DENTRIX ENTERPRISE

DENTRIX ENTERPRISE 11.0.48

USER'S GUIDE
for Indian Health Service



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: Introduction and Initial Setup

From front desk to operatory, Dentrix Enterprise provides profitable integration solutions for managing a variety of information, including patient demographics, clinical details, and production analyses. Dentrix Enterprise can boost staff productivity, enhance professionalism, increase collections, help keep your chairs full, and improve your bottom line.

This chapter covers the following topics about the various Dentrix Enterprise modules and the basic steps to set up and begin using the program in your office:

- Dentrix Enterprise Modules
- Opening Dentrix Enterprise
- Closing Dentrix Enterprise
- National Configuration Settings
- Setting Up Clinics
- Setting Up Third-party Integrations
- Setting Up Clinic Resources
- Setting Up Appointment Book
- Setting Up Ledger
- Setting Up Continuing Care Types
- Setting Up Fee Schedules
- Editing Procedure Codes
- Setting Up Multi-codes
- Customizing Practice Definitions
- Setting Up Practice Defaults
- Customizing IHS Standard Codes Definitions
- Setting Up Auto Chart Numbering
- Setting Up Default Printers
- Setting Up Security
- Setting Up Program Preferences

Before setting up your Dentrix Electronic Dental Record (EDR), it is important to understand the relationship between RPMS and Dentrix. An interface has been installed that allows information to flow or be "pushed" from one program to the other. RPMS will push each patient's demographics ONLY (name, address, birth date, SS#, and so on) into Dentrix.

If dental staff enter a change of address into Dentrix it will not be saved because the demographic information DOES NOT flow from Dentrix back into RPMS. Once that new information is entered into RPMS, however, within seconds, the new information will be displayed in Dentrix because it will automatically flow over to Dentrix from RPMS.

At this time, the only information that is pushed from Dentrix over to RPMS are the completed procedures done in the Patient Chart—the "coding" is sent for billing purposes from the work done in the Patient Chart.

RPMS > Patient Information > Dentrix

Dentrix > Completed ADA and IHS Procedures in Patient Chart > RPMS

Dentrix Enterprise Modules

The following independent modules of Dentrix Enterprise each manage specific types of information:

- **Office Manager** – Office Manager offers useful, customizable reports and lists (reports are also available in DXOne Reporting). Office Manager works with Microsoft Word to help you create effective, professional-looking letters: welcome letters, congratulatory letters, thank-you notes, a variety of appointment and continuing care reminders, progress reports, and collection notices. Additionally, Office Manager contains a set of utilities that you can use to customize Dentrix Enterprise to fit your needs.
- **Family File** – Family File can help you manage patient and insurance information. In Family File, you can keep track of a patient's name, address, employer, insurance information, notes, and continuing care (recare or recall), and other important information.
- **Appointment Book** – Appointment Book can help you manage appointments and maximize production by using visual, goal-oriented scheduling. In Appointment Book, you can make changes to scheduled appointments easily and reschedule appointments by dragging them. Convenient toolbars and flip tabs help you navigate through the schedule, search for open times, organize appointments and notes, record broken appointments, and print route slips. Also, you can clearly see the times when a clinic is closed and when a provider is unavailable.
- **Chart** – Chart can help you manage the clinical information of patients. In Chart, you can post existing, completed, and recommended procedures. Additionally, you can keep extensive and detailed notes regarding patient care in Chart.
- **Ledger** – Ledger helps you manage the financial information of patients. When you set procedures complete from Patient Chart or Appointment Book, Dentrix Enterprise automatically posts those procedures in Ledger. Ledger contains a record of all financial transactions entered into Dentrix Enterprise, including charges, payments, and adjustments. You can create claims and pre-treatment estimates in Ledger. Ledger also provides you with information concerning patient portions versus insurance portions, deductibles owed, and payment arrangements.
- **DXOne Reporting** – DXOne Reporting provides you with reports that will assist you in analyzing your practice. You can schedule these reports to be generated automatically on a daily, weekly, monthly, or one-time basis. Additionally, you can send reports generated in DXOne Reporting as an email attachment to the Central clinic, a consultant, or an accountant.
- **Document Center** – Document Center can help you create a truly paperless office. You can scan, capture, and import documents (such as patient medical and dental history, proof of income, insurance cards, patient letters, EOBs, and referral letters) or images (such as patient pictures and X-rays). You can then attach these documents to patients, providers, insurance carriers, and referral sources; or you can print or email them. You can open Document Center from Appointment Book, Family File, Chart, Collections Manager, Office Manager, and DXOne Reporting.
- **Treatment Planner** – Treatment Planner is designed to bridge the gap between doctor and patient by providing patients with easy-to-understand treatment options. You can open Treatment Planner from Appointment Book, Family File, Chart, Ledger, and Document Center.
- **More Information** – More Information provides you with access to an entire overview of patient information, such as basic demographics, future appointments, treatment plans, medical information, treatment requests, and aged balances. You can add a picture to a patient's profile. You can customize the patient information view to suit your preferences. Also, you can quickly switch between viewing information for a patient and that patient's family members. You can open More Information from Appointment Book, Chart, Family File, Ledger, Treatment Planner, Document Center, Office Manager, and DXOne Reporting.

- **Office Journal** – Office Journal can help you keep administrative notes, peer reviews, billing notices, letters, reminders, and phone call conversations organized. In Office Journal, you can also record communications with patients and team members. You can open Office Journal from Appointment Book, Appointment List, ASAP List, Open List, Unscheduled List, Pinboard List, Continuing Care, Family File, Ledger, Chart, Treatment Planner, Document Center, More Information, Collections Manager, Office Manager, DXOne Reporting, and Referral Analysis.
- **Medical Alerts** – You can access medical alerts (problems, allergies, medications, and implantable devices) from Family File, Chart, and Treatment Planner. When a patient has a health condition that requires attention, the Medical Alerts button on the toolbar in those modules and the Medical Alerts symbol on the patient's appointment in Appointment Book is red. You can click the button, or symbol, to view a list of the patient's medical alerts. You can also add, edit, and delete medical alerts as needed.
- **Collections Manager** – Collections Manager can help you increase your practice's revenue by decreasing your accounts receivable. Based on criteria you select, Collections Manager displays a list of accounts that need to be contacted. From this list, you have access to necessary information when you are contacting a person regarding his or her account, including aged balance, payment information, Office Journal entries, and insurance estimates. You can open Collections Manager from Ledger or Office Manager.
- **Family Balance Manager** – With Family Balance Manager, you can identify accounts with credit and charge balances and then post write-offs on those accounts at the same time. You can open Family Balance Manager from Ledger or Office Manager.
- **Signature Manager** – With Signature Manager, you can sign multiple clinical notes at one time. You can open Signature Manager from Office Manager, Ledger, Family File, Chart, and Appointment Book.
- **Scheduling Assistant** - Scheduling Assistant enhances the scheduling workflow by combining Continuing Care, Unscheduled Appointments, ASAP, Unscheduled Treatment Plans, and Treatment Request Manager lists into one window. Also, Scheduling Assistant includes quick access to a patient's details and Office Journal entries. You can open Scheduling Assistant from Office Manager, Ledger, Family File, Chart, and Appointment Book.

Dentrix Enterprise includes the following dependent modules, which you can open from one of the independent modules:

- **Perio Chart** – With Perio Chart, you can record mobility, furcation grades, plaque, calculus, bone loss, pocket depths, bleeding and suppuration points, gingival margins, CAL levels, and MGJ measurements. Also, you can view Perio Chart data graphically. In Perio Chart, you can print custom reports, charts, and letters for an insurance consultant or the referring dental professional.
- **Quick Letters** – Dentrix Enterprise works with Microsoft Word to help you quickly create a letter for a patient. You can choose from over 40 pre-defined letter templates for your practice correspondence or create your own. You can customize each letter in Microsoft Word to fit the needs of your office.
- **Quick Labels** – With Quick Labels, you can quickly print a variety of labels to put on an envelope or a postcard for a patient.
- **Continuing Care** – With Continuing Care, you can track your patients' on-going dental care. You can create multiple types of patient recare, manage and sort continuing care cards, and monitor continuing care exams.
- **Send Message** – With the Send Message feature, you can create and send email messages to patients from within Dentrix Enterprise.
- **Patient Questionnaire** – Patient Questionnaire can help your office go paperless. It can store the same information that is included on new patient forms, health history updates, and other forms used in your office to collect information from patients. Plus, Patient Questionnaire allows you to create a custom set of questions for your patients so that specific information can be stored in each patient's record.

- **Patient Prescription** – Patient Prescription is designed to help you quickly create prescriptions and accurately track medicines that have been prescribed to your patients.
- **Patient Alerts** – Patient alerts are customizable alerts that you can attach to a patient or family. Whenever you access the areas of Dentrix Enterprise that have been specified for a patient alert, a message appears. Also, if a patient has a patient alert attached to his or her record, a symbol appears on that patient's appointments.

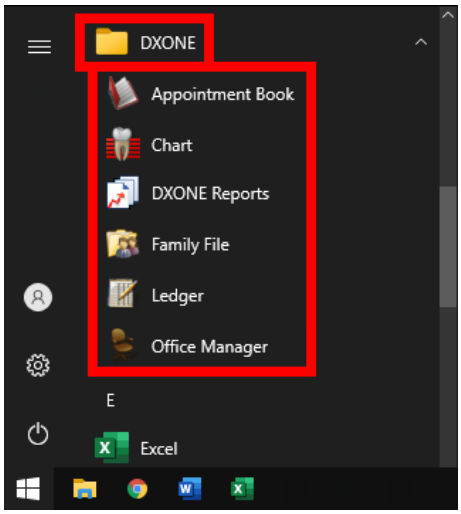
The following products and packages are available as add-ons or integrated technologies for Dentrix Enterprise:

- **Meaningful Use** – With the Meaningful Use feature (sold separately), you can use Dentrix Enterprise as a certified electronic health record for Meaningful Use.
- **Axia Credit Card Processing** – With the integration of Dentrix Enterprise with AxiaMed, you can process credit card payments and refunds from within Ledger using the AxiaMed credit card processing service and a card reader (each sold separately).
- **Dentrix Enterprise Pay** – With Dentrix Enterprise Pay (sold separately), you can process credit card payments in Dentrix Enterprise. Worldpay is the third-party provider of the credit card transaction service, so you must purchase Worldpay merchant accounts. You must also purchase compatible credit card readers.
- **eClaims** – With eClaims (sold separately), you can send electronic insurance claims. The cost of sending claims electronically is significantly lower than the cost of sending paper claims because of the savings on labor, materials, and postage. If your claim cannot be sent to the payor electronically, it will be printed to paper and mailed within 24 hours. Claims sent through eClaims go directly into the insurance company's computer, which helps dental offices receive payment in a more timely manner.
- **QuickBill** – With QuickBill (sold separately), you can generate billing statements without having to print a page, stuff an envelope, or lick a stamp. Instead, QuickBill sends statements to a clearinghouse where they are professionally printed, folded, and mailed.
- **835 EOB Importing** – With the 835 EOB importing features (sold separately), a service automatically receives electronic explanation of benefit statements (eEOBs), or you can import files manually. You must be sending claims using eTrans (eClaims). You can set up a data service to use any existing eTrans accounts or Data Services accounts (each sold separately) and link each account to specific clinics. Also, you must register for the eEOB service with payors. Also, you can manage all eEOBs from a central location. Automated eEOBs and electronic funds transfers (EFTs), which are available separately from some individual carriers, helps streamline the collection process, so you get paid faster and easier.
- **ePrescribe** – With ePrescribe (sold separately), you can send and manage electronic prescriptions online. AllScripts is the third-party provider of the ePrescribe service.
- **Patient Portal** – With Patient Portal (sold separately), you can send messages and patient records to a patient's online portal if you have purchased a subscription for this feature. Updox is the third-party provider of the Patient Portal service.
- **Outcome** – With the Outcome feature (sold separately), you can assess possible oral health outcomes, such as the risk of caries, for a patient based on particular diseases, conditions, and/or exposures that pertain to the patient. Quintiles is the third-party provider of the Outcome service.
- **Automated Insurance Eligibility Verification** – With the automated insurance eligibility verification feature (sold separately), a service automatically verifies patients' insurance eligibilities for their upcoming appointments. You must set up the eligibility service to use any existing eTrans (eClaims) accounts (each sold separately) that you may have or to use Data Services accounts (each sold separately), and you can link each account to specific clinics. Also, you must enroll in the automated eligibility verification service, and there is a per-verification charge to use the service.

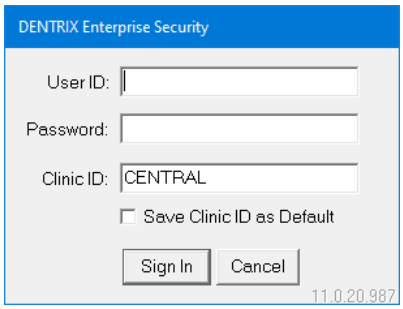
Opening Dentrix Enterprise

There are three ways to open a Dentrix Enterprise module:

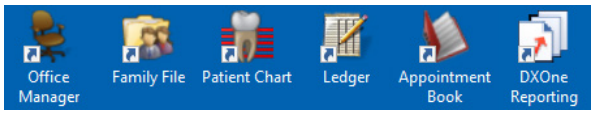
- **The Windows Start menu** – After you install Dentrix Enterprise, on the Windows Start menu, a DXONE folder that contains shortcuts to five independent modules and Office Manager is available. Click the shortcut link of the module that you want to open.



If no other modules are open, the **Dentrix Enterprise Security** dialog box appears. Enter your **User ID**, **Password**, and **Clinic ID** (to save that ID for the next time you log in, select the **Save Clinic ID as Default** check box). Then, click **Sign In**.



- **A shortcut icon on the Windows Desktop** – By default, the installation of Dentrix Enterprise adds a shortcut icon for Office Manager on your Window desktop. You can create a shortcut icon on the Windows desktop for other modules, such as Ledger. Double-click the shortcut icon of the module that you want to open.



If no other modules are open, the **Dentrix Enterprise Security** dialog box appears. Enter your **User ID**, **Password**, and **Clinic ID** (to save that ID for the next time you log in, select the **Save Clinic ID as Default** check box). Then, click **Sign In**.

- **Another Dentrix Enterprise module** – From an open module, you can open other modules: on the File menu, click the name of the module that you want to open; or on the toolbar, click the button that corresponds to the module that you want to open. For example, Treatment Planner includes a Dentrix Enterprise Modules toolbar, and the first four buttons on this toolbar open Family File, Ledger, Appointment Book, and Office Manager, respectively.



Note: If you have a patient selected in one module, and then open another patient-specific module, Dentrix Enterprise will keep the current patient active in the newly-opened module. For example, if you are working in a patient's Ledger record and open Family File from Ledger, information for the same patient appears in Family File, and the patient name appears on the **Family File** window's title bar.

Closing Dentrix Enterprise

When you close an independent module, the other independent modules do not close. Also, you can log off Dentrix Enterprise from an independent module to close all modules.

Exit/Close

You can close independent modules independently of other modules.

To close an independent module

Do one of the following:

- In Office Manager, Ledger, Appointment Book, Chart, Family File, Document Center, More Information, Office Journal, DXOne Reporting, Medical Alerts, Collections Manager, Family Balance Manager, Outstanding Claim Manager, Signature Manager, Treatment Request Manager, Scheduling Assistant, or Dentrix Enterprise Messenger, click the window's **Close** button (X).
- In Office Manager, Ledger, Appointment Book, Chart, Family File, Document Center, Office Journal, DXOne Reporting, or Collections Manager, on the **File** menu, click **Exit**.

The module closes. Any open windows are dependent upon that module close as well. Any other open independent modules stay open.

Log Off

You can close all open modules from independent modules.

To log off all modules

1. Do one of the following:
   - Click the Log Off button on the toolbar of any of the following modules:

     Office Manager, Ledger, Appointment Book, Chart, Family File, or Collections Manager:

     Document Center:

More Information:



DXOne Reporting:



- In Office Manager, Ledger, Appointment Book, Chart, Family File, Document Center, More Information, Office Journal, DXOne Reporting, or Collections Manager, on the **File** menu, click **Log Off**.

2. Click **OK**.

   All modules and dependent windows close.

National Configuration Settings

The Indian Health Service (IHS) National Configuration meeting was held September 15 – 17, 2009, at the Henry Schein Practice Solutions (HSPS) building in American Fork, UT. Representatives from HSPS, Science Applications International Corporation (SAIC), and IHS met to decide upon a national configuration to be used for installation at future clinics as a part of the IHS EDR project. The national configuration established a suggested pattern for installation, while also allowing for some decisions to be made by the local clinic being installed. The purpose of this section is to list the standards established by the national configuration, as well as to establish those settings that will be decided by the local clinic.

The standardized configurations listed in this document have been set up in the default database that is installed at all installations of Indian Health Clinics that are participating in the IHS EDR Project. You will refer back to these configuration settings as your site is set up with Dentrix.

National Settings

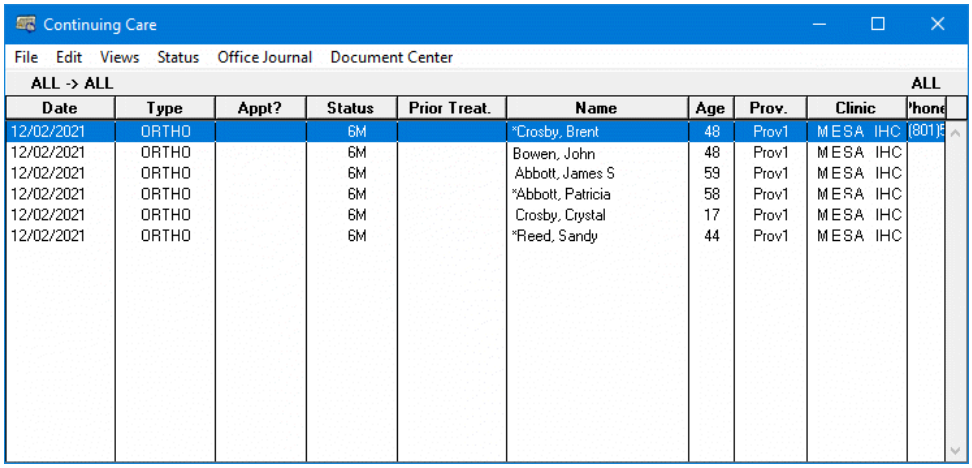
- Within the clinical notes feature of the Dentrix chart there is an option to use an "approve" button to lock a clinical note. This approval will lock the note so that the original note cannot be edited. It will allow for appended notes, but not an edit of the actual note that existed when the "approve" button is utilized.

  Those in attendance at the National Configuration meeting decided that this button needs to be enabled through the global settings utility that is used when a clinic is installed with Dentrix Enterprise.
- In regards to password security settings, it was decided that the security rights settings that are used in RPMS should be followed in the installation of Dentrix Enterprise:
  - A new password must be established every 90 days.
  - A user cannot use any password that has been used as one of the user's previous 6 pass-words.
  - The password must be "strong", meaning at least 8 characters in length, consisting of a combination of upper case letters, lower case letters, numbers and special characters.
  - After three attempts, the user is to be locked out for an automatic stay of 1 hour. Another user with appropriate permissions may unlock the user sooner than the one hour.
- Another setting to be established in the Global Setting utility at the time of installation is the enabling of the Medical History Review option. This option will enable a window that will pop up the first time each day that a patient's record is accessed through the Patient Chart.
- In the Appointment Book, it was decided to create a standard list of definitions to be used as Appointment Statuses. This list is not comprehensive, allowing the local clinic to customize the list to meet the needs of the clinic.

  The appointment statuses that were added to the National Configuration are as follows, including the colors to be assigned:

  - Confirmed
  - Left Message
  - Unable to Contact
  - Patient Here
  - ER/Walk In
  - Special Needs
  - Dark Blue
  - Light Blue
  - Brown
  - Green
  - Red
  - Orange

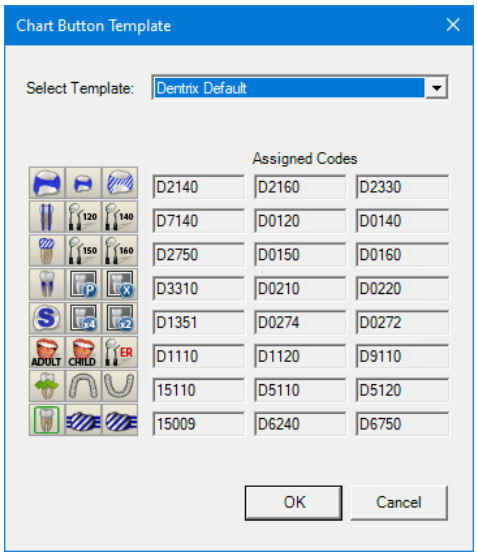
- As Initial Reasons used for scheduling appointments, also found in the Definitions area of the Office Manager, the following procedures were decided upon:
  - New Patient
  - Comprehensive Exam
  - Pano
  - 4 Bitewings
  - 2 Bitewings
  - FMX
  - Prophy
  - Child Prophy
  - Fluoride
  - Oral Hygiene Instructions
  - Periodic Exam
  - Limited Exam
  - Under 3 Exam
  - Consult
  - Office Visit (Follow Up)
  - Palliative Tx
  - Perio Maintenance Therapy
- Also found in the Appointment Book is the Continuing Care List.



  It was decided to include the following standard lists as a part of the National Configuration:
  - Last month of patients who were due for treatment but never seen.
  - Last 3 months of patients who were due for treatment but never seen.
  - Last 6 months of patients who were due for treatment but never seen.
  - All patients that have been due for treatment but never seen.
- The list of available continuing care types that can be tracked automatically by Dentrix Enterprise is to include the following:
  - Space Maintainer to be tracked at every 6 months and attached to ADA codes D1510 and D1515.
  - High Risk Caries to be tracked at every 3 months. The attached code is to be determined.
  - Oral Path to be tracked at every 1 month. The attached code is to be determined.
  - Hygiene is to be tracked at every 6 months and attached to ADA codes D1110, D1120, and D4910.
  - Ortho is to be tracked at every 1 month and attached to ADA code D8670.
- In the Procedure Code Setup area of the Office Manager, the only change to be established on the national level is the op site(treatment area) for ADA code D0220 and D0230 is to be set to tooth, thereby requiring a tooth number.

- In the Letter Merge area of Dentrix Enterprise there will be templates included that will provide Post Op instructions for the following codes and letter names:
  - SSC sscpost.doc
  - Dental Surgery surgery.doc
  - Simple Extraction simpext.doc
  - Pedodontic Extraction pedoext.doc
  - Trauma trauma1.doc
  - Dentures denture.doc
  - Pulpotomy pulppop.doc
  - Sinus Opening sinusop.doc
  - Excuse Letter excslip.doc
- It was decided that Prescriptions will continue to be entered as they currently are, meaning that they will be entered through the EHR.
- It was decided to include the following as Allergies within the Definitions:
  - Latex
  - Penicillin
  - Amoxicillin
  - Clyndamycin
  - Sulfa
  - Ibuprofen
  - Local Anesthetic
  - Tylenol/Acetaminophen
  - Aspirin
  - Codeine
  - Hydrocodone
  - Iodine
  - Erythromycin
  - Tetracycline
  - See Notes
- It was decided to include the following as Medical Alerts (in addition to those already included in the installation):
  - Bisphosphonates
  - Auto Immune Disorders
  - Hepatitis C
- In the Patient Chart, it was decided to use the following color scheme to represent the associated treatment type:
  - Treatment Plan Red
  - Completed Blue
  - Existing Blue
  - Existing Other Blue
  - Conditions Black

- Also in the Patient Chart, it was decided to establish 21 of the 24 Quick Procedure Buttons.



