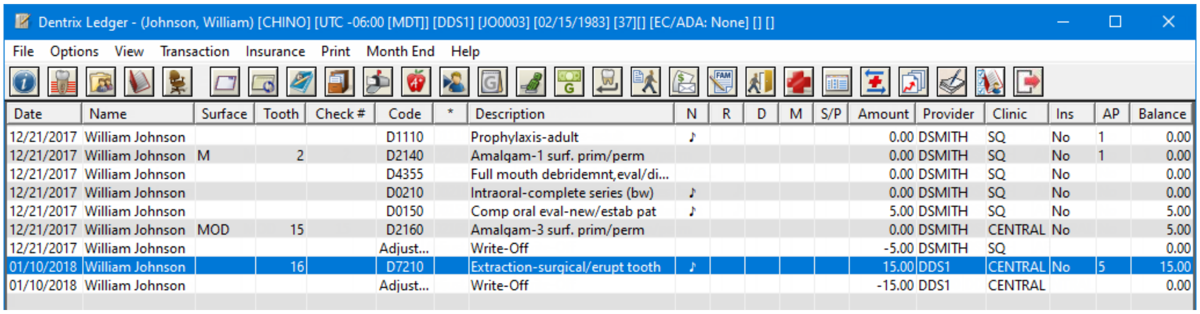
  ^ – A carat indicates that the procedure has been back dated to a month that has been closed out. When the procedure is moved to history, the carat will change to an asterisk.

Editing Procedures

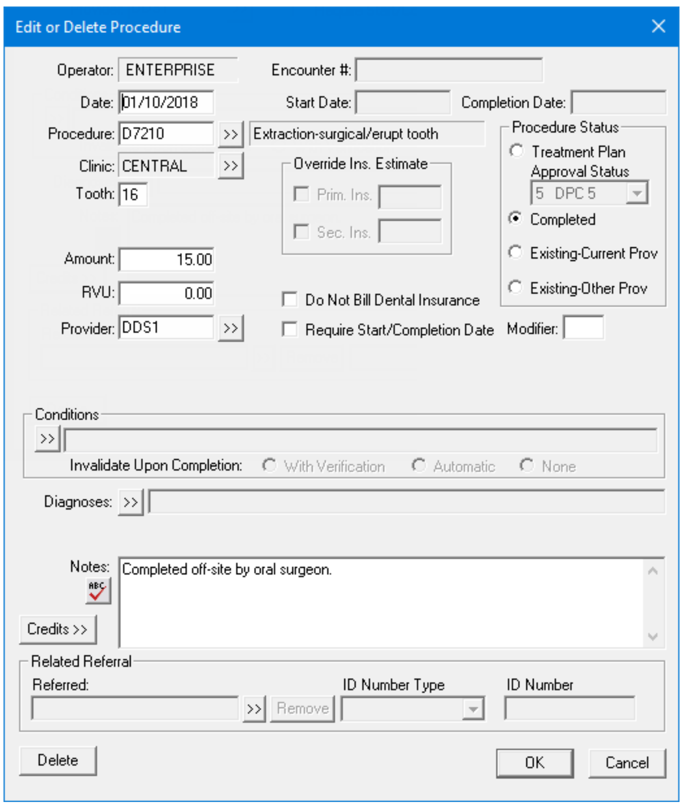
You can edit a procedure as needed, such as when you receive an invoice from a specialist for services performed off-site.

To edit a procedure

1. With a patient selected in the Ledger, double click a procedure.



The **Edit or Delete Procedure** dialog box appears.



2. Make the necessary changes, such as correcting the **Amount**, changing the **Provider**, or entering **Notes**.
3. Click **OK**.

