

## TELEDENTISTRY APPOINTMENT RECORD

### Emergency/Specific Consultation:

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Address: \_\_\_\_\_

Confirmed patient identity by means of \_\_\_\_\_

Date: \_\_\_\_\_ Start/End Times of teledentistry appointment: \_\_\_\_\_ to \_\_\_\_\_

Confirmed patient was in a private location Technology used: \_\_\_\_\_

#### 1. Introduction:

- Patient provided with dentist identity and licensure status
- Discussed risks, benefits, limitations of teledentistry and obtained informed consent to proceed
- Patient questions answered: \_\_\_\_\_

#### 2. Chief complaint:

Patient description of issue: \_\_\_\_\_

Tooth / area of mouth: \_\_\_\_\_

Caused by trauma or event? \_\_\_\_\_

Length of time: \_\_\_\_\_

Pain level: \_\_\_\_\_ worsening  improving  staying the same

Meds taken: \_\_\_\_\_ has helped  has not helped

Has treatment been done before for this issue? \_\_\_\_\_

#### 3. Dental History:

Date of last dental visit: \_\_\_\_\_ Treatment visit  Hygiene visit

Any x-rays taken? \_\_\_\_\_

Any significant findings/treatments: \_\_\_\_\_

#### 4. Extra-oral assessment:

Swelling  Redness  Asymmetry  TMJ  Other  \_\_\_\_\_

Details: \_\_\_\_\_

#### 5. Intra-oral assessment:

Soft Tissue: Bump/Swelling  Pus  Redness  Bleeding  Recession

Details: \_\_\_\_\_

Hard Tissue:

- Visible decay: \_\_\_\_\_
- Fracture of tooth/resto: \_\_\_\_\_
- Percussion test: \_\_\_\_\_

- Hot/cold test: \_\_\_\_\_
- Tooth mobility: \_\_\_\_\_
- Other: \_\_\_\_\_

6. Differential Diagnosis: \_\_\_\_\_

7. Discussion:

- Reviewed differential diagnosis and possible options with the patient (including any limitations)

Options: \_\_\_\_\_

- Patient questions answered: \_\_\_\_\_
- Pt consents to proceed with: \_\_\_\_\_

8. Dentist Action Plan:

- Pharmacotherapy recommended/prescribed \_\_\_\_\_
  - Verified patient identity \_\_\_\_\_
  - Reviewed medical history with patient:
    - Medical Conditions: \_\_\_\_\_
    - Allergies: \_\_\_\_\_
    - Medications: \_\_\_\_\_
    - Any heart, lung, GI, kidney, liver, circulatory, nervous system issues: \_\_\_\_\_
    - Other (e.g. pregnancy): \_\_\_\_\_
  - Pharmacy info \_\_\_\_\_
- Advised pt if anything gets worse to call again, and to go to hospital emergency department if severe swelling or any difficulty breathing, swallowing, or with vision, etc.

9. Admin Action Plan:

- Book a follow-up teledentistry appointment \_\_\_\_\_
- Book in-office appointment:
  - Type of appointment \_\_\_\_\_
  - Time/units \_\_\_\_\_
- Make a referral:
  - Oral surgeon  Periodontist  Endodontist  Oral pathologist  Other

10. Other comments: \_\_\_\_\_

11. Authorization:

Dentist Name: \_\_\_\_\_ Signature: \_\_\_\_\_