The following codes and icons are used:

- 0000 1st Visit This Fiscal Year (10/1)
- 0190 All Subsequent Visits
- D1110 Adult Prophy
- D1120 Child Prophy
- D0274 4 BWX
- D0272 2 BWX
- D7140 Tooth Extraction, erupted/uncomplicated
- D0330 Panorex
- 9990 Treatment Plan Completed
- D1206 Fluoride Varnish
- D2140 Amalgam Restoration (use for anterior and posterior, any number of surfaces)
- D2391 Comp/Resin Restoration (use for anterior/posterior, any number of surfaces)
- D2940 Sedative Filling
- D1330 OHI
- D9110 Palliative Treatment
- D2930 Stainless Steel Crown
- D2750 Porcelain Fused to High Noble Crown
- D3310 RCT – any area of the mouth
- D3220 Pulpotomy
- D1351 Sealant
- D0220 Periapical X-ray, first one
- Site Decision The clinic can decide which code and icon to use
- Site Decision The clinic can decide which code and icon to use
- Site Decision The clinic can decide which code and icon to use

- Within the Password Setup, it was agreed to include five employee password templates that would be used to base the assignment of password rights for all other employees. These five templates will be assigned to "users" with the following names and roles:
  - FD Template Front Desk
  - DA Template Dental Assistant
  - Prov Template Dentist
  - FA Template Full Access
  - RDH Template Dental Hygienist

  The rights assigned to each are as follows:

Security Option	**FD**	**DA**	**Prov**	**FA**	**RDH**
Appointment Day Notes, Modify	X	X	X	X	X
Appointment Lists	X	X	X	X	X
Appointment Views, Add New	X			X	
Appointment Views, Delete	X			X	
Appointment Views, Edit	X			X	
Appointments, Break	X	X	X	X	X
Appointments, Delete	X	X	X	X	X
Appointments, Edit	X	X	X	X	X
Appointments, Open	X	X	X	X	X
Appointments, Purge				X	
Appointments, Schedule New	X	X	X	X	X
Appointments, Set Complete				X	
Appointments, Setup Clinic				X	
Appointments, Setup Providers	O			X	
Appointments, Setup Schedule	O			X	
Approval Status	X	X	X	X	X
Appt Lists, View All Clinics	X	X	X	X	X
ApptBook, Change Prov Color	X			X	
ApptBook, Copy View	X			X	
ApptBook, Copy Views to Users	X			X	
ApptBook, Remove Prov	X			X	
Auto Chart Number Setup	Set up to not assign				
Batch Processor, Delete Reports	X			X	
Batch Processor, Print/Display Reports	X	X	X	X	X
Billing/Payment Agreement, Modify	X			X	
Chart Setup				X	
Chart, Open	X	X	X	X	X
Clinic Admin				X	
Clinic ID Change				X	
Clinic Resource Setup	O			X	
Clinical Notes, Append			X	X	X
Clinical Notes, Approve			X	X	X

Security Option	FD	DA	Prov	FA	RDH
Clinical Notes, Delete			X	X	X
Clinical Notes, Modify		O	X	X	X
Collections Manager, Open				X	
Completed Procedures, Delete		X	X	X	X
Completed Procedures, Edit		X	X	X	X
Completed Procedures, Enter	X	X	X	X	X
Conditions / Diagnosis, Delete		X	X	X	X
Conditions / Diagnosis, Edit		X	X	X	X
Conditions / Diagnosis, Enter		X	X	X	X
Continuing Care, Clear Patients	X	X	X	X	X
Continuing Care, Edit Patients	X	X	X	X	X
Continuing Care, Open	X	X	X	X	X
Continuing Care, Setup				X	
Credit Adjustment, Delete				X	
Credit Adjustment, Edit				X	
Credit Adjustment, Enter				X	
Customize Toolbars				X	
Database Mode Setup				X	
Debit Adjustment, Delete				X	
Debit Adjustment, Edit				X	
Debit Adjustment, Enter				X	
Dunning Messages, Modify				X	
DXOne Report, Launch	X		X	X	X
Employers, Add New/Edit Info					
Existing Procedures, Delete		X	X	X	X
Existing Procedures, Edit		X	X	X	X
Existing Procedures, Enter		X	X	X	X
Family File, Open	X	X	X	X	X
Fast Checkout				X	
Fee Schedule, Setup				X	
Guarantor Notes, Modify				X	
Guarantor Payment, Delete				X	
Guarantor Payment, Edit				X	
Guarantor Payment, Enter				X	
Image, Open	X	X	X	X	X
Ins Payments, Delete				X	
Ins Payments, Edit				X	
Ins Payments, Enter				X	
Insurance Claims, Create New				X	
Insurance Claims, Delete				X	
Insurance Claims, Edit				X	

Security Option	FD	DA	Prov	FA	RDH
Insurance Claims, Open				X	
Insurance Coverage, Modify				X	
Insurance Payment Tables, Modify				X	
Insurance Plans, Add New/Edit Info	X			X	
LC/FC, Delete				X	
LC/FC, Edit				X	
LC/FC, Enter				X	
Ledger + History				X	
Ledger Setup				X	
Ledger, Open				X	
Ledger, Open Treatment Plan				X	
Letters, Add New	X	X	X	X	X
Letters, Birthday				X	
Letters, Collection				X	
Letters, Continuing Care	X	X	X	X	X
Letters, Delete				X	
Letters, Edit	X	X	X	X	X
Letters, Inactive Patient				X	
Letters, Misc.	X	X	X	X	X
Letters, Referral	X	X	X	X	X
Letters, Welcome	X	X	X	X	X
Medical Alerts, Edit	X	X	X	X	X
Medical Alerts, View	X	X	X	X	X
Medical Consultation		X	X	X	X
Month End - Charges				X	
Month End - Payment Plan				X	
Month End - Update				X	
More Info / Family Appointment List	X	X	X	X	X
Multi-Clinics, Purge Appt				X	
Multi-Codes Setup				X	
Office Journal, Add En-tries	X	X	X	X	X
Office Journal, Delete Entries	X	X	X	X	X
Office Journal, Edit Entries	X	X	X	X	X
Office Journal, Open	X	X	X	X	X
Office Manager, Open	X	X	X	X	X
Office, Report Multiple Clinics				X	
Password Administration				X	
Password, Multi-Clinic				X	
Patient Alerts, Modify	X	X	X	X	X
Patient Notes, Modify	X	X	X	X	X
Patient Notes, View	X	X	X	X	X

Security Option	FD	DA	Prov	FA	RDH
Patient Prescriptions, Delete				X	
Patient Prescriptions, New				X	
Patient Prescriptions, Open				X	
Patient Questionnaire Setup				X	
Patient Questionnaire, Edit				X	
Patient Questionnaire, New				X	
Patient Questionnaire, Open				X	
Patient Quick Letters	X	X	X	X	X
Patient Referrals, Delete	X	X	X	X	X
Patient Referrals, Open	X	X	X	X	X
Patients, Add New					
Patients, Archive					
Patients, Delete					
Patients, Edit Family Relations					
Patients, Edit Information	X	X	X	X	X
Payment Agreement Types, Setup				X	
Payment Plans, Add New / Edit Info				X	
Perio Chart, Open	X	X	X	X	X
Practice Definitions Setup				X	
Practice Preferences Setup				X	
Prescriptions Setup				X	
Prescriptions, View				X	
Presenter, Open	X	X	X	X	X
Print Appointment Book Views	X	X	X	X	X
Print Billing Statements				X	
Print Charts or Progress Notes	X		X	X	X
Print Continuing Care Lists	X	X	X	X	X
Print Day Sheets				X	
Print Day Sheets, MTD/YTD				X	
Print Future Due Payment Plans				X	
Print Insurance Aging Reports				X	
Print Insurance Claims				X	
Print Office Journal Reports	X	X	X	X	X
Print Patient Notes	X	X	X	X	X
Print Patient Prescriptions				X	
Print Patient Questionnaire				X	
Print Payment Agreements				X	
Print Perio Chart Letters or Charts	X	X	X	X	X
Print Route Slips	X	X	X	X	X
Print Treatment Plans	X	X	X	X	X
Procedure Code Setup				X	
Procedure-Instructor, Enter / Edit				X	

Security Option	FD	DA	Prov	FA	RDH
Providers, Inactivate				X	
Purge Insurance / Employers				X	
Referral Analysis, Open	X	X	X	X	X
Referrals, Add New/Edit Info	X	X	X	X	X
RVU, Auto Changes				X	
Sched Reports, Delete Any				X	
Sched Reports, Print/View Any				X	
Send Electronic Billing				X	
Send Electronic Claims				X	
Suspended Credits, Apply				X	
Treatment Plan, Delete		O	X	X	O
Treatment Plan, Edit		O	X	X	O
Treatment Plan, Enter		O	X	X	O
Trojan, Import				X	
User Self Setup	X	X	X	X	X
View All Operatories	X	X	X	X	X
View All Patients	X	X	X	X	X
View All Providers	X	X	X	X	X

*Any option listed with an O in the box is to be left for the local clinic to decide.

Local Settings

As a part of the National Configuration Meeting, it was decided that there were aspects of the software setup that should be left to the local clinic for decision making, including the following:

- Production Types
- Appointment Checklist
- Appointment Book time increments
- Multi-codes
- Approval Status for Treatment Plans
- Appointment Types
- Billing Types
- Medications

The local clinics are also to have the ability to add to any of the lists of standardized configurations to make the software apply more effectively to the local clinic.

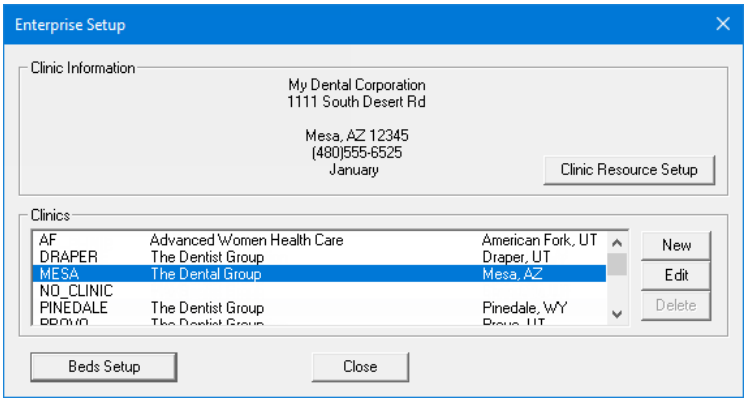
Setting Up Clinics

You can add and edit clinic information for all clinics in Dentrix Enterprise. Set up clinics prior to setting up providers. You must be in the Central clinic to set up a clinic. The Central clinic provides access to all setup features. Configuring clinic information from one computer affects all computers running Dentrix Enterprise on the network.

To set up a clinic

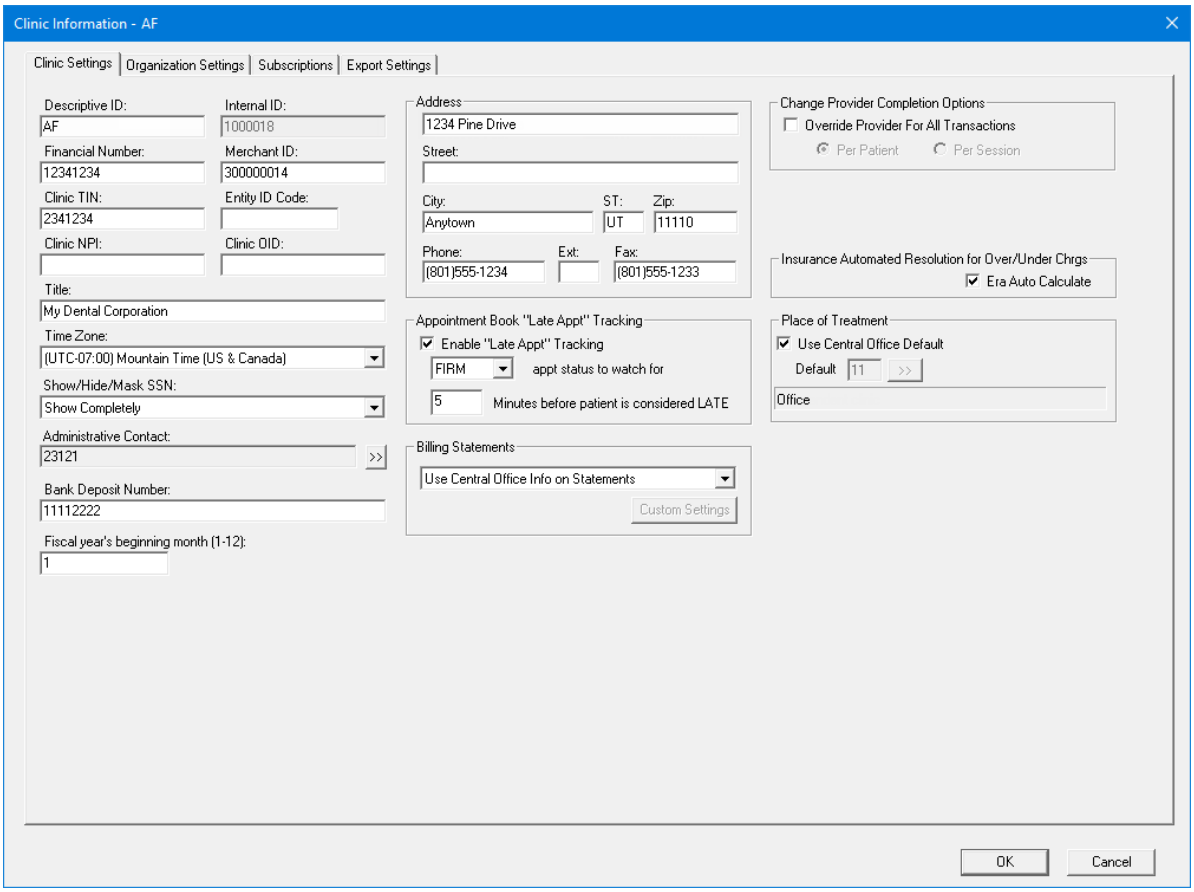
1. While logged on to the Central clinic, in Office Manager, expand the **Maintenance** menu, point to **Practice Setup**, and then click **Enterprise Setup**.

   The **Enterprise Setup** dialog box appears.



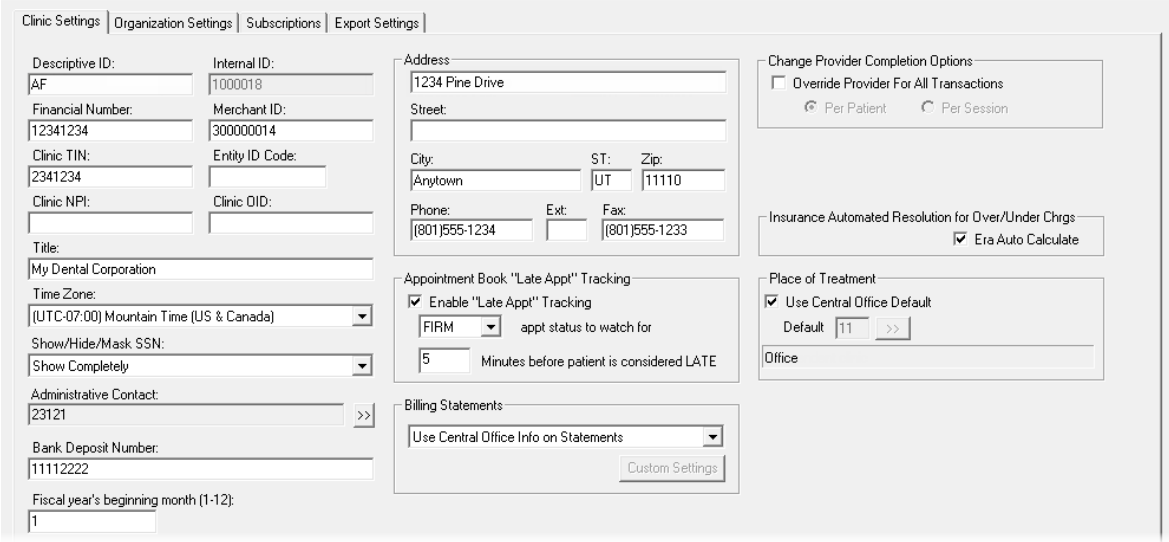
2. Select your clinic (for example, “MESA IHC”), and then click **Edit**.

   The **Clinic Information** dialog box appears.



3. Set up the following options as needed:

Clinic Settings tab (for a local clinic or the Central clinic):



- **Descriptive ID** – Enter an ID that is four to 11 characters in length (the maximum depends on a certain global setting). Valid characters include A-Z, a-z, 0-9, and a hyphen (-). This ID is used to reference the clinic throughout Dentrix Enterprise and on reports.
- **Financial Number** – Enter the account number for the clinic's financial institution.
- **Merchant ID** – Enter the ID used by the clinic for processing credit card payments.
- **Clinic TIN** – Enter the Tax Identification number of the clinic.
- **Entity ID Code** – Enter the code used to identify the entity for the clinic.
- **Clinic NPI** – Enter the NPI of the clinic.
- **Clinic OID** – Enter an External/Other ID for the clinic.
- **Title** – Enter the name of the clinic.
- **Time Zone** – Select the clinic's time zone.
- **Show/Hide/Mask SSN** – Select one of the following options:
  - **Use Central Clinic Option** – The setting will be the same as that for the Central clinic.
  - **Show Completely** – Shows the entire Social Security Number throughout Dentrix Enterprise.
  - **Hide Completely** – Hides the Social Security Number. All boxes that display Social Security Number will be blank except in dialog boxes where the number is entered or edited (for example, the **Patient Information** dialog box).
  - **Mask Completely** – Masks all digits of the Social Security Number.
  - **Mask All But Last Four** – Masks all but the last four digits of the Social Security Number.

  For a comprehensive explanation of where the Social Security Numbers will be shown, hidden, or masked throughout Dentrix Enterprise, see the "Enterprise Setup" topic in the Dentrix Enterprise Help.
- **Administrative Contact** – Click the search button  to select the business contact at the clinic. Only providers who have been entered into Dentrix Enterprise and who have a 10-digit phone number are available for selection.
- **Bank Deposit Number** – To have the clinic's bank account number print on deposit slips, enter the appropriate number.

- **Fiscal year's beginning month (1-12)** – Enter the number of the month that your fiscal year begins. The default value is 1 (January).
- **Address** – Enter the clinic's address, the phone number and extension of the contact person in the clinic (if applicable), and the clinic's fax number.
- **Appointment Book "Late Appt" Tracking** – To allow the time from the scheduled time of appointments to the arrival time of the corresponding patients to be monitored by Dentrix Enterprise (for the Appointment Statistics Report), select this check box. Then, set up the following options:
  - **Appt Status to Watch for** – Select the status appointments will have before the corresponding patient arrives. Dentrix Enterprise will begin monitoring a patient's visit when the specified status is selected for his or her appointment from the **Appointment Information** dialog box.
  - **Minutes before patient is considered LATE** – A patient will be considered late for his or her appointment when the specified number of minutes has elapsed from the time of the scheduled appointment until the status your office uses to indicate a patient has arrived is selected for that appointment. If a patient is late for his or her appointment, the **Late Appt** check box is selected in the **Appointment Information** dialog box, and a red dot appears in the upper-right corner of the appointment on the schedule.
- **Billing Statements** – Select the option that corresponds to the information you want to have appear on billing statements:
  - **Use Central Office Info on Statements** – To print the name and address of the Central clinic on a statement sent to a patient of this clinic.
  - **Use Clinic Info on Statements** – To print this clinic's name and address on a statement sent to a patient of this clinic.
  - **Use Provider Info on Statements** – To print the name and address of the patient's primary provider on a statement sent to a patient of this clinic.
  - **Use Custom Settings on Statements** – To print a specified name, address, phone number, and message on a statement that is sent to a patient of this clinic. This option is available only if a certain global setting is enabled.

    With **Use Custom Settings on Statements** selected, you can specify the clinic or provider name, clinic address, clinic phone number, and statement message separately, and each clinic can have different settings. To customize the settings for this clinic, do the following:

    a. Click **Custom Settings** to open the **Custom Settings** dialog box appears.

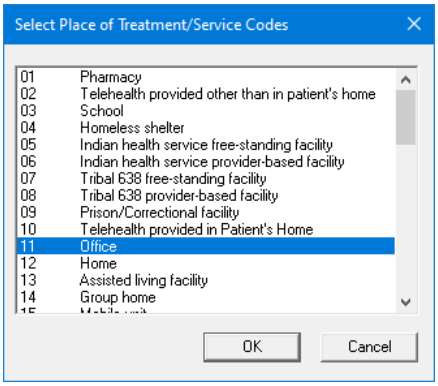
    Note: You must be logged in to the Central clinic to make changes to these settings; otherwise, you can only view them.

    b. Set up the following options:
    - **Name** – Specify whether you want to use a provider's name or a clinic's name, and then select the desired provider or clinic from the corresponding list.
    - **Address** – Select the clinic whose address you want to use.
    - **Phone** – Select the clinic whose phone number you want to use.
    - **Statement Message** – Enter the message that you want to have appear at the bottom of statements that are sent to patients of this clinic. This message will be used only if the **Use same Statement Message for all** check box is clear when setting up options to generate billing statements.

    c. Click **OK**.

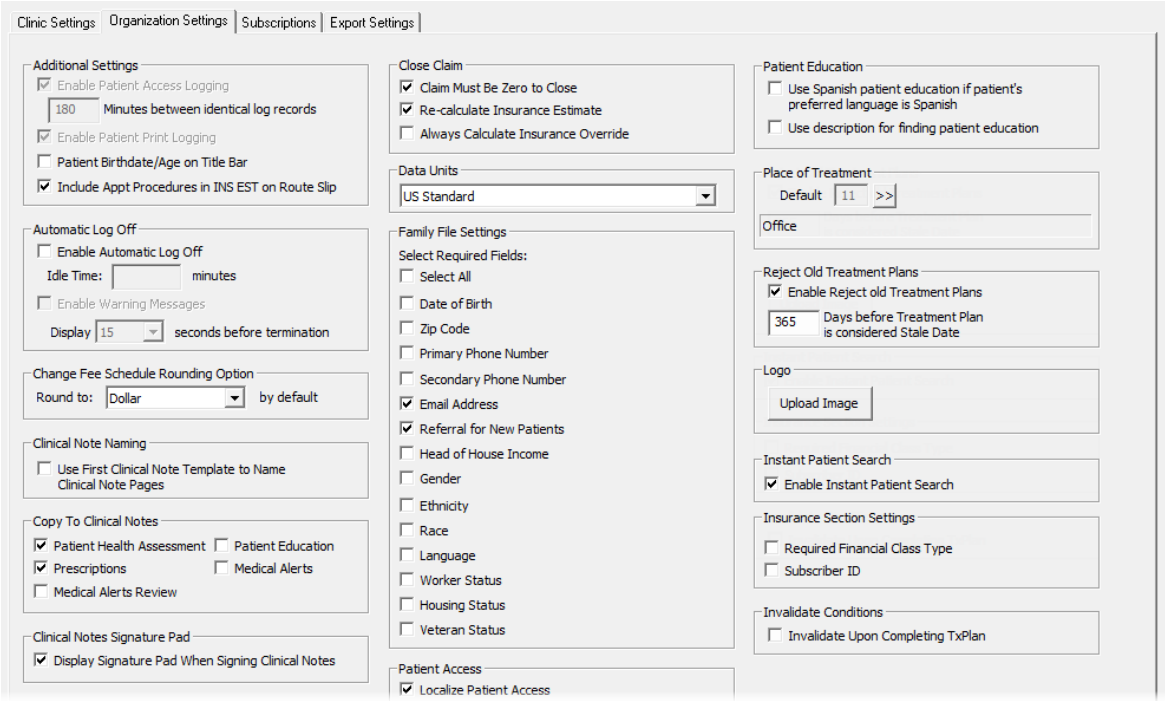
- **Change Provider Completion Options** – If the completing provider for procedures is often not the same as the treatment-planning provider, you can change the provider for those procedures and have that provider be the default for any procedures completed for a selected patient or for all patients. To enable the completing provider override feature, select **Override Provider For All Transactions**, and then select one of the following options:
  - **Per Patient** – The specified provider will be used for completed procedures being posted for a given patient until you select another provider or patient.
  - **Per Session** – The specified provider will be used for completed procedures being posted for all patients until you select another provider or close all Dentrix Enterprise modules.
- **Place of Treatment** – To specify the default place of treatment for claims that get created in this clinic, do one of the following:
  - To use the default place of treatment that was set for the organization, select the **Use Central Office Default** checkbox.
  - To override the organization-level default place of treatment, do the following:
    a. Clear the **Use Central Office Default** checkbox (if it is not already).
    b. Click the **Default** search button >>.

    The **Select Place of Treatment/Service Codes** dialog box appears.



    c. Select a place of treatment.
    d. Click **OK**.

Organization Settings tab (for the Central clinic):



- **Additional Settings**
  - **Enable Patient Access Logging** – To enable the tracking of emergency access to patient information for users without sufficient rights, select this check box. If you change this setting, the change is logged in the Audit - Audit Log Status Report. When accessing a patient record multiple times the same way (in the same module, at the same clinic, on the same date, and by the same user) within the number of minutes specified in the **Minutes between identical records** box, Dentrix Enterprise will create only one entry for the Patient Information Accessed Report. In this box, enter a value from 5 to 1440.

    Notes:

    - A short length may increase the number of identical entries that appear on the Patient Information Accessed Report, so you may want to enter a waiting period of 180 minutes or more.
    - The **Minutes between identical records** box is available only if the **Enable Patient Access Logging** check box is selected.

  - **Enable Patient Print Logging** – Select this check box to enable the tracking of the following: when reports that contain patient information are generated; when patient records are accessed; additions, deletions, and modifications of patient information; and when patient health information is exported to a patient's portal. This audit information appears on the Audit - Combined Report. If you change this setting, the change is logged in the Audit - Audit Log Status Report.