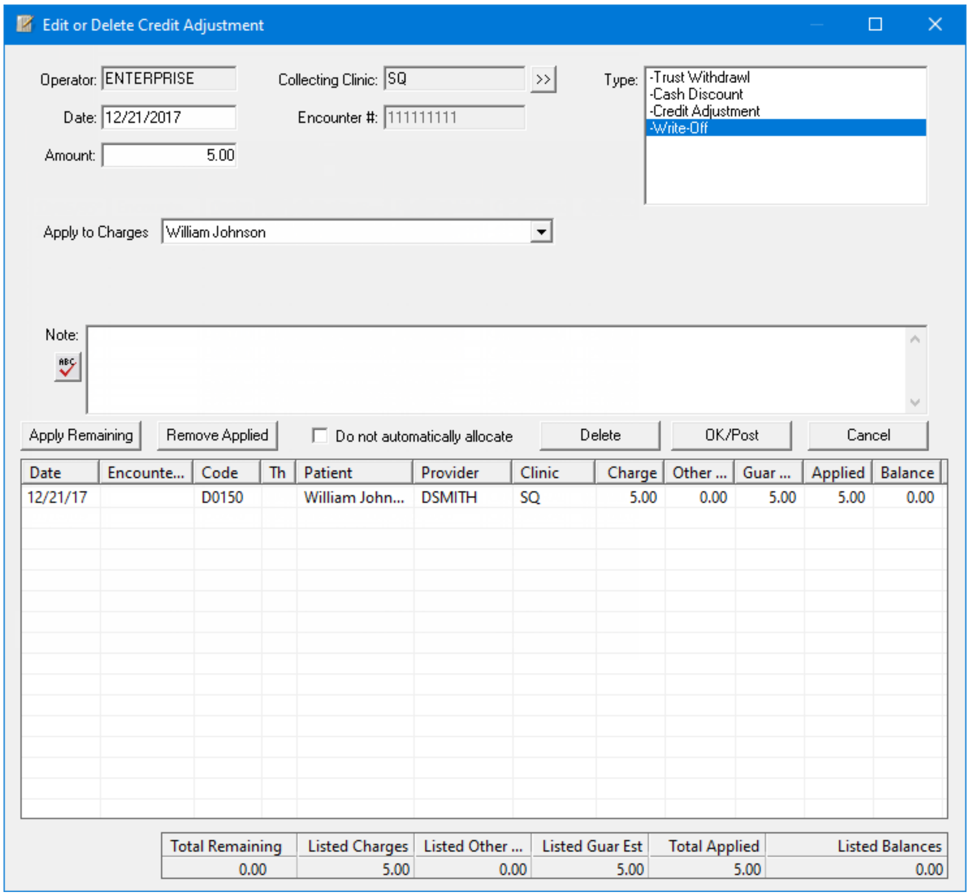
Deleting Adjustments

You can delete an adjustment for a corresponding deleted procedure.

To delete an adjustment

1. With a patient selected in the Ledger, double click an adjustment.

   The **Edit Or Delete Credit Adjustment** dialog box appears.



2. Click **Delete**.

   A confirmation message appears.

3. Click **OK**.

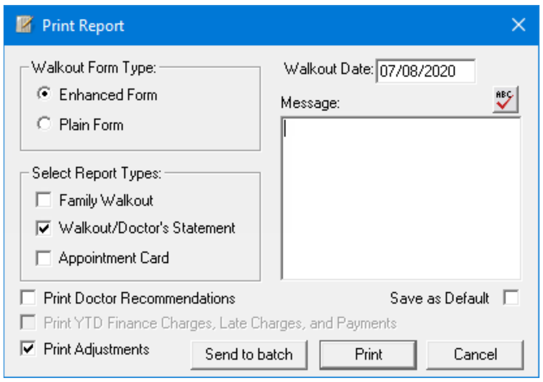
   The patient's Ledger balance should be zero.

Generating a Walkout Statement

A walkout statement is generally given to a patient as a receipt of charges posted and payments made on the day of treatment.

To print a walkout statement

1. In the Ledger, with a patient selected, do one of the following:
   - If you have set up your walkout statement defaults, click the **Print Walkout** button on the toolbar. Ignore the steps that follow.
   - To override the walkout default options to print a different type of walkout for the patient. From the **Print** menu, click **Walkout**. The **Print Report** dialog box appears.



2. Under **Select Report Types**, select **Walkout/Doctor's Statement**.
3. To include adjustments on the statement, select **Print Adjustments**.
4. If you have a standard message that you want to print on all walkout statements by default, type the note in the **Message** field.
5. If you are not doing a one-time override of the default options, to store your settings as the default options for the next time you print walkout statements, select **Save as Default**.
6. Click Send to Batch or **Print**.

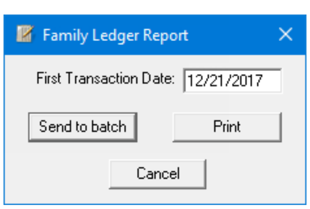
Generating the Patient Ledger Report

The Patient Ledger Report shows transactions for the selected patient.

