



Clinical Essentials

Clinical Essentials Test Blueprint

- ✓ Charting
- ✓ Treatment Planning



Overview

Who should take this Clinical Essentials test?

- Dentrix users with less than a year experience with Dentrix, or that have a limited role with clinical charting and treatment planning
- Front office and clinical staff who manage patient charts or create treatment plans
- Anyone who wants to understand the basics of how clinical charts are managed in Dentrix

What's on the test?

The test for clinical essentials addresses skills in two areas. They are listed here, with an approximate percentage of how much they are represented in the certificate test:

- Clinical Charting and Clinical Notes (70%)
- Treatment Planning (30%)

Number of questions: 15

Time limit: 25 minutes

Passing score: 80%

How can I use this blueprint to prepare for the test?

The skills and tasks related to this test are listed below. Please review them to help you understand and prepare for items on the test. Note tasks that you are unfamiliar with, then study them. For online study resources, training opportunities and a program overview, visit the Mastery Tracks website.



Overview (continued)

How does this test fit in Dentrax Essentials?

The Clinical Essentials test is one of four tests in Dentrax Essentials:

- Clinical Essentials
- Financial Essentials
- Patient Information Essentials
- Scheduling Essentials

Successfully completing this test means you can do basic tasks associated with using Dentrax in a clinical environment. You can also take the other tests to measure your basic skills in other Dentrax functions in the dental office.



Charting and Clinical Notes (70% of test)

The charting and clinical notes portion of the test addresses competence in the following Dentrix skills:

- Viewing clinical information
- Charting clinical information
- Understanding clinical notes
- Viewing clinical notes
- Adding, editing, and deleting clinical notes
- Signing a clinical note
- Adding an addendum to clinical notes

To prepare for the test, you should be able to perform operations and demonstrate understanding of the following detailed tasks and concepts:

A. Viewing clinical information

1. Select Progress Notes views
 - a. Select treatment information to view
 - b. Expand or collapse view information
 - c. Identify the purpose of the default sort option
 - d. Filter view by selected teeth
 - e. Filter view by date
 - f. Filter view by provider
2. Select Dentrix Graphic Chart views
 - a. Use zoom views
 - b. Use 3D views
 - i. Use arch views
 - Move teeth
 - Rotate teeth
 - ii. Use model views
 - Rotate view
 - Show or hide gums
 - Open or close mouth



- c. Paint by progress notes
 - 3. Select Panel views
 - 4. Select Chart Notation views
 - 5. Restore startup settings
 - 6. Change patient dentition
- B. Charting clinical information**
 - 1. Enter treatment information, including: existing, existing other, completed, and treatment-planned procedures
 - a. Select a provider
 - b. Select tooth or teeth
 - i. Clear selected teeth
 - c. Select procedure(s) using a variety of methods, including: choose a code from the procedure code category panel and choose a code using the procedure buttons
 - d. Enter treatment area
 - e. Select treatment status using a variety of methods, including: post treatment using the status buttons, post treatment using the auto-state button
 - 2. Edit and delete treatment information, including: existing, existing other, completed (not in history), and treatment-planned procedures
 - a. Edit treatment date
 - b. Edit procedure code
 - c. Edit treatment area
 - i. Edit surface painting
 - d. Edit procedure status
 - e. Edit provider
 - f. Add, edit, or remove diagnostic codes
 - g. Add, edit, or delete a procedure note
 - h. Insert custom procedure note
 - i. Add, edit, or remove related referral
 - j. Delete a procedure
 - 3. Invalidate procedures in history
 - a. Identify the purpose for invalidating a procedure in history
 - b. Invalidate a procedure
 - 4. Complete treatment-planned procedures
 - a. Identify the correct method for completing a treatment planned procedure
 - b. Complete treatment-planned procedures
- C. Understanding clinical notes**
 - 1. Identify the purpose of clinical notes
 - 2. Identify the differences between clinical notes and procedure notes



D. Viewing clinical notes

1. Displaying clinical notes in the progress notes
2. Viewing clinical notes
 - a. Locate and view a specific clinical note
 - b. Collapse and expand clinical note tree

E. Adding, editing, and deleting clinical notes

1. Create new clinical note
 - a. Add, edit, and delete clinical note text
 - b. Insert date and time
 - c. Add clinical note template
 - d. Save clinical note
2. Edit a clinical note
 - a. Identify the conditions that would prevent you from editing a clinical note
 - b. Edit a clinical note
 - c. Change provider for a selected note
 - d. Change the date for a selected note
3. Delete a clinical note
 - a. Identify the conditions that would prevent you from deleting a clinical note

F. Signing a clinical note

1. Identify the purpose of signing a clinical note
2. Identify the devices you can use to sign a clinical note
3. Sign a clinical note

G. Adding an addendum to clinical notes

1. Identify the purpose of the clinical note addendum
2. Add an addendum to a clinical note



Treatment Planning

(30% of test)

The treatment planning portion of the test addresses competence in the following Dentrrix skills:

- Managing Treatment Plan cases
- Setting up consent forms
- Printing treatment case reports

To prepare for the test, you should be able to perform operations and demonstrate understanding of the following detailed tasks and concepts:

A. Managing treatment plan cases

1. Display completed and rejected cases
2. Create, rename, and delete a treatment plan case
3. Identify what happens when a treatment plan case is deleted
4. Create and edit alternate cases
5. Link and unlink cases
6. Update case status
 - a. Set case status
 - b. Accept a case
 - c. Reject a case
 - d. Refer a case to another provider
 - e. Complete a case
7. Set case severity
8. Order procedures by visit
9. Manage procedures in cases
 - a. Move procedures between cases
 - b. Delete procedures from a case
 - c. Set a procedure complete
10. Set the default treatment plan case
11. Enter supporting information for cases
 - a. Set Case Financing status
 - b. Set an estimate expiration date
 - c. Insert a Case Note template



- d. Add, edit and delete a case note
 - 12. View case status history
 - 13. View case insurance information
 - a. View primary insurance notes
 - b. View secondary insurance notes
 - c. View the insurance benefits summary
 - 14. Update treatment plan fees for current patient
- B. Managing consent forms**
 - 1. Attach a consent form to a case
 - 2. Sign a consent form
 - a. Add an additional note
 - b. Enter patient signature information
 - c. Select practice signature information
 - d. Save a signature
 - e. Print a signed consent form
 - f. Remove a consent form from a case
- C. C. Printing Treatment Case reports**
 - 1. Print the Treatment Case report
 - a. Create, rename, and delete report options
 - b. Print the Patient Treatment Case report
 - c. Print the Practice Treatment Case report