    Running any of the following reports triggers an entry in the audit trail:

    - Treatment Planner – Print Treatment Case, Patient Treatment Case Report.
    - Prescriptions – Print Prescription.
    - Office Manager – Day Sheet (Chronological), Day Sheet (Alphabetical), Billing Statements, Billing Statements (Mailing Labels), Family Ledger, Patient's Ledger, Referral Recap, Daily Appointment List, Operatory Appointment List, Unscheduled Appointment List,

Unscheduled Treatment Plans, Treatment Plan Approval Report, Treatment Plan Approval Status Report, Perio Exam List, New Patient List (Standard), New Patient List (Chart Labels), New Patient List (Mailing Labels), Patient Notes Report.

- Family File – Print Patient Notes.
- Chart – Print Dental Chart, Print Progress Notes with Chart, Referral Recap, Referral Slip.
- Continuing Care – Continuing Care Display List, Continuing Care Display List Mailing Labels.
- Patient Health Assessment – Print Patient Health Assessment, Print Patient Health Assessment Graph.
- Ledger – Walkout Statement, Family Walkout Statement, Walkout (Appointment Card), Single Patient Statement, Single Family Statement, Referral Recap.
- Office Journal – Office Journal Print Family, By Patient, By Provider, By Referred TO.
- Appointment Book – Print Route Slip, Print Appointment Book View.
- Patient health exchange – Export file, Send a file to portal.

Note: Dentrix Enterprise records each patient on a given auditable report as a separate record in the audit trail. In addition to the name of the patient, the audit trail includes the date and time of the event, the corresponding patient, the user who printed the report, and the name of the report.

- **Patient Birthdate/Age on Title Bar** – To have the birth date and age of a patient selected in a patient-specific module (except for Family File) appear on the title bar of that module's window, select this option.
- **Include Appt Procedures in INS EST on Route Slip** – The state of this check box affects route slips generated in all clinics:
  - With this check box selected:
    - The **Patient Information** section includes patient financial information: aged balances, estimated insurance portion, suspended credits, balance, and estimated patient portion (Balance + Appt Amount - Ins Est). The estimated insurance portion (Ins Est) is the insurance estimate for the procedures attached to the appointment for which the route slip is generated.
    - The **Account Information** section includes the estimated guarantor portion (Balance + Appt Amount - Ins Est). The estimated insurance portion (Ins Est) includes the insurance estimate for other family members' completed procedures (whether or not they are attached to a claim) and includes the insurance estimate for the procedures attached to the appointment for which the route slip is generated.
  - With this check box clear:
    - The **Patient Information** section does not include patient financial information.
    - The **Account Information** section does not include the estimated guarantor portion, and the estimated insurance portion is the insurance estimate for the patient's and the other family members' completed procedures (whether or not they are attached to a claim).

- **Automatic Log Off**
  - **Enable Automatic Log Off** – To have users logged off of Dentrix after a specified length of idle time, select this check box. Dentrix Enterprise is considered to be idle while there are no mouse movements or keyboard strokes in any Dentrix module on the computer to which a user is logged on. The exceptions to this rule are the DXOne Report Manager, DXPrint, and DXOne Reporting processes, which are used for reports; however, if a report is being run, and the user is logged off automatically, the generation of the report is canceled.

    Enter the length of **Idle Time** in minutes that is allowed before a user is logged off the program. The default is 15 minutes.
  - **Enable Warning Messages** – To have a warning message appear before users are logged off automatically, select this check box. The message will present the options to the user to continue working in Dentrix without being logged off or to log off immediately. If the message is ignored, after the specified number of seconds, the user is logged off automatically.

    In the **Display** box, enter the length of time in seconds a warning message will appear before a user is logged off automatically. The default is 15 seconds.

  After a user is logged off automatically, a message will appear and state that the user was logged off automatically for security purposes. To log back on to Dentrix, the user can click the **Office Manager** button on that message.
- **Change Fee Schedule Rounding Option** – Select the default rounding option (dollar, dime or penny) for automatic fee schedule changes.
- **Clinical Note Naming** – To have the default name of a new clinical note ("Note#") changed to the category and name of the template that was used to create the note (if multiple templates were used to create the clinical note, the category and name of the first template used is used), select this check box. To use the default name ("Note#") for a clinical note that is created using a template, clear this check box.
- **Copy to Clinical Notes**
  - **Patient Health Assessment** – To have a clinical note be created automatically each time you enter a health assessment for a patient, select this check box. The clinical note will contain the details of the assessment.
  - **Prescriptions** – To have a clinical note be created automatically each time you enter a prescription for a patient, select this check box.
  - **Medical Alerts Review** – To copy a list of a patient's problems, allergies, and medications to a clinical note when you specify that you have reviewed a patient's medical alerts from the **Medical Alerts** dialog box or the **More Information** window. If a clinical note already exists for today, a list of the patient's problems, allergies, and medications are appended to that clinical note; otherwise, a new clinical note is created and the information is inserted.

    Notes:

    - This functionality does not apply when you add a review to a patient's record from the **Medical Alert Review History** dialog box.
    - This functionality does not apply when you specify that you have reviewed a patient's medical alert from the **Medical History Review** dialog box.

- **Patient Education** – To have the details of a patient education topic be copied automatically into a clinical note each time you record that patient education has been presented to a patient.

  Notes:

  - Dentrix Enterprise will combine several patient education recordings that are done on the same day into one clinical note page (unless the character limit for that page is reached; in which case, an additional page will be added).
  - If you attempt to edit the date, provider, or education URL of a record in the **Patient Education History** dialog box, a message, stating that the clinical note will not be updated, will appear.
  - If you delete a record from the **Patient Education History** dialog box, the record will remain in the clinical note until you manually delete it from the clinical note (if the note is not locked).

- **Medical Alerts** – To have a clinical note be created automatically each time you enter a problem, a medication/prescription, or an allergy for a patient, select this check box.

- **Close Claim** – Select any of the following options:
  - **Claim Must Be Zero to Close**:
    - With this check box selected, if you enter an insurance payment that is more or less than what was expected from insurance, and you do not enter an adjustment to offset the difference, Dentrix Enterprise does not automatically mark the corresponding claim as being closed (although the claim's status still changes to Received). In this case, you would have to manually mark the claim as being closed by using the **Close Claim** menu option and choosing whether to credit or debit the patient's balance. Conversely, if the insurance payment is not the same as what was expected from insurance, once you enter an offsetting adjustment, Dentrix Enterprise does automatically mark the corresponding claim as being closed.

      Note: A claim is considered open unless it is marked as being closed either automatically or manually. To find open claims, you can generate the Insurance Claim Aging Report with the **Show Open Claims Only** check box selected.

    - With this check box clear, the functionality of marking a claim as being closed is not available. However, that does not mean you cannot "close" a claim; you can enter an insurance payment (which changes the claim's status to Received) and any write-offs.
  - **Re-calculate Insurance Estimate**:
    - With this check box selected, Dentrix Enterprise will recalculate an insurance estimate if changes are made to the corresponding insurance plan's coverage table or payment table.
    - With this check box clear, once Dentrix Enterprise initially calculates an insurance estimate, it will not change the amount if changes are made to the corresponding insurance plan's coverage table or payment table except when the plan's maximum benefits is reached by another family member's claim. In this case, Dentrix Enterprise will recalculate insurance estimates for all open claims for all family members.

    Note: This check box is available if the **Always Calculate Insurance Override** check box is clear.

- **Always Calculate Insurance Override**:
  - With this check box selected, when you post a completed procedure, in the **Enter Procedure(s)** dialog box, Dentrix Enterprise does the following:
    - Displays the **Override Ins. Estimate** options.
    - Automatically selects the check boxes to override the primary insurance estimate and the secondary insurance estimate according to the patient's insurance coverage.
    - Inserts the estimated insurance portion in the respective boxes as applicable.

    Note: You cannot clear either check box.
  - With this check box clear, Dentrix Enterprise never automatically enters an override for the primary or secondary insurance estimate for a completed procedure that you post in the **Enter Procedure(s)** dialog box. In fact, the **Override Ins. Estimate** options are not even available in the **Enter Procedure(s)** dialog box.

  Notes:
  - You can view or, if allowed by your office's policies, change the override amounts in the **Edit or Delete Procedure** dialog box as well.
  - In the **Enter Procedure(s)** dialog box and the **Edit or Delete Procedure** dialog box, the **Prim. Ins.** check box and amount box are available only if the patient has a primary dental insurance plan. Likewise, the **Sec. Ins.** check box and amount box are available only if the patient has a secondary dental insurance plan.
  - The **Always Calculate Insurance Override** check box does not apply to treatment-planned procedures. In other words, even if the **Always Calculate Insurance Override** check box is selected, if the selected **Procedure Status** is **Treatment Plan** in the **Enter Procedure(s)** dialog box or the **Edit or Delete Procedure** dialog box, Dentrix Enterprise does not automatically enter an override for the primary or secondary insurance estimate but the **Override Ins. Est** options are available according to the patient's insurance coverage.
  - With the **Always Calculate Insurance Override** check box selected, if you change the status of a procedure from Completed to Treatment Plan, Dentrix Enterprise automatically removes any overrides and clears the check boxes under **Override Ins. Estimate**. Also, the check boxes become available.
  - With the **Always Calculate Insurance Override** check box selected, if a procedure has a Treatment Plan status, and you have entered any overrides, when you change the status to Completed, Dentrix Enterprise clears your manual overrides under **Override Ins. Estimate** and enters the automatic calculations of the insurance portions according to the patient's insurance coverage. Also, the check boxes become unavailable.
  - If you select the **Always Calculate Insurance Override** check box, the **Re-calculate Insurance estimate** check box is cleared and becomes unavailable.

- **Data Units** – Select whether you want to use US or metric units for patient health assessments.
- **Family File Settings** – Select or clear any of the following check boxes to specify whether certain patient demographics are required for adding or updating a patient record in Family File:
  - **Date of Birth** – With this check box selected, a birth date must be entered for a patient.
  - **Zip Code** – With this check box selected, a ZIP Code must be entered for an address that gets attached to a patient.
  - **Primary Phone Number** – With this check box selected, a primary contact phone number must be entered for a patient.

- **Secondary Phone Number** – With this check box selected, a secondary contact phone number must be entered for a patient.
- **Email Address** – With this check box selected, either a personal/home email address must be entered for a patient, or it must be indicated that a patient has declined to provide an email address.
- **Referral for New Patients** – With this check box selected, a referral source must be selected when a new patient record is created.
- **Head of House Income** – With this check box selected, if a patient is the head of house, his or her income must be entered, and the frequency/recurrence must be selected.
- **Gender** – With this check box selected, a gender identity must be selected for a patient.
- **Ethnicity** – With this check box selected, an ethnicity must be selected for a patient.
- **Race** – With this check box selected, a race must be selected for a patient.
- **Language** – With this check box selected, a language must be selected for a patient.
- **Worker Status** – With this check box selected, a worker status must be selected for a patient.
- **Housing Status** – With this check box selected, a housing status must be selected for a patient.
- **Veteran Status** – With this check box selected, a veteran status must be selected for a patient.

Note: These are organization-wide settings (for all clinics) and are available only when you are setting up the Central clinic's information.

- **Localize Patient Access** – With this checkbox selected, all users are prevented from accessing patient information across clinics in Appointment Book according to the following rescrictions:
  - When you start the scheduling of an appointment from various areas of Dentrix Enterprise (such as More Information, Treatment Request Manager, and Scheduling Assistant), the **Select View** dialog box that appears displays only the Appointment Book views that have been assigned the same clinic as the selected patient's preferred clinic.
  - In Appointment Book, if the current Appointment Book view includes operatories for multiple clinics, you can schedule appointments only in the operatories of the clinic that has been assigned to the current view.

    Note: Regardless of the status of the **Localize Patient Access** setting, if the current view includes operatories for multiple clinics, Appointment Book displays all the operatories that are associated with that view.

  - In Appointment Book, if the current Appointment Book view includes operatories for multiple clinics, you can access patient-specific areas of Dentrix Enterprise (such as Family File) from an appointment only if the appointment was scheduled in the clinic that has been assigned to the current view.

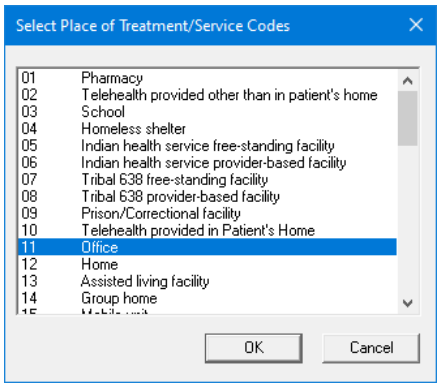
    Note: Regardless of the status of the **Localize Patient Access** setting, if the current Appointment Book view includes operatories for multiple clinics, you can open an appointment only if the appointment was scheduled in an operatory of the clinic that has been assigned to the current view

  Note: This is an organization-wide setting (for all clinics) and is available only when you are setting up the Central clinic's information.

- **Patient Education**
  - **Use Spanish patient education if patient's preferred language is Spanish** – With this check box selected, and if a patient's language preference is **Spanish** (in the **Patient Information** dialog box, under **Demographics**, **Spanish** is selected as the **Language**), when the **Patient Education** dialog box appears for that patient, the **Spanish** option is selected; otherwise, **English** is the default selection. With **Spanish** or **English** selected, when you click **Search Online** to search online with MedlinePlus for patient education resources for a problem, medication, or lab that match the search criteria that you enter, the results will be in Spanish or English, respectively.
  - **Use description for finding patient education** – Select this check box to have the description instead of the code (SNOMED, NDC, or LOINC) be used when you do either of the following:
    - Click the **Patient Education** button in the **Medical Alerts** dialog box or **Patient Prescription** dialog box or the **Education** button in the **Lab Tests** dialog box to search for patient education resources online with MedlinePlus for a selected problem, medication, allergy, prescription, or lab test.
    - Click **Show Education** in the **Patient Education** dialog box, which you can open from a patient-specific module (such as Family File), to search for patient education resources online with MedlinePlus for a selected topic.
- **Place of Treatment** – To specify the default place of treatment for claims that get created in your organization, do the following:

  a. Click the **Default** search button >>.

  The **Select Place of Treatment/Service Codes** dialog box appears.



  c. Select a place of treatment.

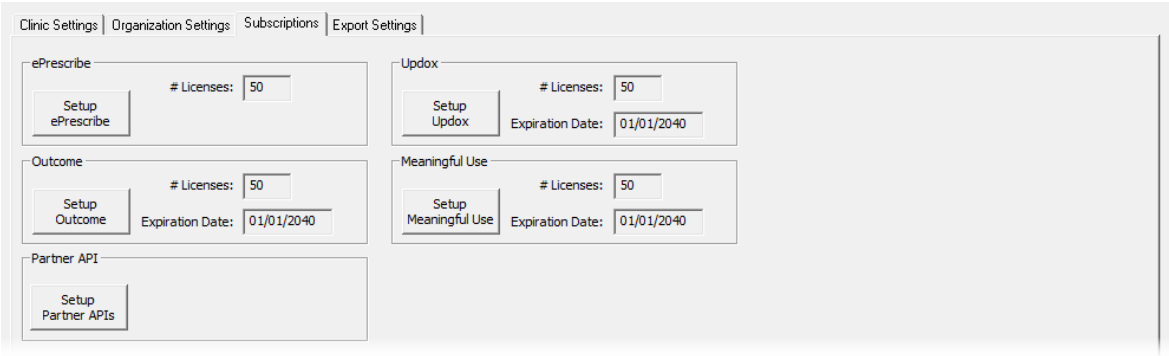
  d. Click **OK**.

  Note: You can override the organization-level default place of treatment per clinic.

- **Reject Old Treatment Plans** – To have old treatment-planned procedures archived automatically so they do not show in the Chart or Treatment Planner, select the **Enable Reject old Treatment Plans** check box. Then, in the **Days before Treatment Plan is considered Stale Date** box, enter the number of days a treatment plan case remains valid. When a treatment plan case becomes "stale," Dentrix Enterprise automatically rejects it, and adds a note, stating why and when the case was rejected, to the case's status history.
- **Logo** – To associate a logo with your organization, click **Upload Image**. In the **Custom Logo** dialog box, click **Browse** to select an image, click **Upload**, and then click **OK** on the message that appears when the image is uploaded successfully. Then, close the dialog box.

- **Enable Instant Patient Search** – With this check box selected, when you are searching for a patient, after you enter the first few characters of your search criteria, Dentrix Enterprise automatically displays matches and updates the list of matches as you enter. With this check box clear, when you are searching for a patient, after you enter your search criteria, you must click **Search** to view the matches.
- **Insurance Section Settings** – Select or clear any of the following check boxes:
  - **Required Financial Class Type** – With this check box selected, a financial class type must be selected when an insurance plan is added or edited.
  - **Subscriber ID** – With this check box selected, a subscriber ID must be entered when an insurance plan is attached to a patient.
- **Invalidate Upon Completing Tx Plan**:
  - If the **Invalidate Upon Completing Tx Plan** check box is selected, when you link conditions to a procedure, **Automatic** is selected by default for **Invalidate Upon Completion**. Unless you select a different option, when you complete the procedure, the linked condition are invalidated automatically without providing a confirmation message to allow you to choose which, if any, of the linked conditions to invalidate.
  - If the **Invalidate Upon Completing Tx Plan** check box is clear, when you link conditions to a procedure, **With Verification** is selected by default for **Invalidate Upon Completion**. Unless you select a different option, when you complete the procedure, a confirmation message appears so you can choose which, if any, of the linked conditions to invalidate.

Subscriptions tab:



- **Outcome** – If you have purchased a subscription for this feature (Quintiles is the third-party provider of the Outcome service), click **Setup Outcome** to enable and set up Outcome.
- **ePrescribe** – If you have purchased a subscription for this feature (AllScripts is the third-party provider of the ePrescribe service), click **Setup ePrescribe** to enable and set up ePrescribe.
- **Updox** – If you have purchased a subscription for this feature (Updox is the third-party provider of the Patient Portal service), click **Setup Updox** to enable and set up Patient Portal.
- **Meaningful Use** – If you have purchased a subscription for this feature, click **Setup Meaningful Use** to enable and set up Meaningful Use.

4. Click **OK**.

For comprehensive information about setting up Outcome, ePrescribe, Updox, and Meaningful Use, see the "Subscribing to Outcome," "Subscribing to ePrescribe," "Subscribing to Updox," and "Subscribing to Meaningful Use" topics in the Dentrix Enterprise Help.

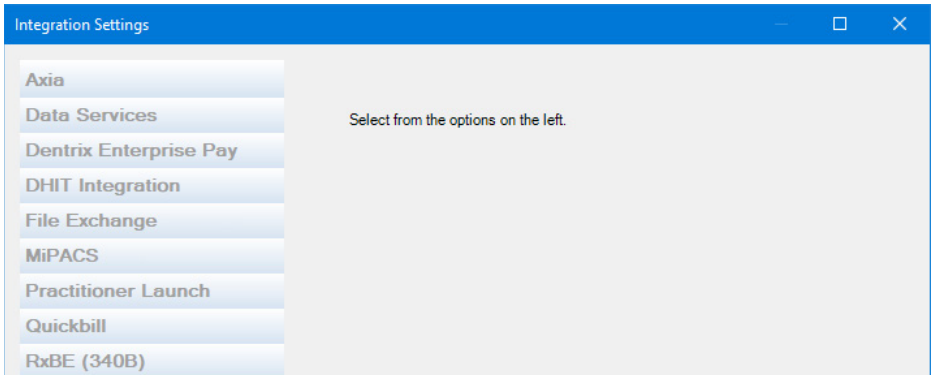
Setting Up Third-party Integrations

You can integrate credit card processing.

To set up integrations

1. In the Office Manager, from the **Maintenance** menu, point to **Practice Setup**, and then click Integration Settings.

   The **Integration Settings** dialog box appears.



2. Select any of the following tabs:
   - **Axia** – If you have purchased the Axia credit card processing add-on, before you can begin processing credit card payments in Dentrix Enterprise through Axia, you must set up the integration.
   - **Data Services**:
     - During the installation of Dentrix Enterprise, you can choose to install a service for handling automated insurance eligibility verifications for patients' upcoming appointments. Then, you can set up that service to use any existing eTrans (eClaims) accounts that you may have or to use Data Services accounts, and you can link each account to specific clinics. You can also configure other options to control the service.
     - With eTrans for Dentrix Enterprise, you can send claims electronically in Office Manager and Ledger to simplify the complex and time-consuming task of sending insurance claims. To use eTrans to send electronic claims, you must configure some settings in Dentrix Enterprise.
   - **Dentrix Enterprise Pay** – If you have purchased the Dentrix Enterprise Pay credit card processing add-on, before you can begin processing credit card payments in Dentrix Enterprise through Dentrix Enterprise Pay, you must set up the integration.
   - **File Exchange** – If you have a primary database (the main Dentrix Enterprise database) and a secondary database (a database for working in Dentrix Enterprise offline), and want to use services to watch for exported files so that they can be imported automatically into the primary database through HL7 when the secondary database is back online, you must configure the File Exchange integration settings. The primary database will be updated automatically with patient demographics, problems, allergies, and medications (PAM), charges, payments, treatment plans, Document Center files, and provider/staff exports.
   - **MiPACS** – If you use MiPACS to acquire digital X-ray images, before you can open MiPACS from Dentrix Enterprise, you must set up the integration.
   - **RxBE (340B)** – You can export prescription data from Dentrix Enterprise to send to Walgreens in compliance with the 340B government program. This functionality requires some configuration.

For comprehensive information about setting up integration with Axia, Data Services, Dentrix Enterprise Pay, File Exchange, MiPACS, and RxBE, see the "Integration Settings" topics in the Dentrix Enterprise Help.

Setting Up Clinic Resources

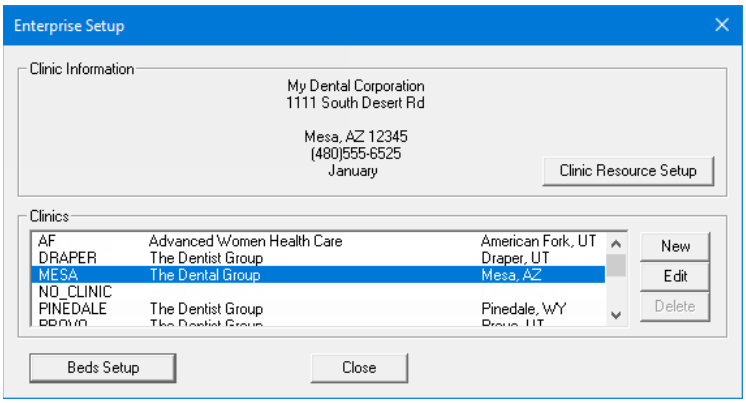
You can edit your clinic information, operatory IDs, provider information, and staff information.

To access the Clinic Resource Setup

- **For any clinic**

  1. While logged on to the Central clinic, in Office Manager, expand the **Maintenance** menu, point to **Practice Setup**, and then click **Enterprise Setup**.

     The **Enterprise Setup** dialog box appears.

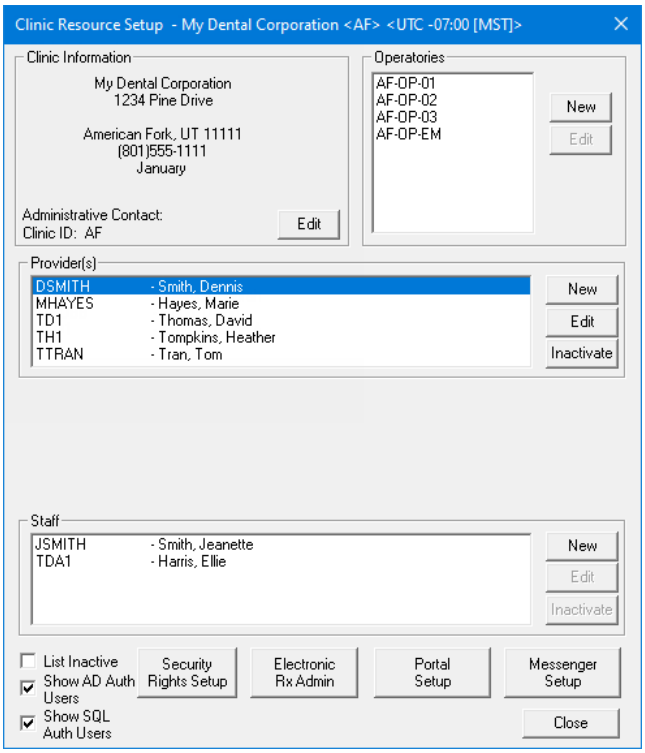


  2. Select the clinic that you want to edit.
  3. Under **Clinic Information**, click **Clinic Resource Setup**.

     The **Clinic Resource Setup** dialog box appears.