To print the Patient Ledger Report for one patient

1. In the Ledger, with a patient selected, from the **Print** menu, click **Patient Ledger**.

   The **Patient Ledger Report** dialog box appears.



2. Type a **First Transaction Date**. All transactions posted after the entered date will be included on the report.
3. Click Send to batch or **Print**.

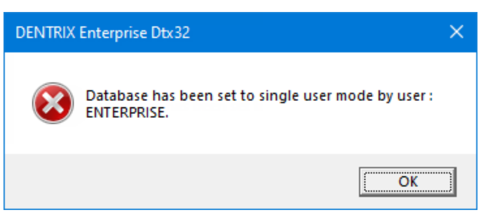
Chapter 16: Reports

Within Dentrix Enterprise, there are two areas from which you run reports:

- **Office Manager** – The reports here are mostly clerical reports that are specific to the clinic that a user is logged in to.
- **DXOne Reporting** – The reports here require a higher security level and are administrative reports. You access the DXOne Reporting module by clicking the **DXOne Reports** button  on the toolbar of the Office Manager.

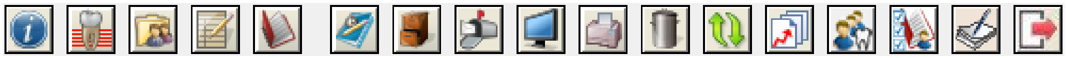
Single-User Mode Message

If a message, which states that the database is in single-user mode, appears when you attempt to open the Office Manager module, one of your IT personnel has turned on this mode, so no other users can open Dentrix Enterprise. Once your IT person has turned off single-user mode, you can open Dentrix Enterprise.

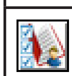


Office Manager Toolbar

The toolbar contains several buttons that you can click to access certain areas or features of Dentrix Enterprise.



The function of each button on the toolbar is explained in the following table.

Button	Name	Description
	More Information	Opens the **Select Patient** dialog box to select a patient, and then selected patient's **More Information** window opens.
	Patient Chart	Opens the Patient Chart module.
	Family File	Opens the Family File module.
	Ledger	Opens the Ledger module.
	Appointment Book	Opens the Appointment Book module.
	Office Journal	Opens the Office Journal module.
	Document Center	Opens the **Select Provider/Staff** dialog box to select a provider or staff member, and then the selected person's Document Center opens.
	Message Center	Opens the Cerner Message Center.
	Print Preview	Opens the **Dentrix Print Preview** window to display the report selected in the batch processor.
	Print Report(s)	Prints the reports selected in the batch processor.
	Delete Report(s)	Opens the **Delete Options** dialog box to delete all or certain reports.
	Refresh/Clear Selection	Clears all report selections in the batch processor.
	DXOne Reports	Opens the DXOne Reporting module.
	Treatment Request Manager	Opens the **Treatment Request Manager** window.
	Scheduling Assistant	Opens the **Scheduling Assistant** window.
	Signature Manager	Opens the **Signature Manager** dialog box to sign multiple clinical notes.

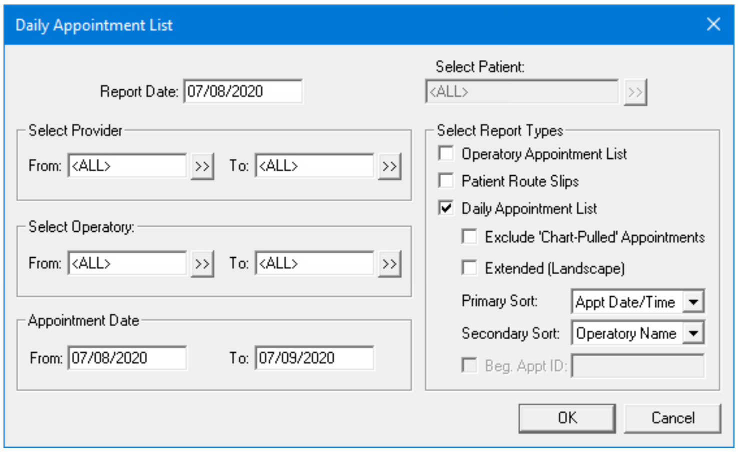
Daily Appointment List

The Daily Appointment List lists all appointments for a selected range of dates and by the selected providers and operatory ranges. The list includes the appointment date, status, time, patient name, provider and operatory, appointment reason, and appointment duration.

To run the report

1. In the Office Manager, from the **Reports** menu, point to **Lists**, and then click **Daily Appointment List**.

   The **Daily Appointment List** dialog box appears.