- **For the clinic that you are logged on to**

  In Office Manager, expand the **Maintenance** menu, point to **Practice Setup**, and then click **Clinic Resource Setup**. The **Clinic Resource Setup** dialog box appears.



The following sections explain about setting up clinic resources:

- Changing Clinic Information
- Setting Up Operatories
- Setting Up Providers
- Inactivating Providers
- Setting Up Staff
- Inactivating Staff

Changing Clinic Information

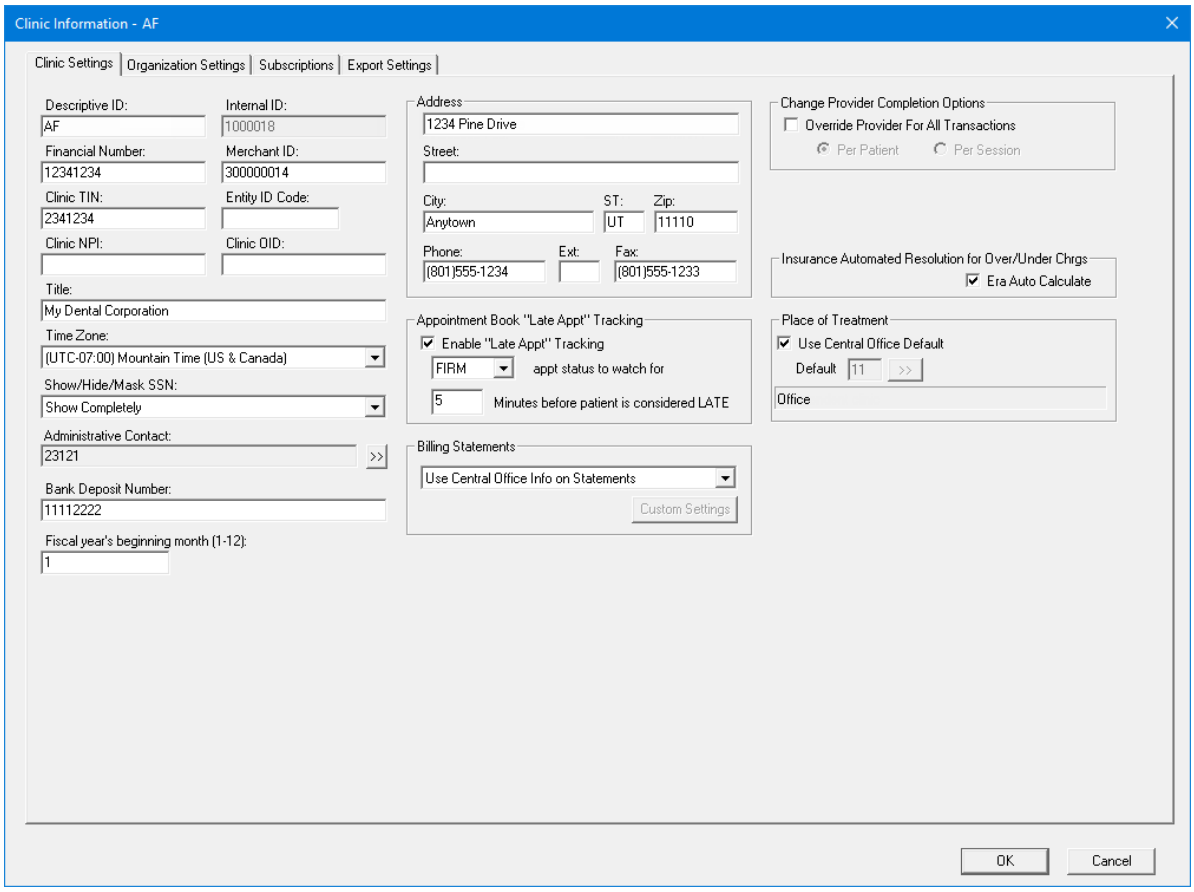
You can edit a clinic's information as needed.

To edit a clinic's information

1. In the **Clinic Resource Setup** dialog box, under **Clinic Information**, click **Edit**.



The **Clinic Information** dialog box appears.



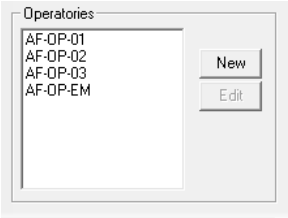
2. Change the clinic information as needed. For information about the available options, see "Setting Up Clinics" in this chapter.
3. Click **OK**.

Setting Up Operatories

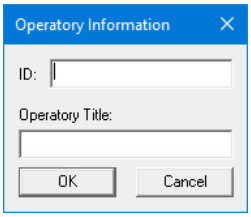
An operatory is a room, chair, or other location where treatment is performed in your office. Appointments are scheduled by operatory on any given day.

To add or edit an operatory

1. In the **Clinic Resource Setup** dialog box, under **Operatories**, do one of the following:
   - Click **New** to add an operatory.
   - Select an existing operatory, and then click **Edit** to edit that operatory.



The **Operatory Information** dialog box appears.



2. Enter the following information:
   - **ID** – The unique ID for the operatory.
   - **Operatory Title** – The title to use for the operatory instead of the ID when printing the Operatory Appointment List.
3. Click **OK**.

Setting Up Providers

Each individual that provides billable treatment to patients is considered a provider in Dentrix Enterprise.

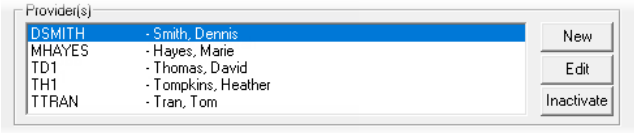
During the initial push of information, all doctors (primary providers) will be moved into Dentrix from RPMS. This initial information will need to be edited so that Dentrix contains appropriate User lD's, logon information, site address, NPI numbers, and so forth.

Hygienists do not get pushed over from RPMS. There will be one "place holder" hygienist in the Dentrix Clinic Setup that can be tweaked to contain a dental hygienist's information. Additional hygienists can be added and mapped into Dentrix allowing that production to move back to RPMS under the Dental Chief's Dentrix lD for billing purposes.

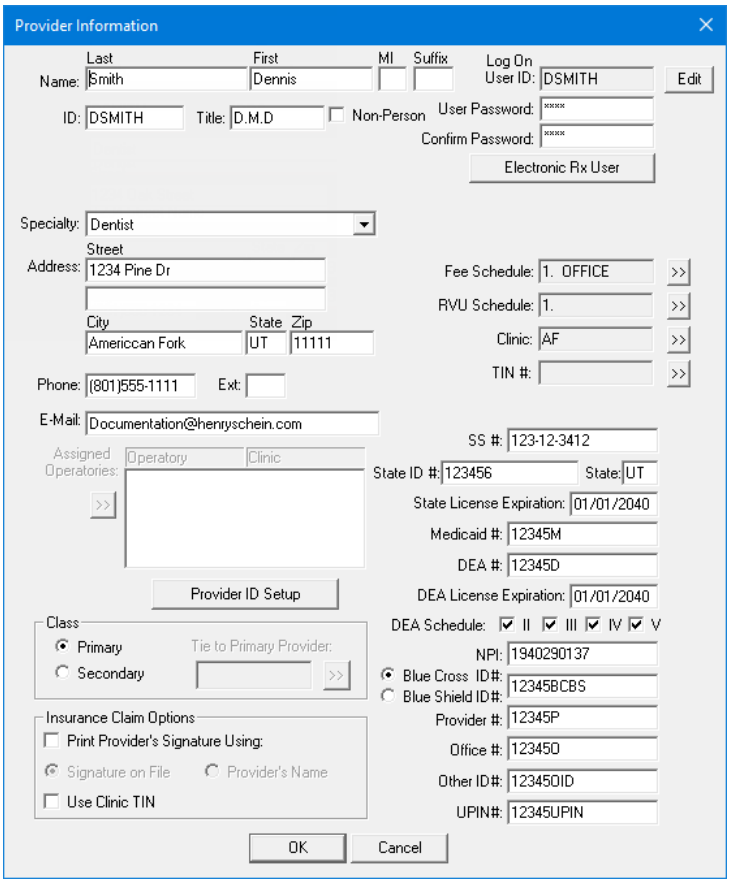
Important: To add a primary provider not listed in Dentrix Enterprrise, you MUST have that provider set up in RPMS first, and then call Dentrix Technical Support to have a technician "map" the provider in RPMS to Dentrix Enterprise. After that, the new doctor can be pushed to Dentrix Enterprise.

To edit a provider

1. In the **Clinic Resource Setup** dialog box, under **Provider(s)**, select an existing provider, and then click **Edit** to edit that provider's information.



The **Provider Information** dialog box appears.



Tip: If you want to view providers that have been inactivated in addition to the active providers listed, select **List Inactive** at the bottom of the **Clinic Resource Setup** dialog box.

2. Enter or change the following information:
   - **Name** – Enter the provider's **Last** name, **First** name, and **MI** (middle initial).
   - **ID** – This ID is pre-populated with the provider's NPI number Change the ID to something more descriptive (for example, DRWROBERTS, for Dr. Wesley Roberts; and HYMJONES, for Mary Jones, RDH). Enter a unique ID for the provider. The ID must be 4 to 10 characters in length. You can use letters, numbers, and hyphens (-).

     Note: Provider IDs are used throughout Dentrix Enterprise. Whenever a provider is displayed or printed, it is usually only the provider ID that is seen.
   - **Title** – Enter the provider's title, such as DDS, DMD, or RDH.
   - **Non-Person** – If this provider is an entity, such as a corporation or association, select this check box.
   - **Specialty** – Select the appropriate specialty for the provider.
   - **Address** – Enter the business address of the provider. This address will be used on all correspondences to patients, referrals, insurance carriers, and so forth. Also, enter the provider's **E-Mail** address.
   - **Phone** – Enter the business phone number and extension (if applicable) of the provider.
   - **Class** – Select the class for the provider: **Primary**, for primary care providers, such as dentists; or **Secondary**, for secondary care providers, such as hygienists.
   - **Insurance Claim Options** – To avoid having to sign each printed insurance claim, select **Print Provider's Signature Using**, and then select **Signature on File** or **Provider's Name**. If you want to use the clinic TIN on insurance claims, select **Use Clinic TIN**.
   - **Log On User ID** – If you are adding a new provider, enter the ID that this provider will use to access Dentrix Enterprise.
   - **Password** – In the **User Password** box, enter the password that this provider will use to access Dentrix Enterprise. Enter the same password in the **Confirm Password** box.

     Important: The password must be at least 8 (for standard users) or 15 (for administrative users) characters in length and meet the following requirements: have at least one uppercase letter, have at least one lowercase letter, have at least one number, and have at least one special character (for example, #, %, or &).
   - **Fee Schedule** – If this provider will use a different fee schedule from the default fee schedule, click the search button ››, and then select the appropriate fee schedule.
   - **RVU Schedule** – To associate an RVU schedule with this provider, click the search button ››, and then select the appropriate RVU schedule.
   - **Clinic** – Click the search button ››, and then select the clinic where the provider works.
   - **TIN** – If the clinic Tax Identification number (TIN) will be used by the provider (**Use Clinic Tin** is selected under **Insurance Claim Options**), the box displays "<CLINIC>." Click the **Tin #** search button ››, and then add, edit, or remove the TIN of any clinics as needed. You must have at least one TIN entered.
   - **SS #** – Enter the provider's Social Security number. This number will appear on insurance claims.
   - **State ID #, State, and State Expiration Date** – Enter the provider's state license number, the state where that license was issued, and the expiration date of that license. The state ID will appear on insurance claims.

- **DEA #, License Expiration, and Schedule** – Enter the provider's DEA number and the date that DEA license expires, and select the classes of medication that the provider can prescribe. The DEA number can be used with specialized insurance claims.
- **Additional IDs** – Enter any of the following IDs, which can be used with specialized claims: **Medicaid #**, **NPI**, **Blue Cross/Blue Shield ID #** (you must select one or the other), **Provider #**, **Office #**, **Other ID #**, and **UPIN#**.

3. Click **OK**.

For information about adding other IDs through the Provider ID Setup, see the "Setting up provider IDs for dental insurance" topic in the Dentrix Enterprise Help. For information about setting up the provider to use ePrescribe, see "Editing and disabling/enabling ePrescribe user accounts" in the "Adding, editing, inactivating, and reactivating providers" topic in the Dentrix Enterprise Help.

Inactivating Providers

You cannot delete providers. When a provider no longer works at a clinic, you can inactivate that provider. Inactivated providers are not available for selection throughout Dentrix Enterprise wherever providers can be selected except when setting up options for reports. New procedures and treatment plans cannot be posted for inactivated providers. New prescriptions and payment plans cannot be entered for an inactive provider. Also, existing treatment-planned procedures associated with an inactivated provider cannot be set complete.

To inactivate a provider

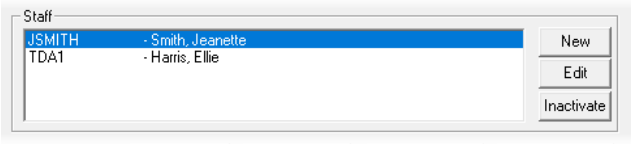
In the **Clinic Resource Setup** dialog box, under **Provider(s)**, select the provider who you want to inactivate, and then click **Inactivate**.

Setting Up Staff

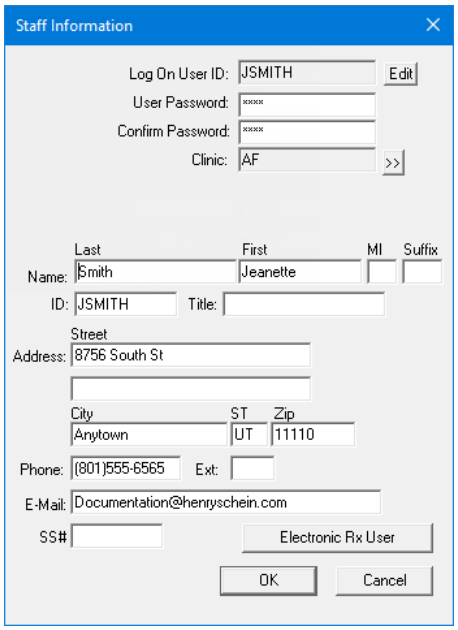
Staff members are employees who have not been entered as providers and who will use Dentrix Enterprise.

To add a staff member or edit a staff member's information

1. In the **Clinic Resource Setup** dialog box, under **Staff**, do one of the following:
   - Click **New** to add a staff member.
   - Select an existing staff member, and then click **Edit** to edit his or her information.



The **Staff Information** dialog box appears.



2. Enter or change the following information:
   - **Log On User ID** – Enter or edit the ID that this staff member will use to access Dentrix Enterprise.
   - **Password** – In the **User Password** box, enter the password that this staff member will use to access Dentrix Enterprise. Enter the same password in the **Confirm Password** box.

     Important: The password must be at least 8 (for standard users) or 15 (for administrative users) characters in length and meet the following requirements: have at least one uppercase letter, have at least one lowercase letter, have at least one number, and have at least one special character (for example, #, %, or &).

   - **Clinic** – Click the search button >>, and then select the clinic where the staff member works.
   - **Name** – Enter the staff member's full name.
   - **ID** – Enter a unique ID for the staff member. The ID must be 4 to 10 characters in length. You can use letters, numbers, and hyphens (-).
   - **Title** – Enter the staff member's position (for example, receptionist or office manager).
   - **Address** – Enter the staff member's home address.

- **Phone** – Enter the staff member's home phone number and extension (if applicable).
- **E-Mail** – Enter the staff member's email address.
- **SS #** – Enter the staff member's Social Security number.

3. Click **OK**.

Inactivating Staff

Staff cannot be deleted. When a staff member no longer works at a clinic, you can inactivate that staff member.

To inactivate a staff member

In the **Clinic Resource Setup** dialog box, under **Staff**, select the staff member who you want to inactivate, and then click **Inactivate**.

Setting Up Appointment Book

You can customize several features of Appointment Book to meet the needs of your practice. These options can be set up and/or changed at any time without affecting data already entered. However, for consistency, you should set them up before you begin using Dentrix Enterprise.

This section covers the following topics about setting up the Appointment Book:

- Setting Up Views
- Setting Up a Clinic
- Setting Up a Provider
- Setting Up an Operatory
- Setting Up Flip Tabs

Setting Up Views

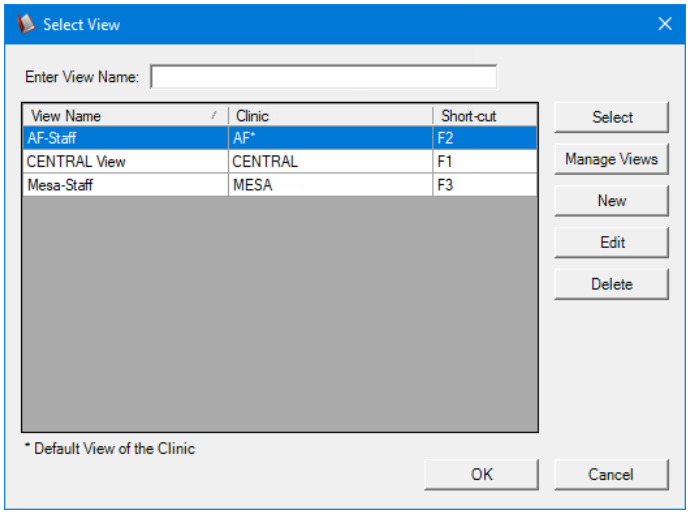
Views allow you to see Appointment Book in various ways; for example, you can have one view for when you are in the operatory and a different one for when you are at the front desk. For each view, you specify which providers, operatories, hours, and patient details are shown in Appointment Book.

You can have up to 111 different views for Appointment Book on any given computer in the office unless a certain global setting is enabled; in which case, you can have an unlimited number of views.

To add or edit a view

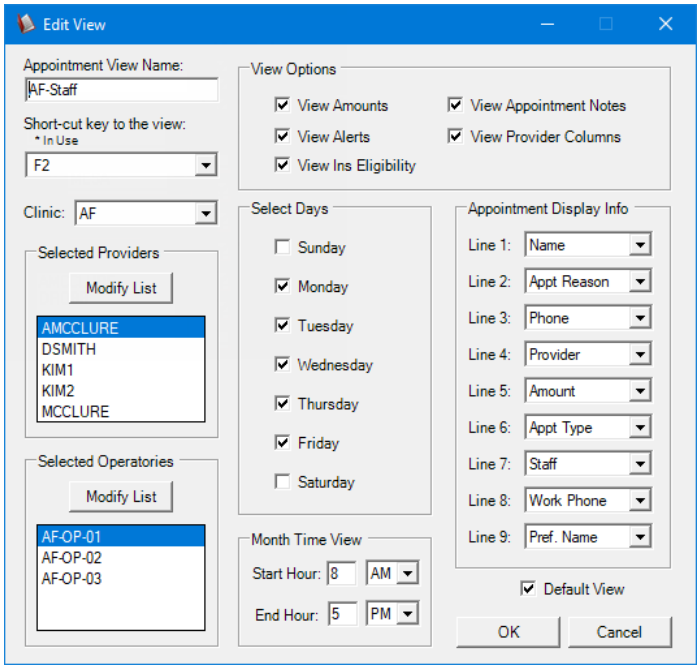
1. In the Appointment Book, click **View** on the menu bar.

   The **Select View** dialog box appears.



2. Do one of the following:
   - To add a new view, click **New**.
   - To edit a view, select it, and then click **Edit**.

   The **Edit View** dialog box appears.



3. Set up the following options as needed:

- **Appt. View Name** – The name for the Appointment Book view.
- **Short-cut key to view** – The shortcut key for quickly accessing the view. For example, with F4 assigned to this view, you can press the F4 key to quickly switch to this view. If you have more than 111 views (as allowed by a certain global setting), and all the shortcut keys are assigned to other views, you cannot assign a shortcut key to this view unless you first remove the shortcut key assignment from one of the other views.
- **Clinic** – The clinic assigned to the view. By default, the clinic that you are currently logged in to is selected, but you can select a different clinic to assign to this view. If you change the clinic, on the confirmation message that appears, click **Yes** to change the clinic and clear all provider and operatory selections for the view.
- **Selected Providers** – The providers assigned to the view. Up to 10 providers can be assigned to the view. To add or remove providers, click **Modify List**.

  Note: When this view is in use, if it has been set up to display provider color bars, the color bar of each provider who is assigned to the view appears along the left side of Appointment Book.

- **Selected Operatories** – The operatories assigned to the view. Up to 10 operatories can be assigned to the view. To add or remove operatories, click **Modify List**.
- **View Options** – Miscellaneous options for the schedule and appointment tiles. Select or clear any of the following check boxes:
  - **View Amounts** – With this check box selected, a small box appears in the upper-right corner of the schedule. The box displays the scheduled production amount for the day, week, or month (depending on the view mode). Dentrix Enterprise rounds production amounts to the nearest dollar and adds a zero in front of the amount, making it less likely that patients will associate the number with revenue.
  - **View Appointment Notes** – With this check box selected, a note symbol appears in the upper-right corner of any appointment tile that corresponds to an appointment with an appointment note attached.

- **View Alerts** – With this check box selected, a red plus sign appears in the upper-right corner of any appointment tile that corresponds to an appointment for a patient with active medical alerts.
- **View Provider Columns** – With this check box selected, the provider color bars appear along the left side of the schedule.
- **View Ins Eligibility** – With this check box selected, an "E" icon, which indicates the status of a patient's eligibility for insurance coverage, appears in the upper-right corner of any appointment tile that corresponds to an appointment for a patient with active insurance plans.

- **Select Days** – The days of the week that the office is normally open. Select the check box of each day that the office is open. Clear the check box of each day that the office is closed. Only the selected days appear in Appointment Book for the week and month views.
- **Month Time View** – The start and end times for the month view. In the **Start Hr** box, enter the earliest hour patients will be seen, and then select **AM** or **PM** from the corresponding list. In the **End Hr** box, enter the latest hour appointments will last until, and then select **AM** or **PM** from the corresponding list.

  Note: If this information is not entered correctly, you might get error messages when you try to switch to the month view.

- **Appointment Display Info** – Depending on the length of an appointment, up to nine lines of information can appear on the face of an appointment. You can customize and prioritize the text lines for each appointment. For each Line, select the item that you want to display on that line:
  - **[None]** – No information.
  - **Name** – The patient's name. Typically, this item is assigned to the first position.
  - **Appt Reason** – The reason for the appointment.

    Tip: If you frequently schedule several different procedures for an appointment, you can use the appointment reason option for two or three adjacent lines. That way, if the description will not fit on one line, it will wrap to the next line.

  - **Phone** – The patient's home phone number.
  - **Provider** – The provider ID.
  - **Amount** – The production amount for the appointment.
  - **Appt Type** – The appointment type (High Production, Medium Production, and so forth).
  - **Staff** –The staff member assigned to the appointment.
  - **Work Phone** – The patient's work phone number.
  - **Pref. Name** – The patient's preferred name. You can use this option instead of the name option to leave the line blank if the patient does not have a preferred name.
  - **Chart Num** – The patient's chart number.
  - **Operator** – The ID of the user who is logged in when the appointment is made.
  - **Pri Elig Date** – The date of the last verification of eligibility for coverage under the patient's primary insurance plan.
  - **Sec Elig Date** – The date of the last verification of eligibility for coverage under the patient's secondary insurance plan.
  - **DOB - age** – The patient's birth date and age.
  - **Ins Carrier** – The name of the patient's primary dental insurance carrier.
  - **Billing Type** – The billing type of the patient's account.

- **Financial Class** – The financial class that is associated with the patient's primary dental insurance plan.
- **Patient Tags** – The patient tags that are attached to the patient's record.

  Tip: If it is common for patients to have many patient tags assigned to them, you can use the patient tags option for two or three adjacent lines. That way, if the patient tag names will not fit on one line, they will wrap to the next line.

Note: Typically, most appointments display two to four lines of information. When selecting information to display, assign the most important items to the top-most lines.

- **Default View** – With this check box selected, this view is your default view when you open Appointment Book while you are logged in to the clinic that is assigned to this view.

4. Click **OK**.

Setting Up a Clinic

For each clinic, you can customize the hours of operation and the scheduling intervals (time blocks), which are used in Appointment Book and throughout Dentrix Enterprise. Also, you can customize workstation-specific settings for Appointment Book: appointment defaults, background colors, the toolbar position, and the time bar on the right.