2. Clear **Operatory List**, and select **Daily Appointment List**.
3. The default **Report Date** is the current system date. You can type a different date to have that date print at the top of the report.
4. Click **OK** to send the report to the Batch Processor, where it can be viewed or printed.

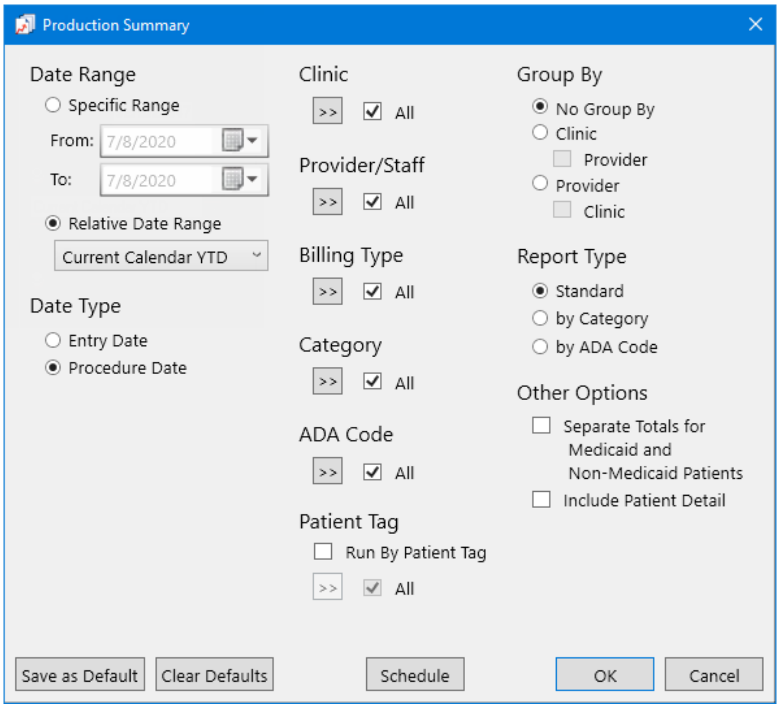
Production Summary Report

With the Production Summary Report, you can review production by procedure code categories for a date range. Among other reasons, you will use the report to view the number of comprehensive exams that have been completed year-to-date for all clinics.

To run the report

1. In DXOne Reporting, select **Analysis**, and then double-click **Production Summary**.

   The **Production Summary** dialog box appears.



2. Set up the following options:
   - **Date Range** – Select **Relative Date Range**, and then select **Current Calendar YTD**.
   - **ADA Code** – Click the search button >> to include **D0150 Comprehensive Exam** on the report.
3. Click **Save as Default** if you want to save the current settings for the next time you run the report.
4. Click **OK**.

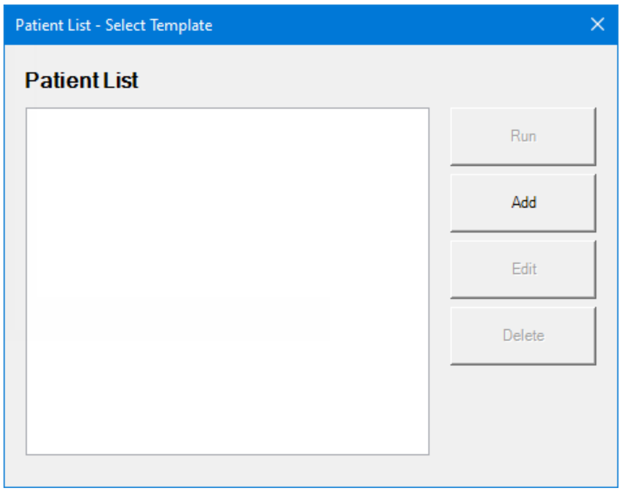
Patient List

The Patient List displays a list of patients according to specified criteria, such as information from their medical alerts/problems, medications, prescriptions, demographics, and laboratory test results. For example, male patients in any date range, at any clinic, who have had a D2160 completed.