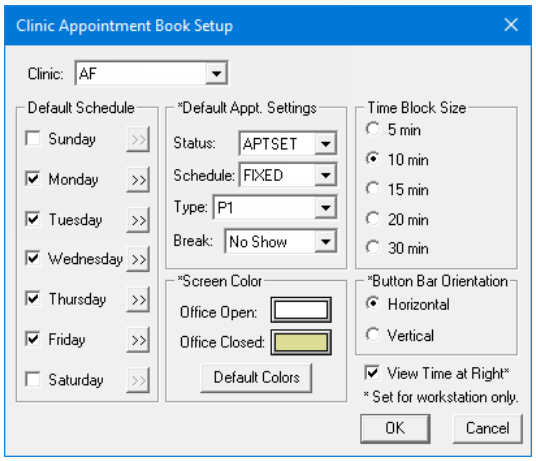
Notes:

- Clinic-specific settings apply to all computers and every Appointment Book view with that clinic assigned to it.
- Workstation-specific settings apply to all clinics and users, regardless of Appointment Book view being used, but only on this computer.

To set up a clinic

1. In Appointment Book, from the **Setup** menu, click **Clinic Setup**.

   The **Clinic Appointment Book Setup** dialog box appears.



2. By default, the clinic that you are currently logged in to is selected in the **Clinic** list. To configure the settings for a different clinic, select that clinic.
3. Set up the following options as needed:

For the selected clinic (on any computer):

- **Default Schedule** – For each day of the week that the selected **Clinic** is normally open, to set the working hours, do the following:

  a. Do one of the following:

  - If the check box is selected, but you want to close that day, clear the check box. Ignore steps b-c.
  - If the check box is clear, but you want to enter the hours for that day, select the check box.

    The **Set Time Limits** dialog box appears. Proceed to step b.
  - If the check box is selected, but you want to change the hours for that day, click the search button ».

    The **Set Time Limits** dialog box appears. Proceed to step b.

  b. In the **Set Time Limits** dialog box, you can divide up the working hours for the day into one to three time ranges. The office is considered closed during times that are not included in the specified time ranges. For each time range, enter the **Start Time** and/or **End Time** as needed:

  Note: None of the time ranges can overlap.

  c. Click **OK**.

- **Time Block Size** – Select the time block size option that fits the scheduling needs of the selected **Clinic**. You can schedule your appointments in 5-minute, 10-minute, 15-minute, 20-minute, or 30-minute intervals.

  Note: When you are setting up a procedure code, you can specify time blocks, which represent how long the procedure will take to complete. Dentrix Enterprise stores this information in units, not actual time; as a result, changing the time block size changes the allocated time for your procedure. For example, if your practice uses 10-minute time blocks, a procedure that takes 60 minutes needs 6 units (6 X 10 = 60). However, if you then change the time block size to 15 minutes, the procedure still uses 6 units, but instead of being 60 minutes, the procedure is now 90 minutes (6 X 15 = 90). You would need to adjust the procedure's settings to use 4 units to return the procedure to its 60-minute allocation (4 X 15 = 60).

For all clinics (on this computer only):

- **Default Appt. Settings** – Set up the following options:
  - **Status** – Select the default appointment status for each new appointment.
  - **Schedule** – Select Fixed, Open, or ASAP to specify the default scheduling type for each new appointment.
  - **Type** – Select the default appointment type for each new appointment.
  - **Break** – Select No Show, Phone Cancellation, or In-Office Cancellation to specify the default reason for breaking an appointment.
- **Screen Color** – Appointment Book displays the office's open times and closed times in different colors. By default, open times have a yellow background, and closed times have a grayish-yellow background. Do any of the following as needed:
  - To modify the open color, click the colored button next to **Office Open**.
  - To modify the closed color, click the colored button next to **Office Closed**.
  - Dentrix Enterprise users typically find that the default color choices are easiest to read. If you have modified the color options and want to reset them to the original colors, click **Default Colors**.

- **Button Bar Orientation** – To specify where you want to position the toolbar, select one of the following options:
  - **Horizontal** – To position the toolbar near the top of the window.
  - **Vertical** – To position the toolbar along the left edge of the window.
- **View Time at Right** – To display a time bar on the right side of the schedule in addition to the one that appears on the left, select this check box. With this check box clear, a time bar appears only on the left.

4. Click **OK**.

For a comprehensive explanation about all the available options for clinics, see the "Setting up a clinic" topic in the Dentrix Enterprise Help.

Setting Up a Provider

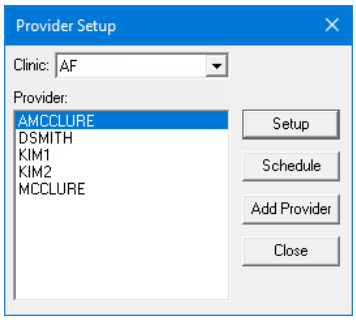
You can customize the work hours, colors, and time blocks for each provider in each clinic. Also, you can set up a provider for more than one clinic; and when setting up the provider's default schedule, Dentrix Enterprise will warn you if the scheduled hours overlap in other clinics.

Note: A provider's settings for a clinic apply to all computers and every Appointment Book view with that clinic and provider assigned to it.

To set up a provider

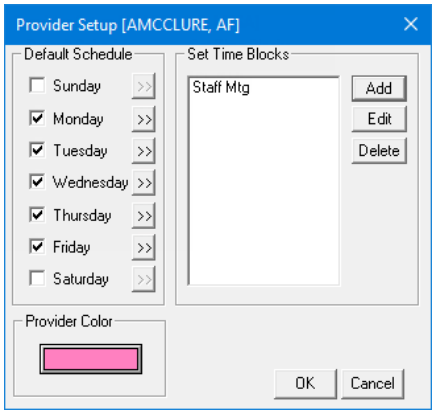
1. In Appointment Book, from the **Setup** menu, click **Provider Setup**.

   The **Provider Setup** dialog box appears.



2. By default, the clinic that you are currently logged in to is selected in the **Clinic** list. To configure the settings for providers at a different clinic, select that clinic.
3. Select a **Provider**.
4. Click **Setup**.

   The **Provider Setup** dialog box appears.



5. Set up the following options for the selected provider:
   - **Default Schedule** – For each day of the week that the provider normally works, to set the working hours, do the following:
     a. Do one of the following:
        - If the check box is selected, but you want to remove the hours for that day, clear the check box. Ignore steps b-c.
        - If the check box is clear, but you want to enter the hours for that day, select the check box.

          The **Set Time Limits** dialog box appears. Proceed to step b.
        - If the check box is selected, but you want to change the hours for that day, click the search button >>.

          The **Set Time Limits** dialog box appears. Proceed to step b.

     b. In the **Set Time Limits** dialog box, you can divide up the provider's working hours for the day into one to three time ranges. The provider is considered unavailable during times that are not included in the specified time ranges. For each time range, enter the **Start Time** and/or **End Time** as needed.

        Note: None of the time ranges can overlap.

     c. Click **OK**.
   - **Provider Color** – On the schedule, the appointments that are scheduled with the provider and the corresponding provider color bars appear in a color that you specify. To assign the provider a unique color, click the colored button.

     Note: The text on an appointment is black, so select a light color that contrasts enough with the black text.

6. Click **OK**.

For information about setting up provider time blocks, see "Setting Up Perfect Day Scheduling Time Blocks" in Chapter 3: Appointment Book.

Setting Up an Operatory

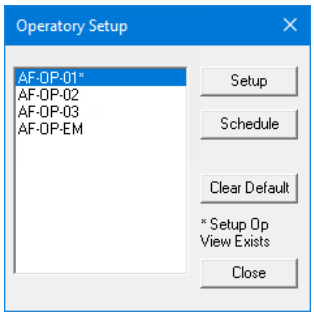
You can customize the available hours for each operatory in each clinic.

Note: An operatory's settings for a clinic apply to all computers and every Appointment Book view with that clinic and operatory assigned to it.

To set up an operatory

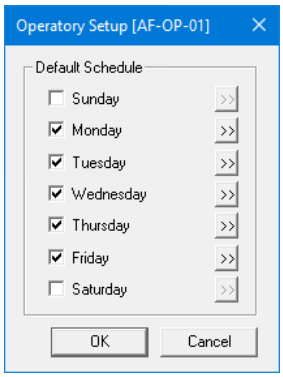
1. While viewing the operatories for a clinic in Appointment Book (the view does not have to be displaying all operatories), from the **Setup** menu, click **Operatory Setup**.

   The **Operatory Setup** dialog box appears.



2. In the list, select the correct operatory.
3. Click **Setup**.

   The **Operatory Setup** dialog box appears.



4. Under **Default Schedule**, for each day of the week that the operatory is available, to set the hours, do the following:
   - If the check box is selected, but you want to close that day, clear the check box. Ignore step 5.
   - If the check box is clear, but you want to enter the hours for that day, select the check box. The **Set Time Limits** dialog box appears. Proceed to step 5.
   - If the check box is selected, but you want to change the hours for that day, click the search button ». The **Set Time Limits** dialog box appears. Proceed to step 5.
5. In the **Set Time Limits** dialog box, you can divide up the available hours for the day into one to three time ranges. The operatory is considered unavailable during times that are not included in the specified time ranges. For each time range, enter the **Start Time** and/or **End Time** as needed
6. Click **OK**

Setting Up Flip Tabs

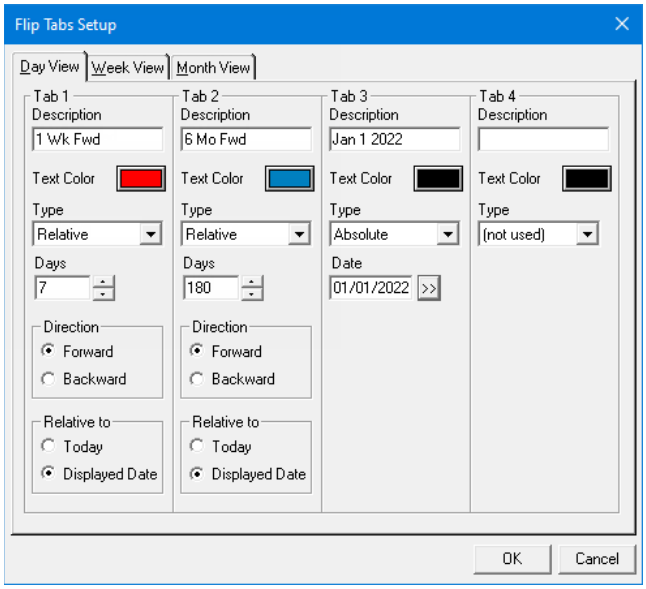
A flip tab acts like a bookmark. It allows you to jump forward or backward several days, weeks, or months in Appointment Book, according to a specified length of time, such as seven days, two weeks, or six months. You can customize the flip tabs for Appointment Book as needed.

Note: Flip tabs are workstation specific. Workstation-specific settings apply to all clinics and users, regardless of Appointment Book view being used, but only on this computer.

To set up a flip tab

1. In Appointment Book, from the **Setup** menu, click **Flip Tabs Setup**.

   The **Flip Tabs Setup** dialog box appears.



2. Click the **Day View**, **Week View**, or **Month View** tab to set up flip tabs for the corresponding Appointment Book view.
3. For each flip tab that you want to create or change (you can have up to four), set up the following options:
   - **Description** – In the box, enter a short description for the flip tab (for example, "1 Week" or "6 Months"). The description can be up to 15 characters in length.
   - **Text Color** – To assign a color to the text description of the flip tab, lick the colored button.
   - **Type** – From the list, select one of the following types:
     - **Absolute** – Requires you to specify a certain calendar date, such as 11/11/2018. An absolute tab will always jump to that specific date in Appointment Book. Enter the correct date.
     - **Relative** – Requires you to specify a certain number of days, weeks, or months. Do the following:
       a. Enter the number of **Days**, **Weeks**, or **Months** (depends on the flip tab) be specified.
       b. Select a **Direction** option: **Forward**, to go forward by the specified number of days, weeks, or months in Appointment Book; or **Backward**, to go backward by the specified number of days, weeks, or months.
       c. Under **Relative to**, select whether the tab will move you relative to the current date or relative to the date being displayed in Appointment Book.

Note: A relative tab will jump you to a date relative to the current date or the displayed date. For example, if today's date is January 1st, a relative tab set to move you seven days forward relative to today will move you to January 8th when you click it; then, if you click the tab again, you will remain on the 8th. However, a relative tab set to move you seven days forward relative to the displayed date, will move you to the 8th when you click it; then, if you click the tab again, the tab will move you to the 15th (another seven days ahead).

4. Click **OK**.

Setting Up Procedure Button Templates

There are 24 procedure buttons in the Patient Chart that allow for quick access to recording charting needs. You can set up templates for those procedure buttons based on specific needs and then assign those templates to users. Also, each user can choose to use one of the templates or create a custom set of procedure buttons. This section covers the following topics:

- Adding Procedure Button Templates
- Assigning a Procedure Button Template to Users

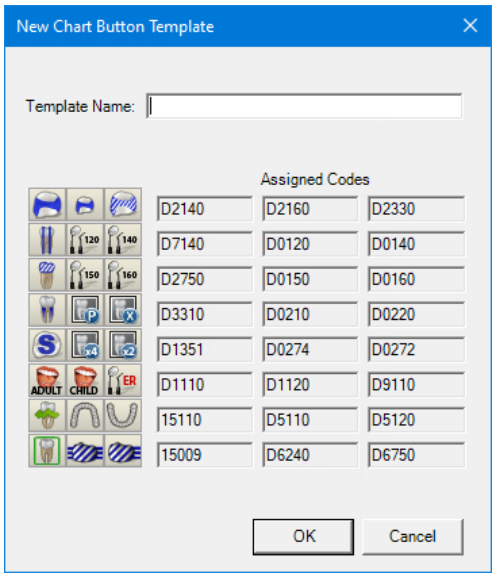
Adding Procedure Button Templates

You can create a new template for the 24 procedure buttons that are available to users in the Patient Chart.

To add a procedure button template

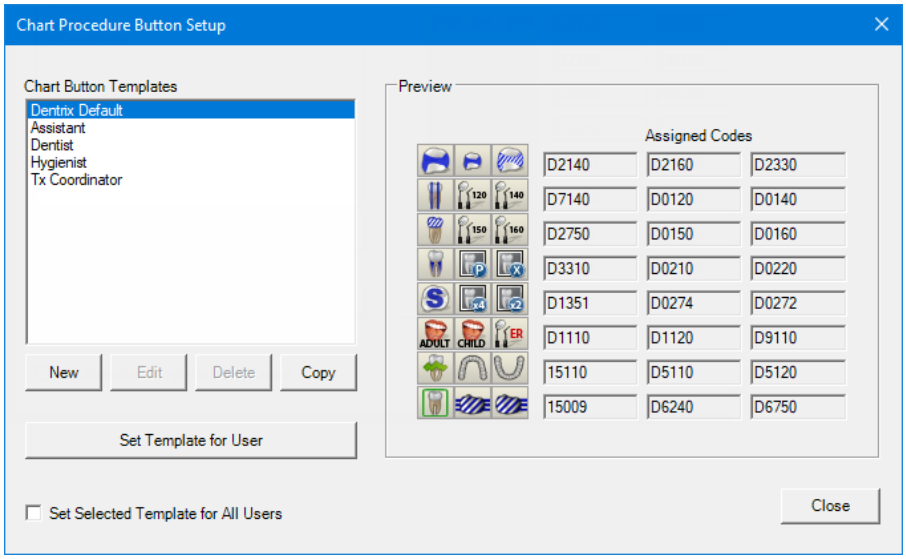
1. In Office Manager, from the **Maintenance** menu, point to **Practice Setup**, and then click **Chart Procedure Button Setup**.

   The **Chart Procedure Button Setup** dialog box appears.



2. Do one of the following:
   - To create a new template based on the default button set, click **New**.
   - To create a new template based on an existing template, select the template, and then click **Copy**.

   The **New Chart Button Template** (or **Copy Chart Button Template**) dialog box appears.

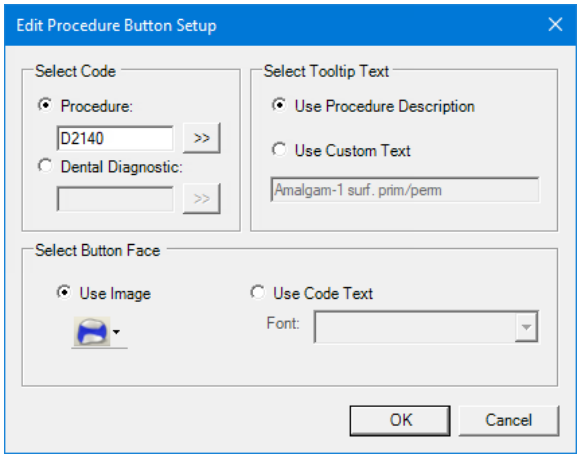


Note: For each button in the table on the left, the corresponding code appears in the table on the right.

3. In the **Template Name** box, enter a name for the template.
4. For each button that you want to customize, do the following:

   a. Click the button, such as  .

   The **Edit Procedure Button Setup** dialog box appears.



   b. Under **Select Code**, select one of the following options:

   - **Procedure** – To assign a procedure code to the button. Then, either enter the desired procedure code (ADA, administrative, condition, or product code) or multi-code, or click the search button >> to select the desired code.
   - **Dental Diagnostic** – To assign a dental diagnostic code to the button. Then, either enter the desired dental diagnostic code, or click the search button >> to select the desired code.

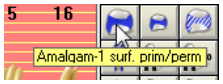
   Notes:

   - Dentrix Enterprise uses a smart-code feature. When you are charting a procedure code, depending on the surfaces or roots selected, the procedure will be updated when it is posted. For example, if you chart a one-surface amalgam (D2140) but select three surfaces, Dentrix Enterprise will automatically post the three-surface amalgam (D2160).

- With the smart-code feature, Dentrix Enterprise not only updates procedure codes based on surfaces and roots when posting resins and amalgams but also updates them by tooth number. For example, if you use a one-surface anterior resin procedure button when posting a three-surface resin to tooth 28, Dentrix Enterprise will update and post the procedure to reflect three surfaces and the posterior tooth.
- Because of the smart-code feature, you do not need to assign multiple variations of the same code, such as for amalgams or root canals, to your procedure buttons.

c. If you position your pointer over a procedure button, a tooltip will appear with identifying text for that button. Under **Select Tooltip Text**, select one of the following options:

- **Use Procedure Description** – To use the procedure or diagnostic code's description in the tooltip.



- **Use Custom Text** – To use custom text in the tooltip. Then, enter the desired description in the box provided.

d. Under **Select Button Face**, select one of the following options:

- **Use Image** – To use a pre-defined graphic to identify the button. Then, from the button menu, click one of the 65 charting symbols that represent procedure codes.



- **Use Code Text** – To use the procedure or diagnostic code to identify the button. Then, select the desired **Font**.

  Tip: For best results, use a 6-point Arial font.

e. Click **OK**.

5. In the **New Chart Button Template** (or **Copy Chart Button Template**) dialog box, click **OK**.

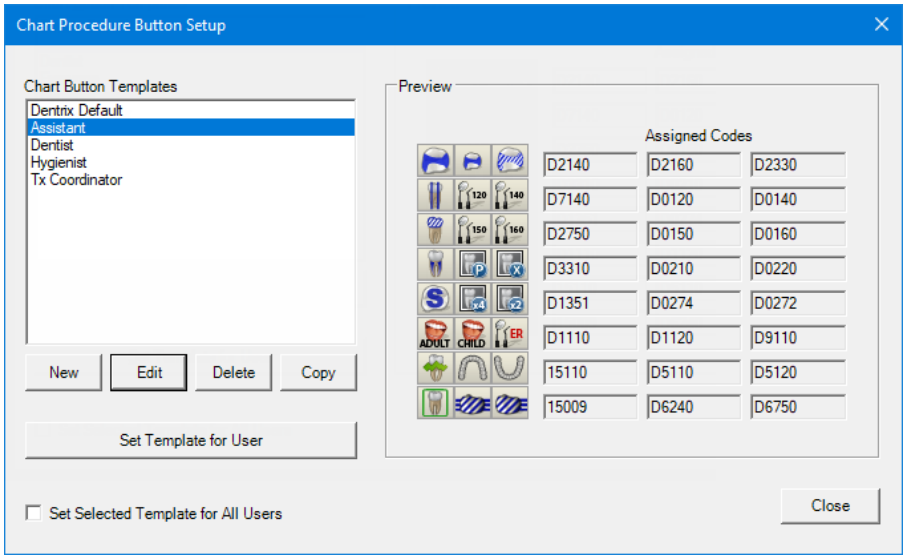
Assigning a Procedure Button Template to Users

You can assign any procedure button template as the default for all users or specific users.

To assign a procedure button template to users

1. In Office Manager, from the **Maintenance** menu, point to **Practice Setup**, and then click **Chart Procedure Button Setup**.

   The **Chart Procedure Button Setup** dialog box appears.



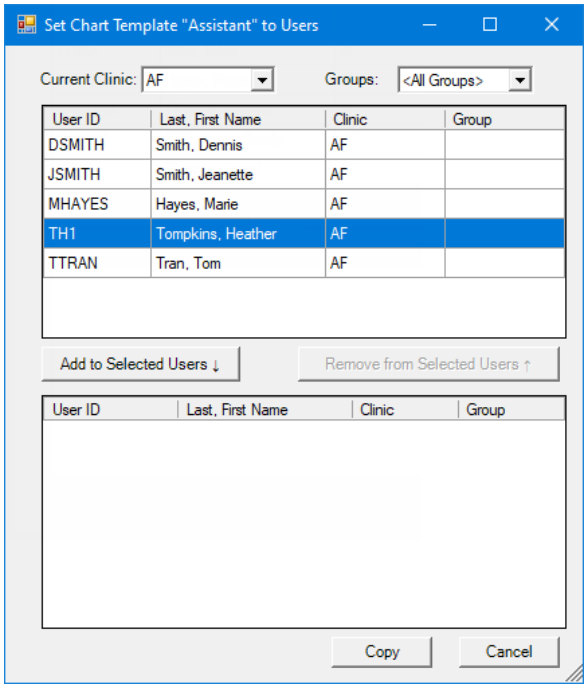
2. Select a template.
3. Do one of the following:
   - To assign the template to all users, select the **Set Selected Template for All Users** check box (or the **[Template Name] is set as the default template for all users** check box, if a template is already assigned to all users). Ignore the following steps.

     Important: With a template assigned as the default for all users, users cannot use a different button set or create their own custom button sets.

   - To assign the template to specific users as their default procedure button set, click **Set Template for User**. This button is not available if a template has been assigned to all users.

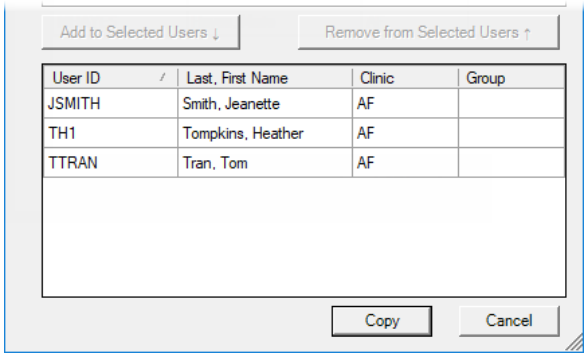
     Note: Users can customize the procedure button set for the template from the Patient Chart. The original template will not be affected. Users can also create their own custom procedure button sets.

   The **Set Chart Template "[Template Name]" to Users** dialog box appears.



4. Filter the list of users as needed:
   - To view users with rights in a specific clinic, select that clinic from the **Current Clinic** list. To view users with rights in any clinic, select **<All Clinics>** from the **Current Clinic** list.
   - To view users that belong to a specific user group, select that group from the **Groups** list. To view users that belong to any user group, select **<All Groups>** from the **Groups** list.
5. Select the desired users, and then click **Add to Selected Users**.

   The selected users are moved to the Selected Users list (the lower list).



6. Click **Copy**.

Setting Up Ledger

There are several features of the Ledger that you can customize to meet the needs of your practice. You can set up or change these at any time without affecting data already entered. However, for consistency sake, it is a good idea to set them up before you begin using the system. This section covers the following topics about setting up the Ledger:

- Setting Up Checkout Options
- Setting Up Automatic Credit Allocation Options
- Setting Up Direct Print Options

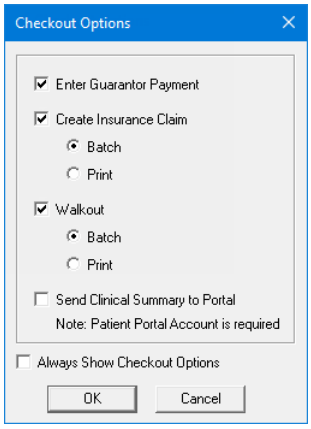
Setting Up Checkout Options

In most offices, there are typically three tasks that are completed as a patient checks out after a visit. The **Fast Checkout** button  combines these three tasks. With the click of a button you can collect a payment, generate an insurance claim, and print a receipt.

To customize the Fast Checkout button

1. In Ledger, from the **File** menu, click **Set Checkout Options**.

   The **Checkout Options** dialog box appears.