To run the report

1. In the Office Manager, from the **Analysis** menu, click **Patient List**.

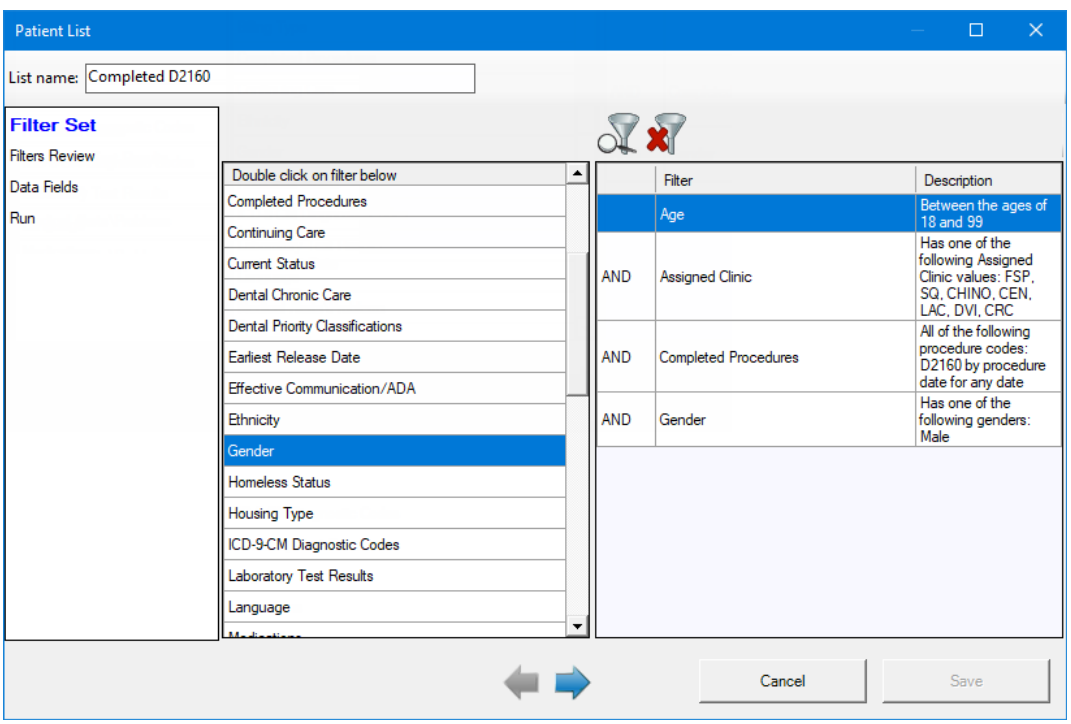
   The **Patient List - Select Template** dialog box appears.

   Note: You can run, edit, or delete any saved template from this dialog box.

2. Click **Add**.

   The **Patient List** dialog box appears and displays the **Filter Set** screen.

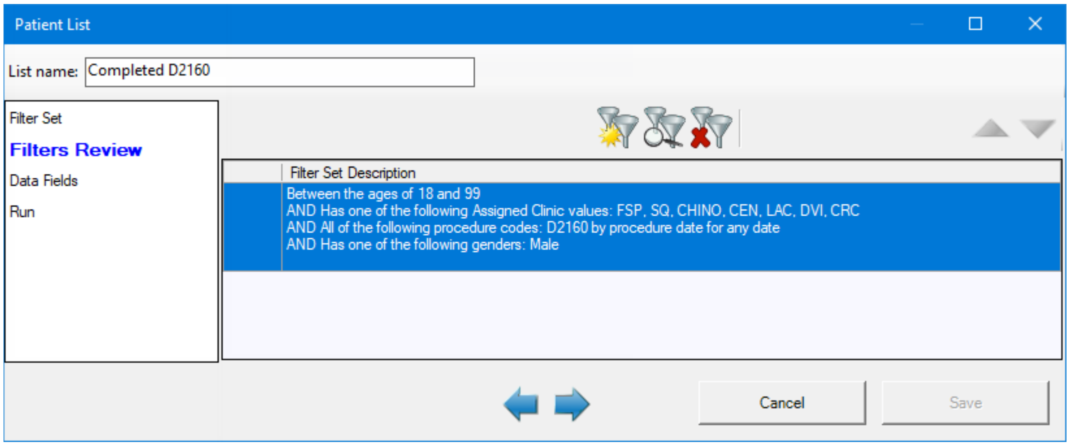
   

3. Enter a **List name** if you are going to save your search criteria as a template for future use.

4. For as many filters as you want to set up, under **Double click on filter below**, double-click each desired item to specify the criteria of that filter in the dialog box that appears (the name depends on the filter that you double-click):

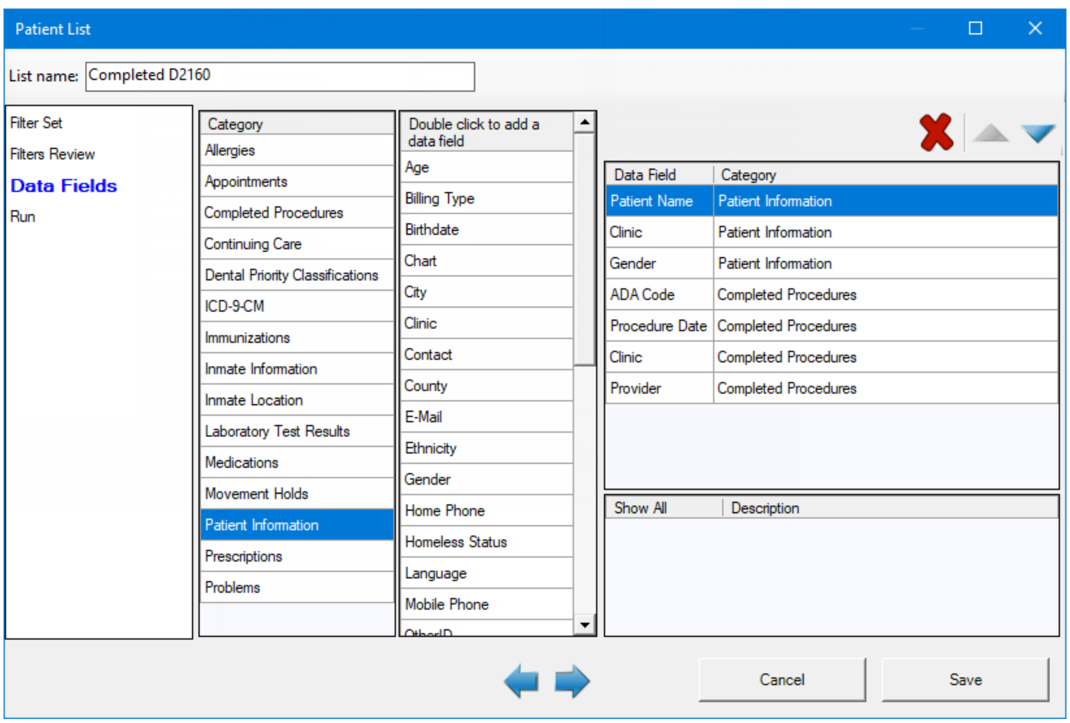
5. Click the **Next** button .

   The **Filters Review** screen appears.



6. Add any additional filter sets (click the **Add Filter Set** button , and then repeat steps 4 – 5). Then, click the **Next** button .

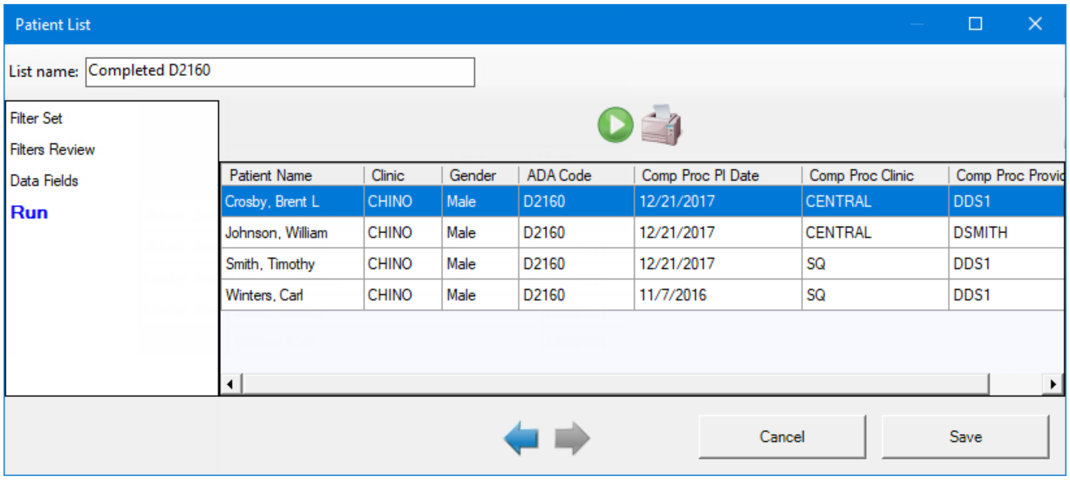
   The **Data Fields** screen appears.