2. Select the task options you want to complete when the **Fast Checkout** button is clicked:
   - **Enter Guarantor Payment** – To post a payment to the Ledger.
   - **Create Insurance Claim** – To generate an insurance claim. Also, select whether you want to send the claim to the batch processor in the Office Manager or print the claim immediately.
   - **Walkout** – To print a receipt for the patient. Also, select whether you want to send the report to the batch processor in the Office Manager or print the report immediately.
   - **Always Show Checkout Options** – If the tasks you perform as a patient leaves vary, you can select this option so that the **Checkout Options** dialog box will appear each time the **Fast Checkout** button is clicked, thus allowing you to select the options you need for each patient individually.
3. Click **OK**.

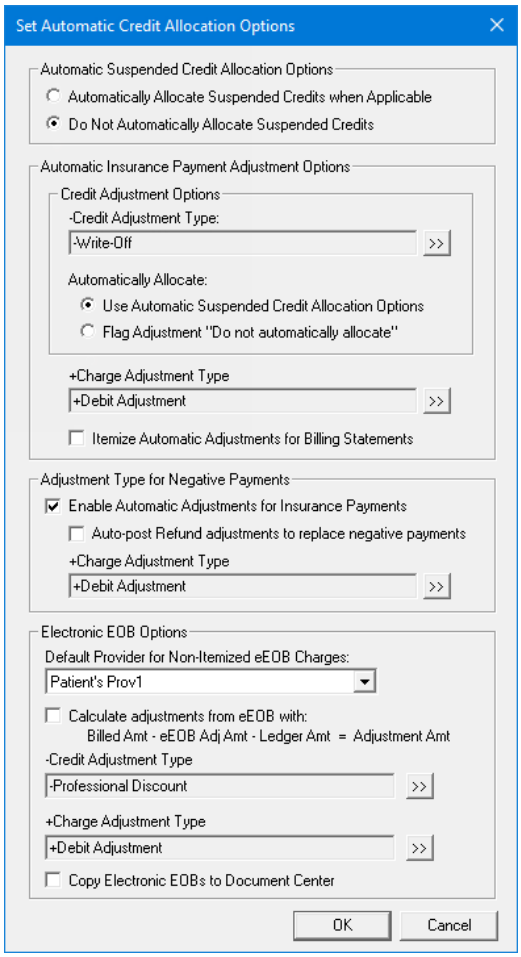
Setting Up Automatic Credit Allocation Options

Dentrix Enterprise can automatically apply suspended credits and post automatic adjustments for re-allocating credits according to selections you make.

To set up the options for automatic credit allocation

1. In the Ledger, from the **File** menu, click **Set Auto Credit Allocation Options**.

   The **Set Automatic Credit Allocation Options** dialog box appears.



2. Set up the following options:

   - **Automatic Suspended Credit Allocation Options**
     - **Automatically Allocate Suspended Credits when Applicable** – To have Dentrix Enterprise automatically allocate any suspended credits to all charges that have a remaining balance. This will apply all applicable suspended credits to all applicable charges, not just the recently posted charges.
     - **Do Not Automatically Allocate Suspended Credits** – To have Dentrix Enterprise not automatically allocate any suspended credits.
   - **Automatic Insurance Payment Adjustment Options**
     - **Credit Adjustment Type** – Click the search button [>>] to select the adjustment type that you want Dentrix Enterprise to use for the credit adjustment to offset a charge adjustment when a leftover insurance payment amount needs to be allocated automatically.

- **Automatically Allocate** – Select **Use Automatic Suspended Credit Allocation Options** to default to the selection made for **Automatic Suspended Credit Allocation Options** when entering insurance credit adjustments, or select **Flag Adjustment "Do not automatically allocate"** to have Dentrix Enterprise not allocate the insurance credit adjustment automatically regardless of selection for **Automatic Suspended Credit Allocation Options**.
- **Charge Adjustment Type** – Click the search button ›› to select the adjustment type that you want to use for the charge adjustment when a leftover insurance payment amount needs to be automatically allocated.
- **Itemize Automatic Adjustments for Billing Statements** – To have Dentrix Enterprise itemize automatic adjustments on billing statements.

  Note: It is recommended that you leave this check box clear because the automatic adjustments will always be offsetting adjustments, so they will not affect an account balance and can be confusing if included on billing statements.

- **Adjustment Type for Negative Payments**
  - **Enable Automatic Adjustments for Insurance Payments** – To allow negative insurance payments to be posted for claims, select this option.
  - **Auto-post Refund adjustments to replace negative payments** – To allow negative insurance payments to be posted for claims, select this option. A negative payment will appear as a charge adjustment on the Ledger. Next, select the Charge Adjustment Enter you want to have used as the charge adjustment that automatically replaces a negative insurance payment.

    Tip: You may need to add a new adjustment type in Practice Definitions for this charge adjustment.

- **Electronic EOB Options**
  - **-Credit Adjustment Type** – Click the search button ›› to select the default adjustment type to use for credit adjustments in the **Batch Insurance Payment Entry** dialog box.
  - **+Charge Adjustment Type** – Click the search button ›› to select the default adjustment type to use for charge adjustments in the **Batch Insurance Payment Entry** dialog box.

3. Click **OK**.

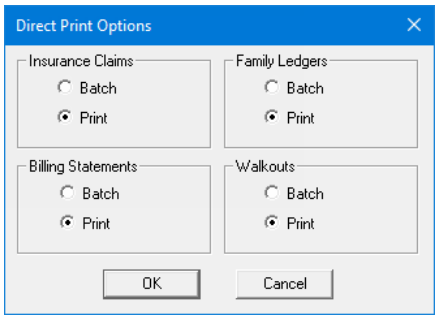
Setting Up Direct Print Options

You can print insurance claims and several reports from Ledger: walkout statements, billing statements, and a family ledger report. A button for each of these reports is located on the toolbar. With the direct print options, you can indicate whether the report should be printed immediately or sent to the batch processor in Office Manager, where you can print it at a later time.

To set up direct print options

1. In Ledger, from the **File** menu, click **Direct Print Options**.

   The **Direct Print Options** dialog box appears.



2. For each report, select whether you want the report to go directly to your printer or to be sent to the Batch Processor.

   Tip: If your office will be sending claims electronically, click Batch for insurance claims, so all insurance claims generated during the day will be sent to the Batch Processor and can be transmitted simultaneously at the end of the day.

3. Click **OK**.

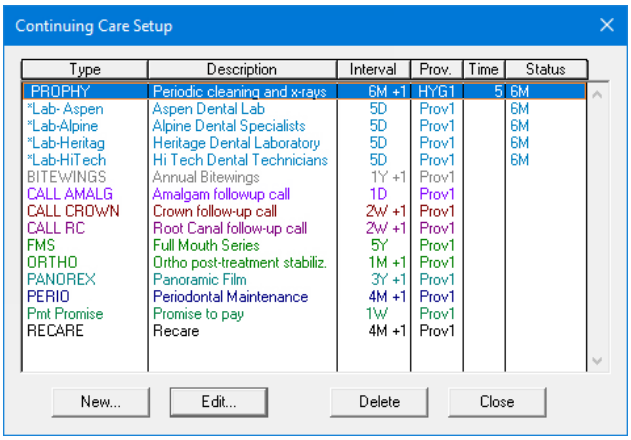
Setting Up Continuing Care Types

You can add or edit the default continuing care types that you assign to patients to help you track ongoing patient care (recall or recare).

To add or edit a continuing care type

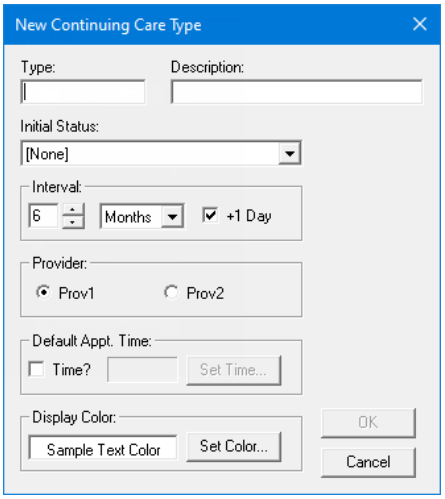
1. In the Office Manager, from the **Maintenance** menu, point to **Practice Setup** > **Continuing Care**, and then click **Continuing Care Setup**.

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



2. Do one of the following:
   - Click **New** to add a continuing care type.
   - Select an existing continuing care type, and then click **Edit** to edit that type.

   The **New Continuing Care Type** or **Edit Continuing Care Type** dialog box appears.



3. Set up the following options:
   - **Type** – Enter an abbreviated name for this type of continuing care in all capital letters.
   - **Description** – Enter a more complete description of this continuing care type. This description will be used on continuing care reminder cards, so pay special attention to spelling, punctuation, and so forth.
   - **Interval** – The interval indicates how often the patient should be recalled for treatment or follow-up. Specify the number of days, weeks, months, or years for the interval. Select **+1 Day** to prevent insurance billing problems if the carrier has strict interval requirements.

- **Provider** – If you want the provider of continuing care appointments to be the patient's primary provider by default, click **Prov1**. If you want the provider of continuing care appointments to be the patient's assigned secondary provider, click **prov2**.
- **Default Appt. Time** – To enter the amount of time this patient will need for appointments with this continuing care type attached, select **Time?**. Drag the slider to set the number of units, and then set up the time pattern for each unit (chair time , assistant's time , or provider's time) to help you make use of all operatories when scheduling appointments and maximize your productivity.

4. Click **OK**.

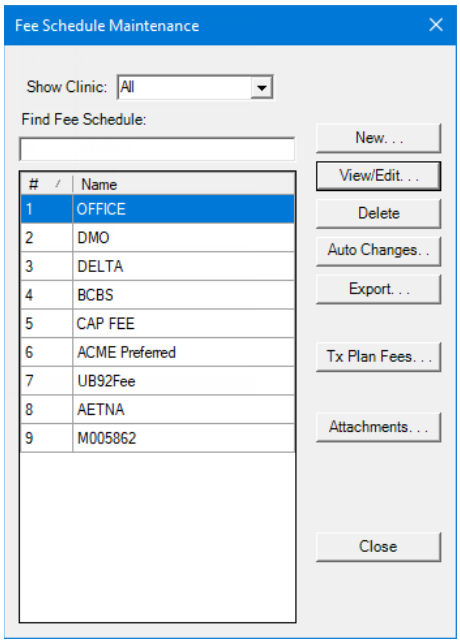
Setting Up Fee Schedules

You can add or edit fee schedules to specify the fees that you charge for each procedure. You can have up to 99,999 fee schedules.

To add or edit a fee schedule

1. In the Office Manager, from the **Maintenance** menu, point to **Practice Setup**, and then click **Fee Schedule Setup**. (This option is available only if you are logged in to the Central clinic.)

   The **Fee Schedule Maintenance** dialog box appears.

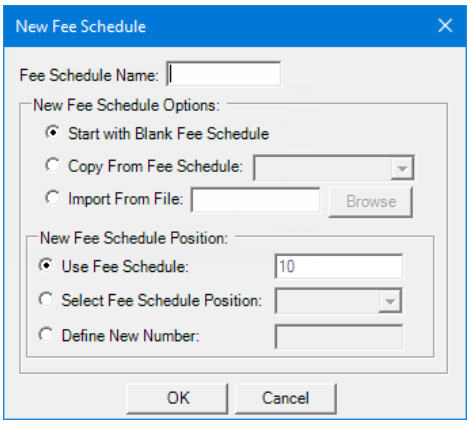


   Tip: To search for a fee schedule, begin typing the name of a fee schedule in the **Find Fee Schedule** box. Continue typing as needed to narrow down the list.

2. Do one of the following:

   - **Add** – To add a fee schedule, click **New**. Proceed to step 3.
   - **Edit** – To edit a fee schedule, select that fee schedule, and then click **Edit**. Skip step 3.

   The **New Fee Schedule** dialog box appears.

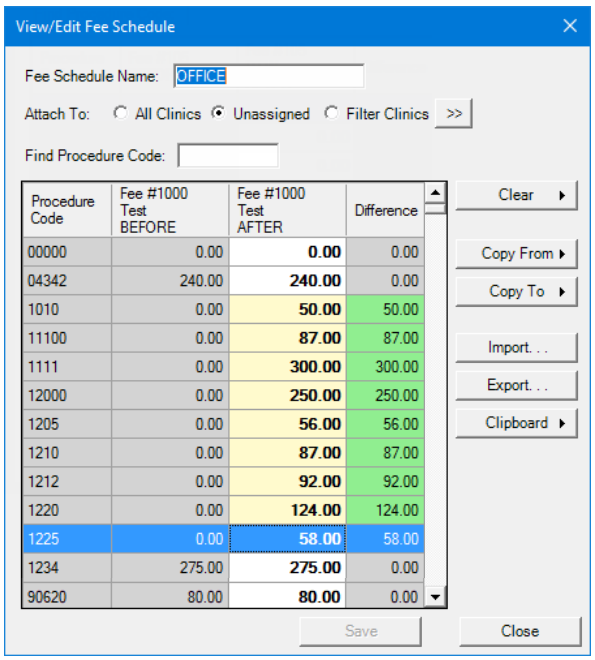


3. Set up the following options:
   - **Fee Schedule Name** – The name of the fee schedule.
   - **New Fee Schedule Options** – Select one of the following options:
     - **Start with Blank Fee Schedule** – To begin with a fee schedule with zeros for all the amounts.
     - **Copy From Fee Schedule** – To use an existing fee schedule as the basis or as-is for this new fee schedule. Select the desired fee schedule from the list.

     Note: You can change any of the amounts as needed later on.
   - **New Fee Schedule Position** – Select one of the following options:
     - **Use Fee Schedule** – To use the first available ID number for this new fee schedule.
     - **Select Fee Schedule Position** – To use the ID number of an existing fee schedule for this new fee schedule. Select the desired ID number from the list.
     - **Define New Number** – To specify the ID number for this new fee schedule.

     Tip: Overwriting an existing fee schedule affects all patients, providers, and insurance carriers with that existing fee schedule attached. To view the number of patients, providers, and/or insurance carriers that the fee schedule is attached to, click **Attachments** in the **Fee Schedule Maintenance** dialog box.
4. Click **OK**.

   The **View/Edit Fee Schedule** dialog box appears.



5. Do any of the following:
   - Change the **Fee Schedule Name**.
   - To replace all the amounts in this fee schedule with those from another fee schedule, click **Copy From**, and then search for and select the desired fee schedule.

- To attach the fee schedule to one or more clinics, next to **Attach To**, select **All Clinics** or **Filter Clinics** (and then click the search button ›› to select the desired clinics). To not attach the fee schedule to a clinic, select **Unassigned**. With the fee schedule attached to a clinic, everywhere in Dentrix Enterprise that you can select a fee schedule (such as a patient's dental insurance plan in the Family File), you can filter the list of fee schedules by clinic.
- To change a procedure code's amount (as displayed in the **BEFORE** column), click that procedure code's fee in the **AFTER** column, and then enter the new amount. The background color of the **AFTER** cell changes to yellow, and the **Difference** between the original and the new fee appears with a green background (for an increase) or a red background (for a decrease). Repeat this process as needed to change other amounts.

  Tip: To help you quickly find a procedure code, begin typing a procedure code in the **Find Procedure Code** box. The first matching code is selected.

- To change all amounts to zeros, click **Clear**, click **Clear only the fee amounts**, and then click **Yes**.
- To change all amounts to zeros and clear the **Fee Schedule Name** box, click **Clear**, click **Clear the name and fee amounts**, and then click **Yes**.

6. Click **Save**.

For a comprehensive explanation of fee schedules, see the "Fee Schedule Maintenance" topics in the Dentrix Enterprise Help.

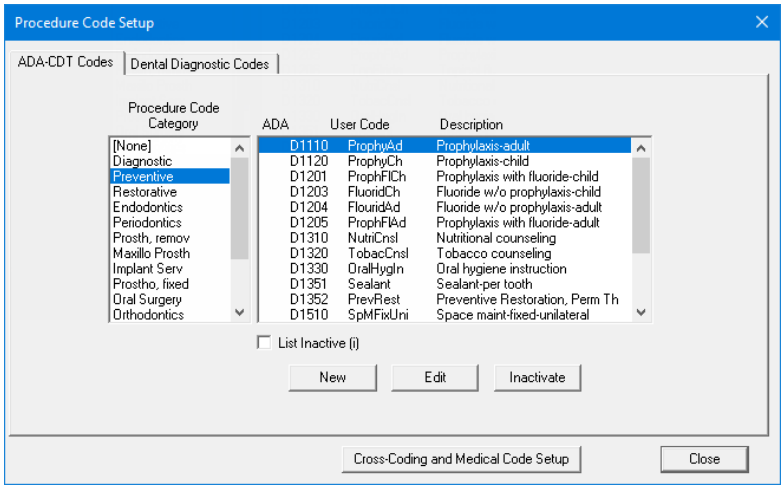
Editing Procedure Codes

Many tasks and transactions in a dental office are linked to an ADA Procedure Code. Dentrix Enterprise comes with all of the procedures listed in *American Dental Association Code on Dental Procedures and Nomenclature*. Edit, or at least review, the following information for the procedure codes you use in your office: fees, procedure time, and attached continuing care.

To edit a procedure code

1. In Office Manager, from the **Maintenance** menu, point to **Practice Setup**, and then click **Procedure Code Setup**.

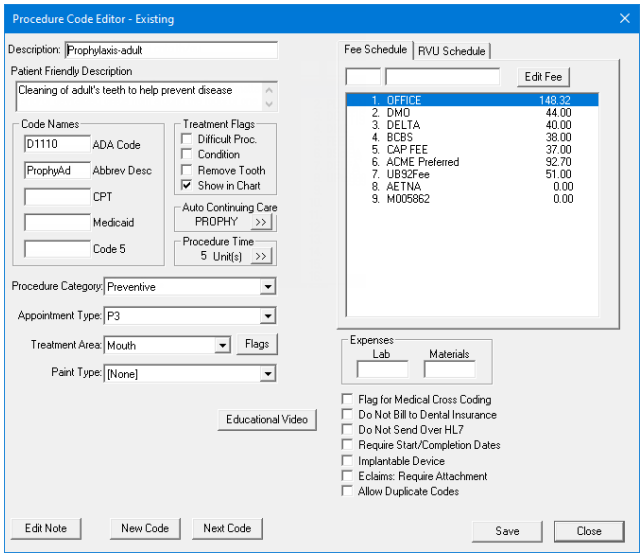
   The **Procedure Code Setup** dialog box appears.



2. Select a **Procedure Code Category**. All procedure codes associated with that category appear in the list box to the right.

3. Select a procedure code, and then click **Edit**.

   The **Procedure Code Editor - Existing** dialog box appears.



4. Set up the following options:
   - **Auto Continuing Care** – When a procedure with a continuing care type attached to is completed, Dentrix Enterprise automatically adds the continuing care type to the patient and/or updates that patient's continuing care due date. Click the search button ›› to select a continuing care type for this procedure.
   - **Procedure Time** – To enter the number of Appointment Book units this procedure takes to perform, click the **s**earch button ››. Drag the slider to set the number of units, and then set up the time pattern for each unit (chair time, assistant's time, or provider's time) to help you make use of all operatories when scheduling appointments and maximize your productivity.
   - **Fee Schedule** – No fees are pre-assigned with the initial install of Dentrix Enterprise. To change the fees for a procedure, select the fee for the fee schedule that you want to change, and then click **Edit Fee**. The fee in a box next to the name of the fee schedule can now be edited. Next, enter the dollar amount you want to charge, and then press Enter to save the change or Tab to move down to the next fee schedule. Repeat this process for all fees that you want to change.

     Tip: The practice's usual, customary, and reasonable (UCR) fees should be the first fee schedule.

5. Click **Save**.

For a comprehensive explanation of all the options available for procedure codes, see the "Editing procedure codes" topic in the Dentrix Enterprise Help.

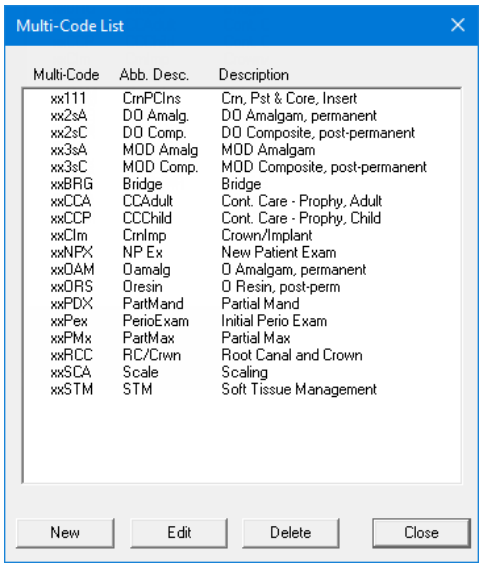
Setting Up Multi-codes

A multi-code allows you to post several procedures simultaneously. A multi-code is a group of procedure codes that are typically recommended, scheduled, or completed at the same time.

To add or edit a multi-code

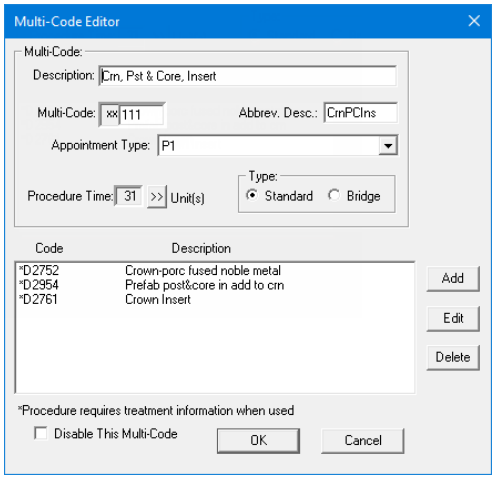
1. In Office Manager, from the **Maintenance** menu, point to **Practice Setup**, and then click **Multi-Code Setup**.

   The **Multi-Code List** dialog box appears.



2. Do one of the following:
   - Click **New** to add a multi-code.
   - Select an existing multi-code, and then click **Edit** to edit that code.

   The **Multi-Code Editor** dialog box appears.



3. Set up the following options:
   - **Description** – Enter a description for the multi-code.
   - **Multi-Code** – Dentrix Enterprise automatically assigns "xx" as the first two characters of a multi-code. Enter three additional alphanumeric characters to represent the code that will be used to identify the multi-code when posting.

- **Abbrev. Desc.** – Enter an abbreviated description of the multi-code.
- **Type** – If the multi-code will post a bridge, select **Bridge**; otherwise, select **Standard**.
- **Procedure Codes** – To add a procedure code to the multi-code, click **Add**. In the **Add Code** dialog box, enter an ADA procedure code, or click the search button ›› to select a procedure code. If the procedure code selected requires the entry of additional information, additional options appear in the lower-right corner of the **Add Code** dialog box so that you can pre-define a surface(s), a quadrant, or a sextant. Then, click **OK**.

  Important: A multi-code may consist of one or more procedures that require additional treatment information to be entered, such as a tooth number. Multi-codes that require additional information will be flagged with an asterisk (*) in the list box. The additional information must be supplied when posting the multi-code.

4. Click **OK**.

Customizing Practice Definitions

Dentrix Enterprise provides several "practice definitions" and allows user-definable entries for each. These practice definitions, in addition to other features, can help you customize Dentrix Enterprise for your specific needs.

You can add and edit practice definitions.

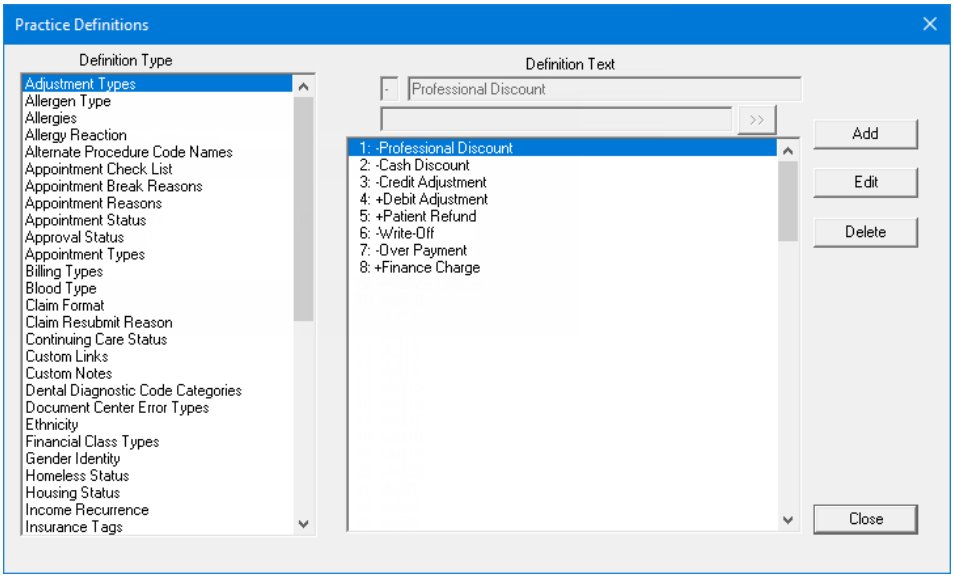
Important: Before you customize definitions, read the following recommendations carefully:

- Customize definitions that have not yet been assigned to patients in order to avoid potential problems.
- Dentrix Enterprise assigns the definition number to a patient, not the customizable description. Modifying the text description of a definition will change that definition for all patients to whom the definition has been assigned. For example, if patients are assigned medical alert 13 "hay fever," and it is changed to "pregnancy," those patients will still have medical alert 13, but it will now show as "pregnancy" in their file.
- Before deleting a definition, try changing the existing description to a new, more useful description. Deleting a definition can lead to data corruption. For example, if the appointment status 4 "Patient has Arrived" will not be used in your office, you can change it to a more useful definition such as, "Left Message."
- With the exception of medical alerts, definitions are listed in numerical order. As a result, the first definition serves as a default selection for most definition types. Be sure to make the most commonly used definition the first definition in the list.