Note: If a data field specifically has the ability to show all records for a given data field regardless of the applied, corresponding filters, the data field will appear in the lower-right corner with a check box that may be selected to show all records pertaining to the specific data field type for a patient. Only certain data fields can allow this functionality.

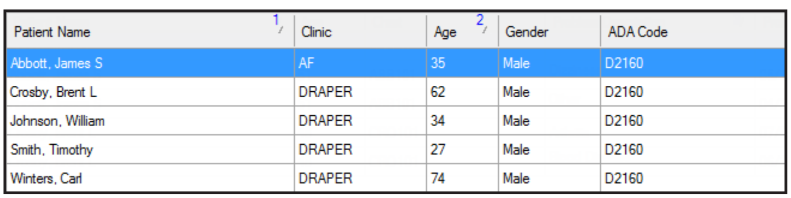
7. In the desired categories, double-click the data fields that you want to include. Then, click the **Next** button .

   The **Run** screen appears and displays the results list.



Tips:

- To open the Ledger, Patient Chart, or Family File of a patient on the list, right-click that patient's name, and then click the desired menu option.
- Click a column header to sort the list by that column in ascending order. Click the same column header to switch to descending order for that column. To sort by multiple columns, click each column header in the order by which you want to sort (for example, first by patient name and then by the problem description; numbers appear next to the names of the column headers by which you are sorting). Right-click a column header to remove the sort option for that column.



Patient Name 1	Clinic	Age 2	Gender	ADA Code
Abbott, James S	AF	35	Male	D2160
Crosby, Brent L	DRAPER	62	Male	D2160
Johnson, William	DRAPER	34	Male	D2160
Smith, Timothy	DRAPER	27	Male	D2160
Winters, Carl	DRAPER	74	Male	D2160

- To print the list, click the **Print** button .
- To copy the list as tab-delimited text to the Windows Clipboard, click in the list, and then press Ctrl + A and then Ctrl + C.
- To re-generate the list, to make sure you have the most current information, click the **Run** button .

8. To save the search criteria as a template, click **Save**.

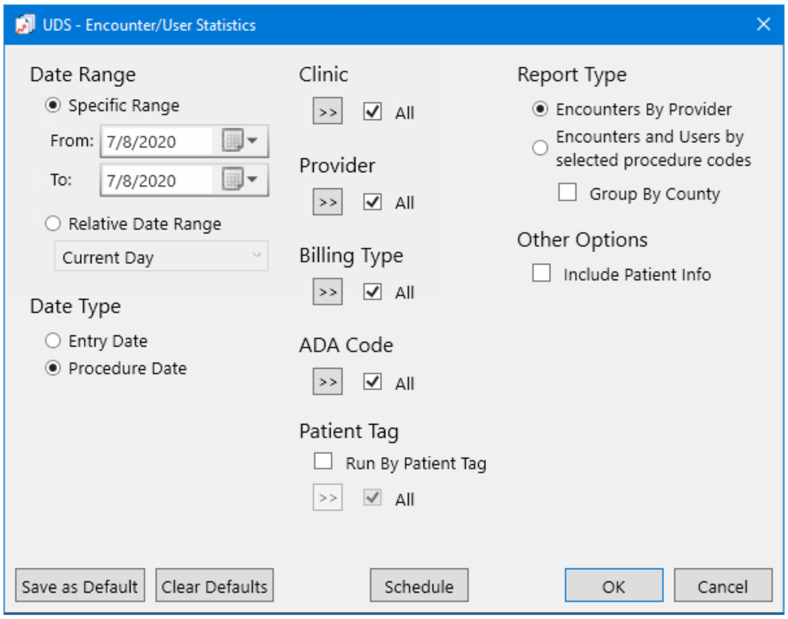
UDS - Encounter and User Statistics Report

The UDS - Encounter/User Statistics Report lists the number of encounters by provider and procedure code. This report uses the UDS (Uniform Data System) standards for reporting.

To run the report

1. In DXOne Reporting, select **UDS**, and then double-click **UDS - Encounter/User Statistics**.

   The **UDS - Encounter/User Statistics** dialog box appears.



2. Set up the filters as needed.
3. Click **OK**:

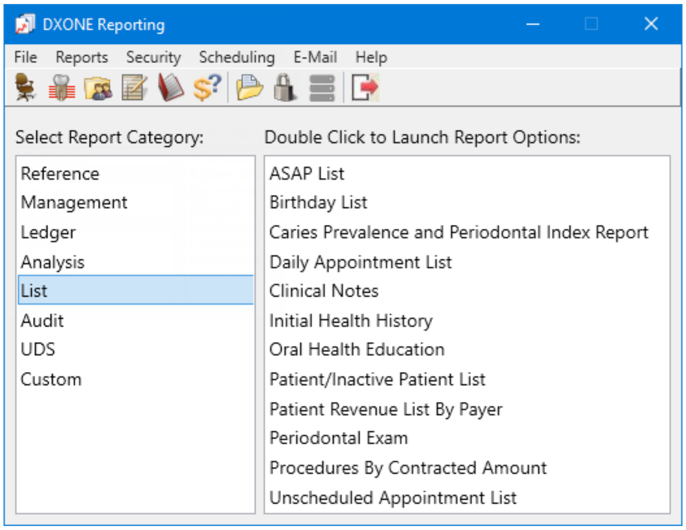
Unsigned Clinical Notes Report

The Unsigned Clinical Note Report is a list of patients with clinical notes that need approval (to be signed).

To generate the report

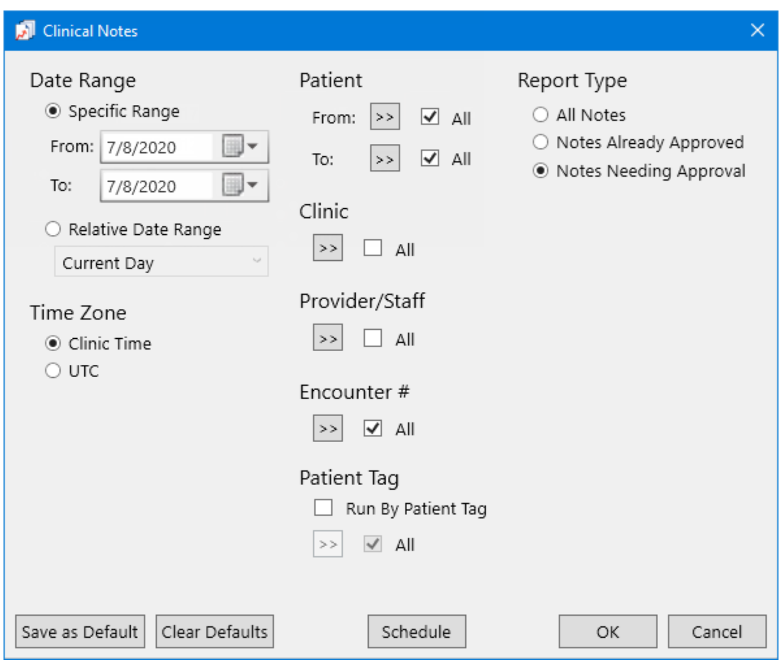
1. In the Office Manager, click the **DXOne Reports** button on the toolbar.

   The **DXONE Reporting** dialog box appears.



2. From the **Select Report Category** list box, select **List**.
3. In the **Double Click to Launch Report Options** list box, double-click **Clinical Notes**.

   The **Clinical Notes** dialog box appears.



4. Set up the following options:
   - **Date Range** – Do one of the following:
     - Leave **Date Range** selected. Then, either leave today's date entered in the **From** and **To** fields, or specify a different date range.
     - Select **Relative Date Range**, and then select **Current Day** or a different date range option from the list.

     Notes:

     - Using a relative date range is recommended if you are saving your report settings as the default so that you do not have to manually type a date range each time you run the report.
     - For a clinical note to be included on the report, it must have a date within the date range or relative date range.

     Also, select either **Clinic Time** to use the clinic time zone or **UTC** to use Coordinated Universal Time.
   - **Clinic** – Click the search button to select the clinics you want to include on the report, or leave **All** selected to include all clinics.
   - **Provider/Staff** – Click the search button to select the providers/staff you want to include on the report, or leave **All** selected to include all providers.
   - **Report Type** – Select **Notes Needing Approval** to include clinical notes that have not been approved or signed.
5. Click **Save as Default** to save the current settings for the next time you run the report.
6. Click **Clear Defaults** to revert the dialog box options to the original defaults.
7. Click **Schedule** to open the **Schedule Report** dialog box and schedule the report to be emailed.
8. Click **OK** to preview the report.