To customize a practice definition

1. In the Office Manager, from the **Maintenance** menu, point to **Practice Setup**, and then click **Definitions**.

   The **Practice Definitions** dialog box appears.



2. Select a **Definition Type** to add or edit definitions for that type.
3. Do one of the following:
   - To add a new definition, for some definitions, select and replace the existing **ID** (if relevant) and **Definition Text** with a new ID and description, and then click **Add**. For other definitions, click **Add** to set up the necessary options.

- To edit a definition, for some definitions, select that definition, replace the existing **Definition Text**, and then click **Change**. For other definitions, select the definition, and then click **Change** to modify the options.

For comprehensive details about customizing each definition type, see the "Practice Definitions" topic and its subtopics in the Dentrix Enterprise Help.

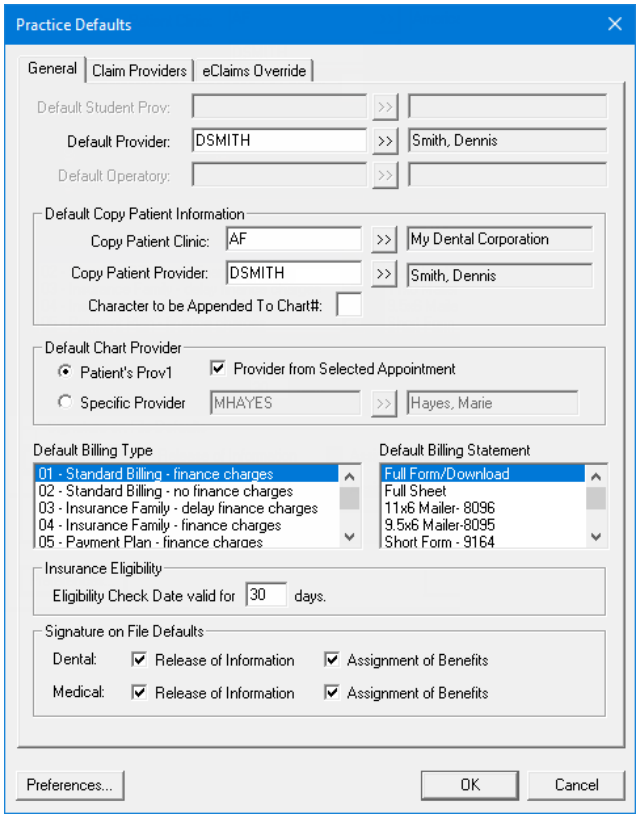
Setting Up Practice Defaults

When entering patient information or performing certain tasks, the process of having to choose a provider or operatory can be redundant. Dentrix Enterprise allows you to set a default provider, billing type, chart provider, insurance claim providers, and billing statement. Changing the practice defaults affects only the computer from which you are changing the defaults. You can change the practice defaults at any time.

To set up the practice defaults

1. In Office Manager, from the **Maintenance** menu, point to **Practice Setup**, and then click **Practice Defaults**.

   The **Practice Defaults** dialog box appears.



2. Set up the following defaults:

   General tab:

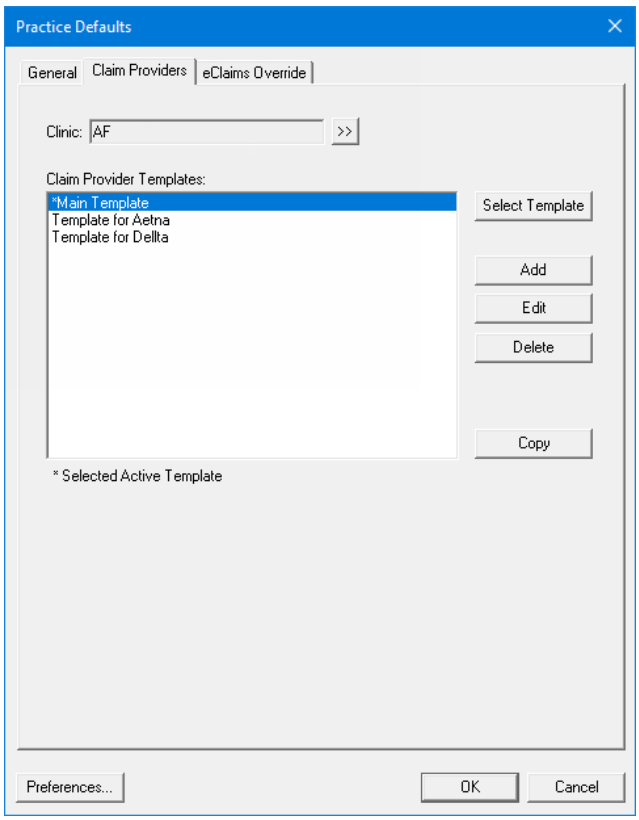
   - **Default Provider** – The provider selected will be the primary provider assigned to each new head-of-house. If you want to remove a selection, delete the text.
   - **Default Chart Provider** – The provider selected will be the default provider when charting procedures for the patient. Click **Patient's Prov1** to have the patient's primary provider act as this default, or click the **Specific Provider** search button [>>] to select a provider.

     By default, the **Provider from Selected Appointment** check box is clear. Select this check box if you want to keep the provider for a selected appointment in the Appointment Book as the provider for charting when you open the Patient Chart from the Appointment Book (by clicking the Patient Chart module button or by clicking **Chart** from the **File** menu) with an appointment selected. If an appointment is not selected in the Appointment Book when the Patient Chart is opened, the default Patient Chart provider will be the selected patient's Provider 1 or the provider you specify, regardless of whether or not the **Provider from Selected Appointment** check box is selected.

- **Default Billing Type** – The billing type selected will be the billing type given to each new head-of-house.
- **Default Billing Statement** – The billing statement selected will be the form used when printing billing statements.
- **Signature on File Defaults** – You can specify the default status of the **Release of Information** and **Assignment of Benefits** check boxes when attaching dental insurance plans to patients and attaching medical insurance plans to patients.

  Note: Changing these settings does not affect insurance plans that have already been assigned to patients.

Claim Providers tab:



You can set up the default insurance claim providers for each clinic. Each clinic can have its own defaults. Also, Dentrix Enterprise can handle exceptions for various insurance plans as needed, so you don't have to change the defaults each time you want to create claims for certain insurance carriers.

You set up templates to handle the default providers for claims. Each clinic can have a "main" template and any number of "exception" templates (which may vary based on the insurance plan). The Central clinic's defaults are used for all clinics that do not have a main template.

- **Add** – While logged in to any clinic, you can set up templates for Central or any other clinic. To add a template, do the following:

  a. Select a **Clinic**.

  b. Click **Add**.

c. Set up the following options as needed:

- **Claim Provider Template Name** – The name for the template. Template names within a clinic must be unique, but templates with the same name can exist in multiple clinics.
- **Billing Provider** – The provider will be the provider printed on claims.

  Select one of the following:

  - **Provider of Procedures** – To use the provider applied to procedures.
  - **Patient's Prov1** – To use a patient's primary provider selected in the Family File.
  - **Specific Provider** – To always have a specific provider listed and then click the search button ›› to select the appropriate provider. If you want to override the name in the database, select **Name to use for Provider**; and then click the search button ›› to select a provider name, or enter a name in the box.
- **Rendering Provider** – The provider selected will be the provider that performs the services being billed on a claim.

  Select one of the following:

  - **Provider of Procedures** – To use the provider applied to procedures.
  - **Patient's Prov 1** – To use a patient's primary provider selected in the Family File.
  - **Specific Provider** – To always have a specific provider listed and then click the search button ›› to select the appropriate provider. The rendering provider specified for a claim will only be used for electronic claims.
- **Pay-To Provider** – The provider selected will be the provider whose name appears in the pay to provider section of a claim.

  Select one of the following:

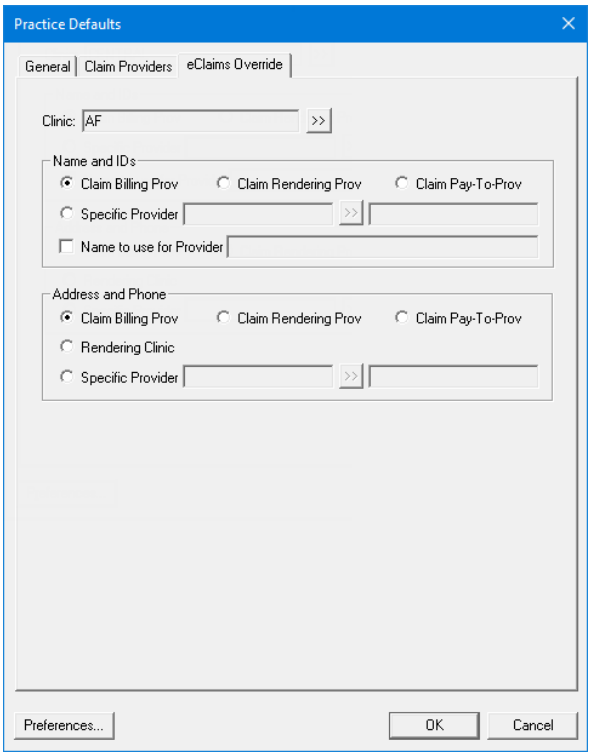
  - **Claim Provider of Procedures** – To use the provider applied to procedures.
  - **Patient's Prov 1** – To use a patient's primary provider selected in the Family File.
  - **Specific Provider** – To always have a specific provider listed and then click the search button ›› to select the desired provider. If you want to override the name in the database, select **Name to use for Provider**; and then click the search button ›› to select a provider name, or enter a name in the box.
- **Insurance Plan Exceptions** (For a main template)
  - Add exceptions after you have added your main template and the necessary exception templates for the selected clinic. To add an exception for a plan that does not use this template, click the **Insurance plan** search button ›› to select the insurance plan that you want to associate with this exception. Then, click **Add**.
  - Remove exceptions that are no longer valid or that were added my mistake. To remove an exception, select that exception, and then click **Remove**. On the confirmation message that appears, click **Yes**. The exception is removed not the associated insurance plan or template.

  Note: Any exceptions that you add to an exception template are ignored when claims are created. Only exceptions for a main template are used for claims.

d. Click **Save**.

- **Delete** – To delete a template, do the following:
  - **a**. Select a **Clinic**.
  - **b**. Under **Claim Provider Templates**, select a template, and then click **Delete**.
  - **c**. On the confirmation message that appears, click **Yes**.
- **Select Template** – Select the main template (the default or primary template) for the selected clinic. By default, the first template you add is the main one, but you can make any template the main one as needed. To specify the main template, select a template under **Claim Provider Templates**, and then click **Select Template**. The main template's name is preceded by an asterisk (*) in the **Claim Provider Templates** list box.
- **Copy** – Copy a template to the same or a different clinic with a different name. Exceptions, if any, from the original template are not copied because each clinic can have its own unique set of templates. To copy a template, do the following:
  - a. Select a **Clinic**.
  - **b**. Select a template, and then click **Copy**. The **Copy Claim Provider Template** dialog box appears.
  - **c**. Click the **New Template Clinic** search button ›› to select the clinic where you want the new template to be added.
  - **d**. Enter a name for the template in the **New Template Name** box (it can be the same as the original if you are copying the template to a different clinic than the original's).
  - **e**. Click **OK**.
  - **f**. Click **OK** on the message that appears.

eClaims Override tab:



For each clinic, do the following:

a. Select a **Clinic**.

b. Set up the following options for the clinic:

- **Name and IDs** – Specify the provider whose name and provider IDs you want to use for the billing provider's name and IDs on claims submitted electronically.
- **Address and Phone** – Specify the provider whose address and phone number you want to use for the billing provider's address and phone number on claims submitted electronically:

3. Click **OK** to save the changes.

For comprehensive information about all the practice defaults, see the "Practice Defaults" topic in the Dentrix Enterprise Help.

Customizing IHS Standard Codes Definitions

One way to customize Dentrix Enterprise to meet the needs of your organization for generating National Patient Information Reporting System (NPIRS) reports is by adding and editing IHS standard codes definitions.

To customize a practice definition

1. In Office Manager, from the **Maintenance** menu, point to **Practice Setup**, and then click **IHS Standard Codes Definitions**.

   The **IHS Standard Codes Definitions** dialog box appears.

   - Admission (SCB)
   - Area (SCB)
   - Blood Quantum (SCB)
   - Classification (Beneficiary) (SCB)
   - Clinic (SCB)
   - Clinical Services (SCB)
   - Community (SCB)
   - ER Disposition Codes (SCS)
   - Facility (SCB)
   - Inpatient Diagnostic Codes (SCS)
   - Insurance Category Codes (SCS)
   - Provider Affiliation (SCS)
   - Service Category Codes (SCS)
   - Service Eligibility Codes (SCS)
   - Service Type Codes (SCS)
   - Services Rendered by Provider (SCB)
   - State (SCB)
   - Tribe (SCB)
   - Type of Provider (SCB)

2. In the **Definition Type** list, select one of the following options:
3. Add, edit, and delete the corresponding definitions as needed. (Refer to the applicable section on any of the subsequent pages for details.)

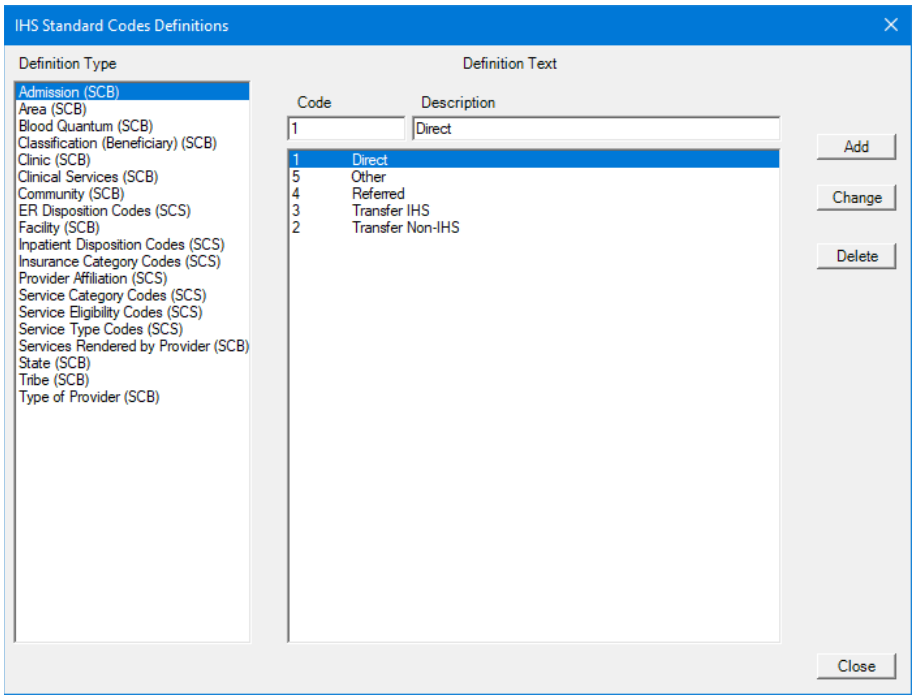
Admission

You can customize admission codes as needed.

To customize Admission

1. In the **IHS Standard Codes Definitions** dialog box, in the **Definition Type** list, select **Admission (SCB)**.

   The corresponding definitions appear in the list to the right.



2. Do any of the following:
   - To add a definition, do the following:
     a. With any definition selected, under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and the existing text in the **Description** box (which can be up to 100 characters in length).
     b. Click **Add**.
   - To edit a definition, do the following:
     a. Select a definition.
     b. Under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and/or the existing text in the **Description** box (which can be up to 100 characters in length).
     c. Click **Change**.
   - To delete a definition, do the following:
     a. Select a definition.
     b. Click **Delete**.

        A confirmation message appears.

     c. Click **Yes**.

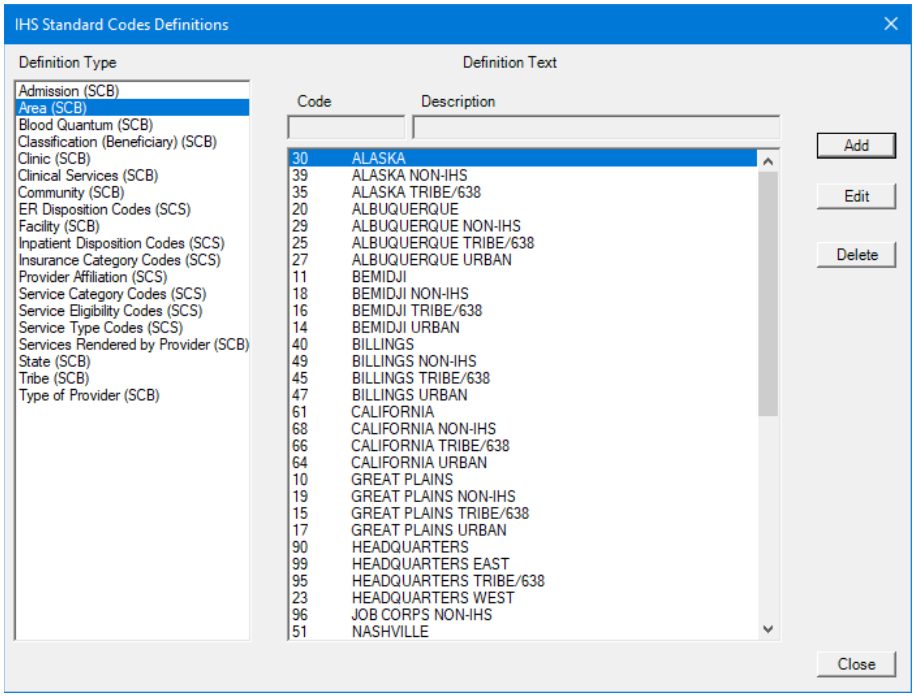
Area

You can customize area codes as needed.

To customize Area

1. In the **IHS Standard Codes Definitions** dialog box, in the **Definition Type** list, select **Area (SCB)**.

   The corresponding definitions appear in the list to the right.



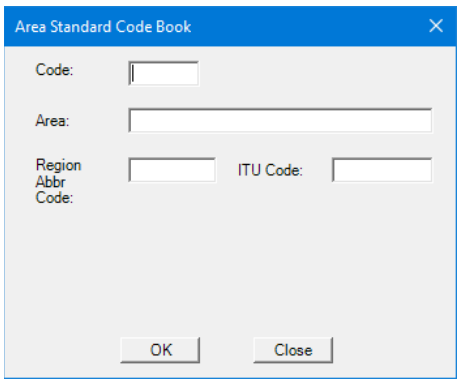
2. Do any of the following:

   - To add a definition, do the following:

     a. Verify that the desired definition does not already exist.

     b. Click **Add**.

     The **Area Standard Code Book** dialog box appears.



     c. Set up the following options:

     - **Code** – The area's code (up to seven characters in length).
     - **Area** – The area's description (up to 100 characters in length).
     - **Region Abbr Code** – The area's abbreviated region code (up to four characters in length).

- **ITU Code** – The area's ITU code (up to four characters in length).

d. Click **OK**.

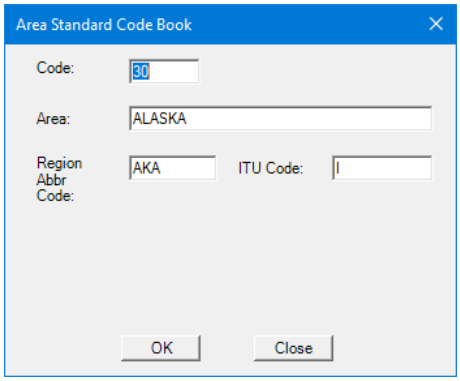
Note: The new definition appears in the list alphabetically by area.

- To edit a definition, do the following:

  a. Select a definition.

  b. Click **Edit**.

  The **Area Standard Code Book** dialog box appears.



  c. Change any of the following options as needed:

  - **Code** – The area's code (up to seven characters in length).
  - **Area** – The area's description (up to 100 characters in length).
  - **Region Abbr Code** – The area's abbreviated region code (up to four characters in length).
  - **ITU Code** – The area's ITU code (up to four characters in length).

  d. Click **OK**.

- To delete a definition, do the following:

  a. Select a definition.

  b. Click **Delete**.

  A confirmation message appears.

  c. Click **Yes**.

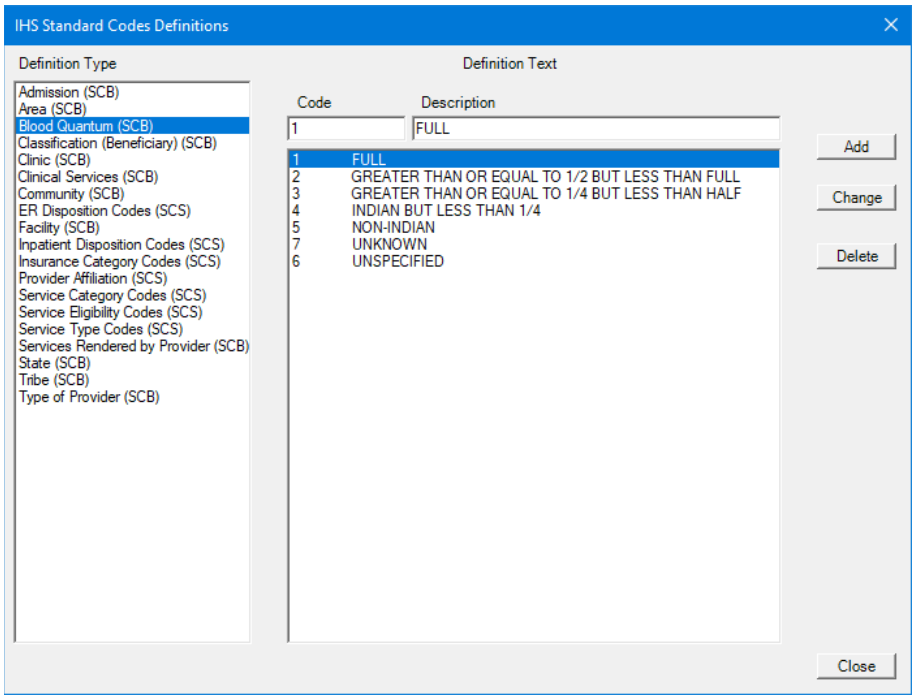
Blood Quantum

You can customize blood quantum codes as needed.

To customize Blood Quantum

1. In the **IHS Standard Codes Definitions** dialog box, in the **Definition Type** list, select **Blood Quantum (SCB)**.

   The corresponding definitions appear in the list to the right.



2. Do any of the following:
   - To add a definition, do the following:
     a. With any definition selected, under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and the existing text in the **Description** box (which can be up to 100 characters in length).
     b. Click **Add**.
   - To edit a definition, do the following:
     a. Select a definition.
     b. Under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and/or the existing text in the **Description** box (which can be up to 100 characters in length).
     c. Click **Change**.
   - To delete a definition, do the following:
     a. Select a definition.
     b. Click **Delete**.

        A confirmation message appears.

     c. Click **Yes**.

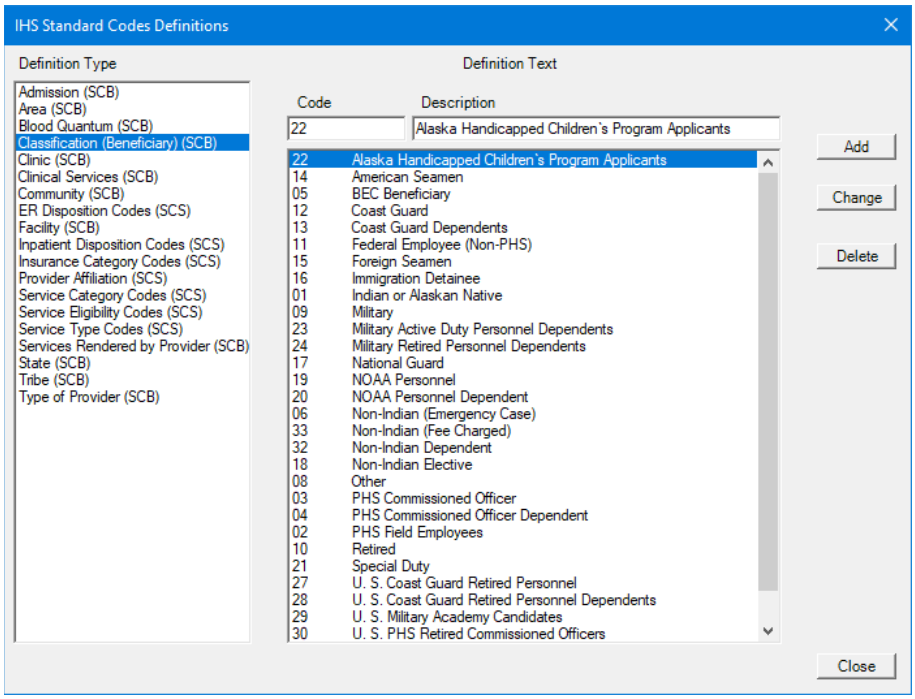
Classification (Beneficiary)

You can customize beneficiary classification codes as needed.

To customize Classification (Beneficiary)

1. In the **IHS Standard Codes Definitions** dialog box, in the **Definition Type** list, select **Classification (Beneficiary) (SCB)**.

   The corresponding definitions appear in the list to the right.



2. Do any of the following:

   - To add a definition, do the following:

     a. With any definition selected, under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and the existing text in the **Description** box (which can be up to 100 characters in length).

     b. Click **Add**.

   - To edit a definition, do the following:

     a. Select a definition.

     b. Under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and/or the existing text in the **Description** box (which can be up to 100 characters in length).

     c. Click **Change**.

   - To delete a definition, do the following:

     a. Select a definition.

     b. Click **Delete**.

        A confirmation message appears.

     c. Click **Yes**.

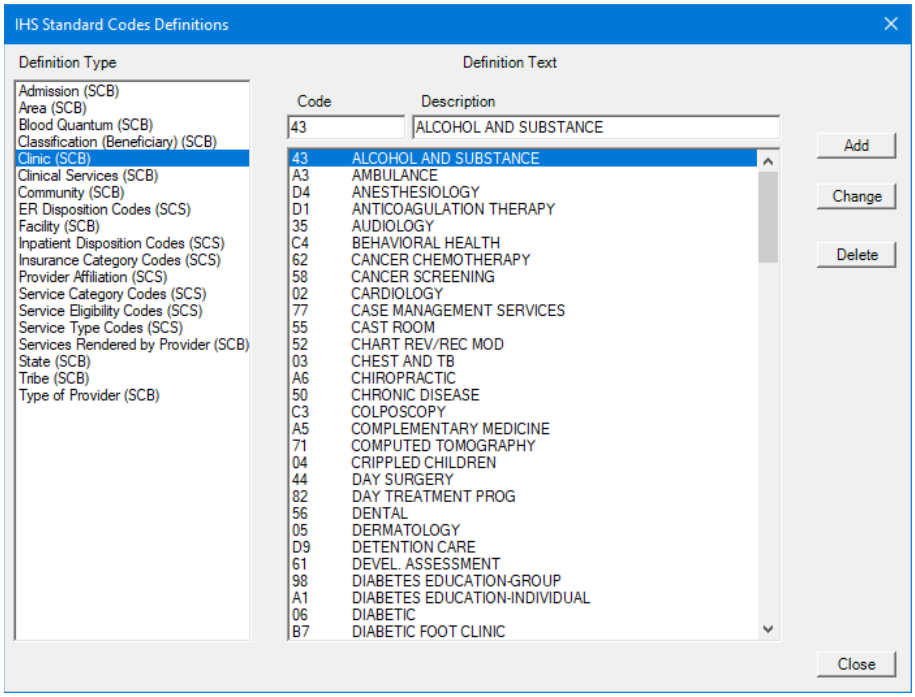
Clinic

You can customize clinic codes as needed.

To customize Clinic

1. In the **IHS Standard Codes Definitions** dialog box, in the **Definition Type** list, select **Clinic (SCB)**.

   The corresponding definitions appear in the list to the right.



2. Do any of the following:

   - To add a definition, do the following:

     a. With any definition selected, under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and the existing text in the **Description** box (which can be up to 100 characters in length).

     b. Click **Add**.

   - To edit a definition, do the following:

     a. Select a definition.

     b. Under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and/or the existing text in the **Description** box (which can be up to 100 characters in length).

     c. Click **Change**.

   - To delete a definition, do the following:

     a. Select a definition.

     b. Click **Delete**.

     A confirmation message appears.

     c. Click **Yes**.

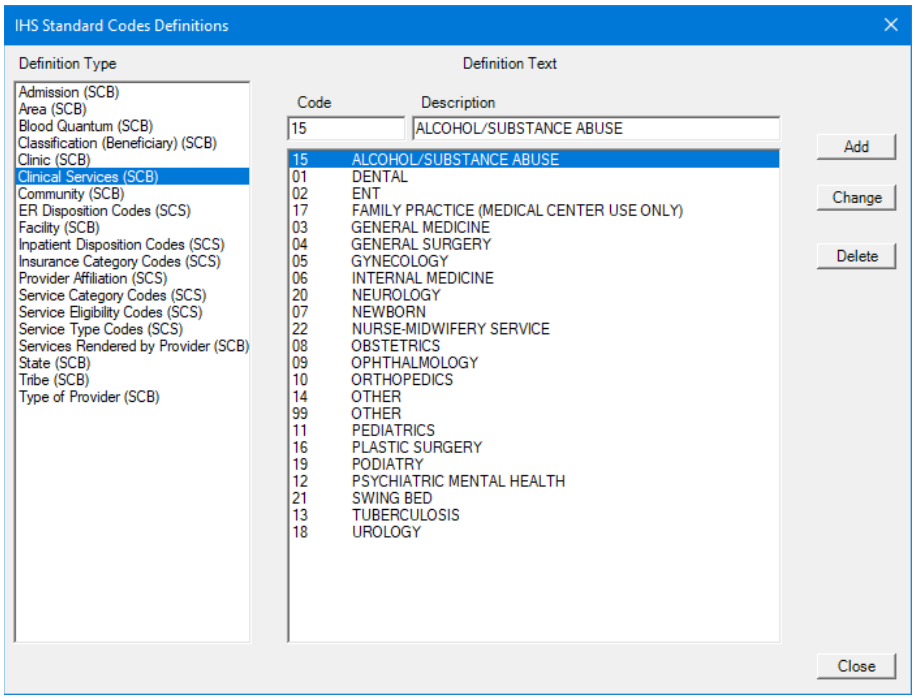
Clinical Services

You can customize clinical services codes as needed.

To customize Clinical Services

1. In the **IHS Standard Codes Definitions** dialog box, in the **Definition Type** list, select **Clinical Services (SCB)**.

   The corresponding definitions appear in the list to the right.



2. Do any of the following:

   - To add a definition, do the following:
     a. With any definition selected, under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and the existing text in the **Description** box (which can be up to 100 characters in length).
     b. Click **Add**.
   - To edit a definition, do the following:
     a. Select a definition.
     b. Under **Definition Text**, replace the existing abbreviation in the **Code** box (which can be up to seven characters in length) and/or the existing text in the **Description** box (which can be up to 100 characters in length).
     c. Click **Change**.
   - To delete a definition, do the following:
     a. Select a definition.
     b. Click **Delete**.

        A confirmation message appears.

     c. Click **Yes**.

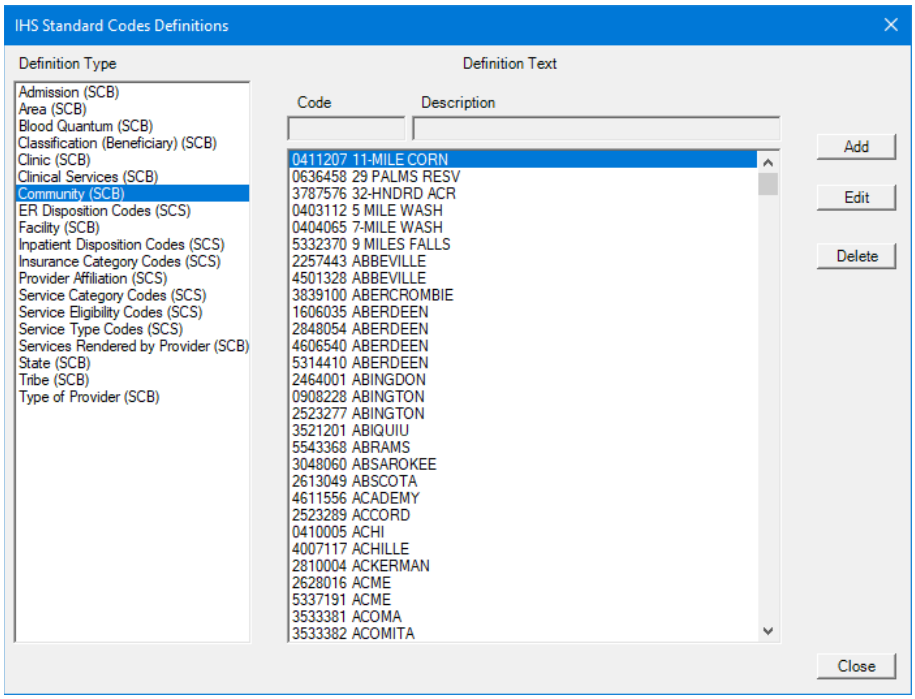
Community

You can customize community codes as needed.

To customize Community

1. In the **IHS Standard Codes Definitions** dialog box, in the **Definition Type** list, select **Community (SCB)**.

   The corresponding definitions appear in the list to the right.



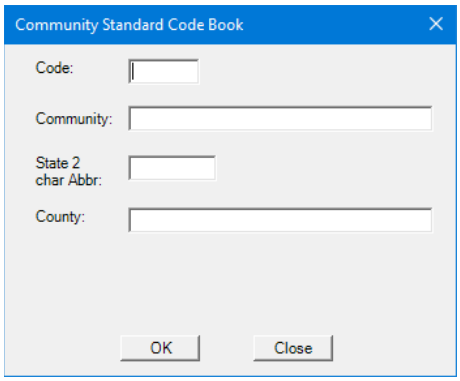
2. Do any of the following:

   - To add a definition, do the following:

     a. Verify that the desired definition does not already exist.

     b. Click **Add**.

     The **Community Standard Code Book** dialog box appears.



     c. Set up the following options:

     - **Code** – The community's code (up to seven characters in length).
     - **Community** – The community's description (up to 100 characters in length).

- **State 2 char Abbr** – The state abbreviation of the community (up to two characters in length).
- **County** – The community's county (up to 200 characters in length).

d. Click **OK**.

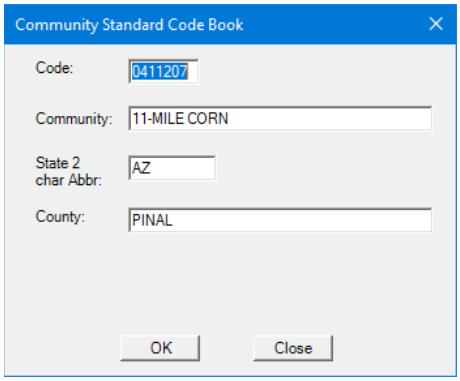
Note: The new definition appears in the list alphabetically by community.

- To edit a definition, do the following:

a. Select a definition.

b. Click **Edit**.

The **Community Standard Code Book** dialog box appears.



c. Change any of the following options as needed:

- **Code** – The community's code (up to seven characters in length).
- **Community** – The community's description (up to 100 characters in length).
- **State 2 char Abbr** – The state abbreviation of the community (up to two characters in length).
- **County** – The community's county (up to 200 characters in length).

d. Click **OK**.

- To delete a definition, do the following:

a. Select a definition.

b. Click **Delete**.

A confirmation message appears.

c. Click **Yes**.

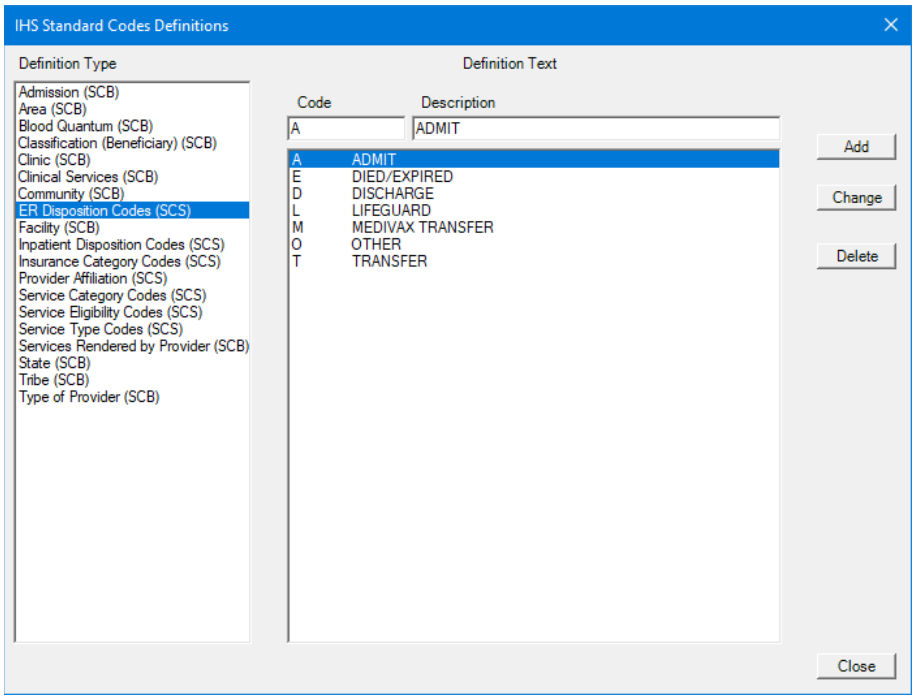
ER Disposition Codes

You can customize ER disposition codes as needed.

To customize ER Disposition Codes

1. In the **IHS Standard Codes Definitions** dialog box, in the **Definition Type** list, select **ER Disposition Codes (SCS)**.

   The corresponding definitions appear in the list to the right.



2. Do any of the following:
   - To add a definition, do the following:
     a. With any definition selected, under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and the existing text in the **Description** box (which can be up to 100 characters in length).
     b. Click **Add**.
   - To edit a definition, do the following:
     a. Select a definition.
     b. Under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and/or the existing text in the **Description** box (which can be up to 100 characters in length).
     c. Click **Change**.
   - To delete a definition, do the following:
     a. Select a definition.
     b. Click **Delete**.

        A confirmation message appears.

     c. Click **Yes**.

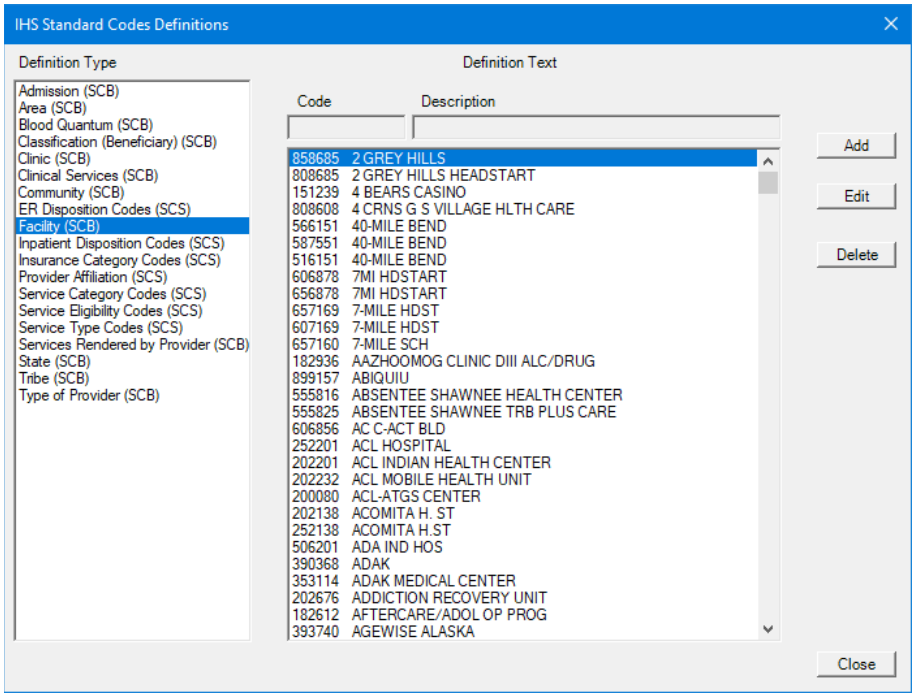
Facility

You can customize facility codes as needed.

To customize Facility

1. In the **IHS Standard Codes Definitions** dialog box, in the **Definition Type** list, select **Facility (SCB)**.

   The corresponding definitions appear in the list to the right.



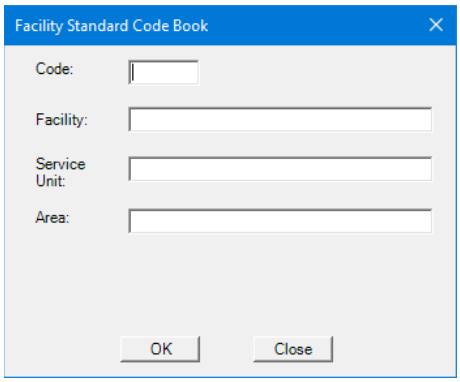
2. Do any of the following:

   - To add a definition, do the following:

     a. Verify that the desired definition does not already exist.

     b. Click **Add**.

     The **Facility Standard Code Book** dialog box appears.



     c. Set up the following options:

     - **Code** – The facility's code (up to seven characters in length).
     - **Facility** – The facility's description (up to 100 characters in length).
     - **Service Unit** – The service unit of the facility (up to 200 characters in length).

- **Area** – The facility's area (up to 300 characters in length).

d. Click **OK**.

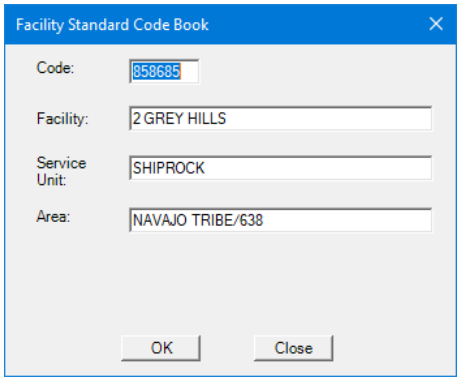
Note: The new definition appears in the list alphabetically by facility.

- To edit a definition, do the following:

  a. Select a definition.

  b. Click **Edit**.

  The **Facility Standard Code Book** dialog box appears.



  c. Change any of the following options as needed:

  - **Code** – The facility's code (up to seven characters in length).
  - **Facility** – The facility's description (up to 100 characters in length).
  - **Service Unit** – The service unit of the facility (up to 200 characters in length).
  - **Area** – The facility's area (up to 300 characters in length).

  d. Click **OK**.

- To delete a definition, do the following:

  a. Select a definition.

  b. Click **Delete**.

  A confirmation message appears.

  c. Click **Yes**.

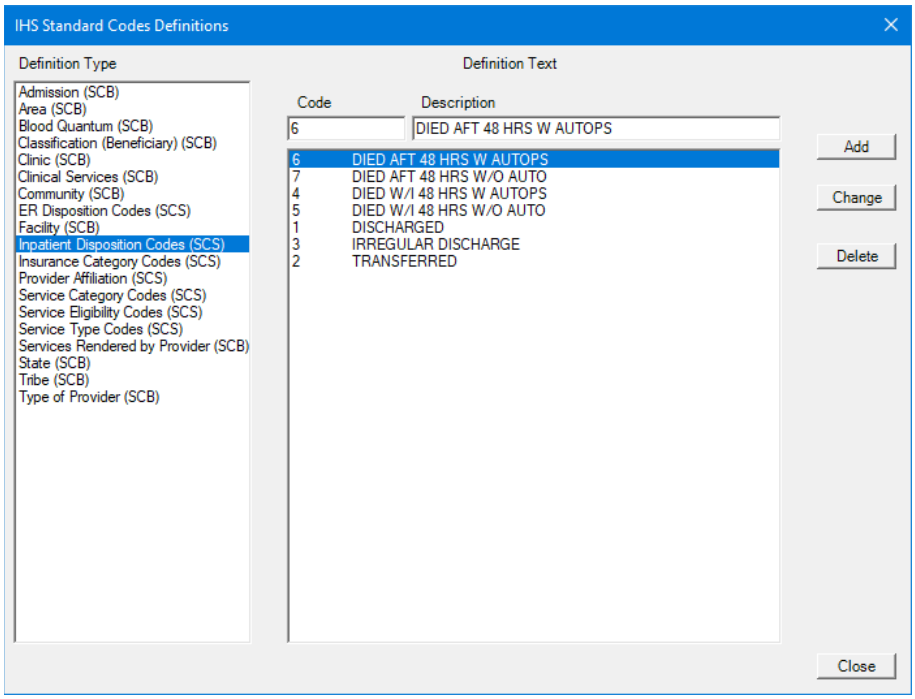
Inpatient Diagnostic Codes

You can customize inpatient diagnostic codes as needed.

To customize Inpatient Diagnostic Codes

1. In the **IHS Standard Codes Definitions** dialog box, in the **Definition Type** list, select **Inpatient Diagnostic Codes (SCS)**.

   The corresponding definitions appear in the list to the right.



2. Do any of the following:
   - To add a definition, do the following:
     a. With any definition selected, under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and the existing text in the **Description** box (which can be up to 100 characters in length).
     b. Click **Add**.
   - To edit a definition, do the following:
     a. Select a definition.
     b. Under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and/or the existing text in the **Description** box (which can be up to 100 characters in length).
     c. Click **Change**.
   - To delete a definition, do the following:
     a. Select a definition.
     b. Click **Delete**.

        A confirmation message appears.

     c. Click **Yes**.

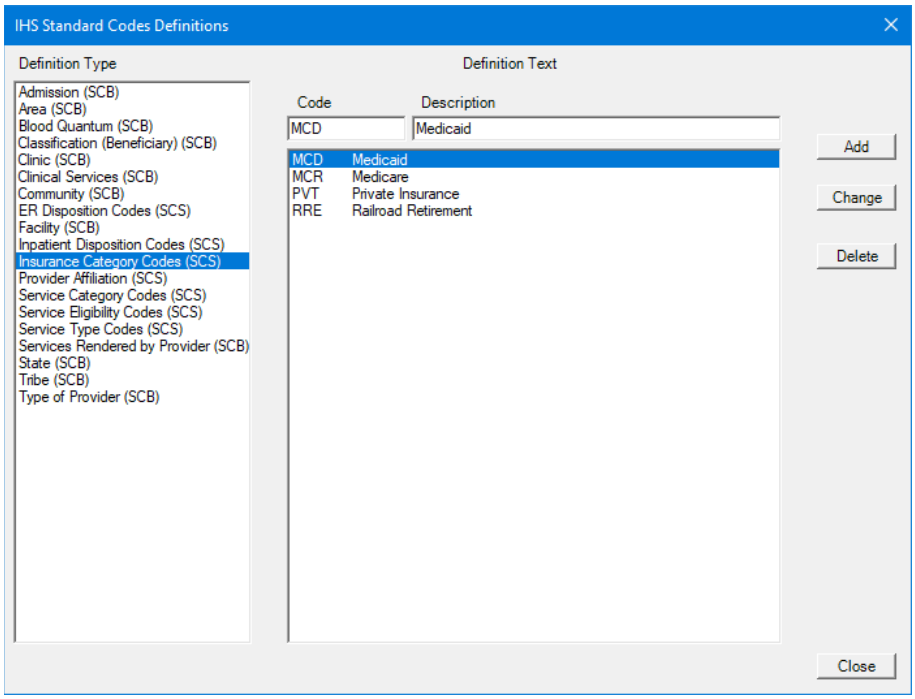
Insurance Category Codes

You can customize insurance category codes as needed.

To customize Insurance Category Codes

1. In the **IHS Standard Codes Definitions** dialog box, in the **Definition Type** list, select **Insurance Category Codes (SCS)**.

   The corresponding definitions appear in the list to the right.



2. Do any of the following:
   - To add a definition, do the following:
     a. With any definition selected, under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and the existing text in the **Description** box (which can be up to 100 characters in length).
     b. Click **Add**.
   - To edit a definition, do the following:
     a. Select a definition.
     b. Under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and/or the existing text in the **Description** box (which can be up to 100 characters in length).
     c. Click **Change**.
   - To delete a definition, do the following:
     a. Select a definition.
     b. Click **Delete**.

        A confirmation message appears.

     c. Click **Yes**.

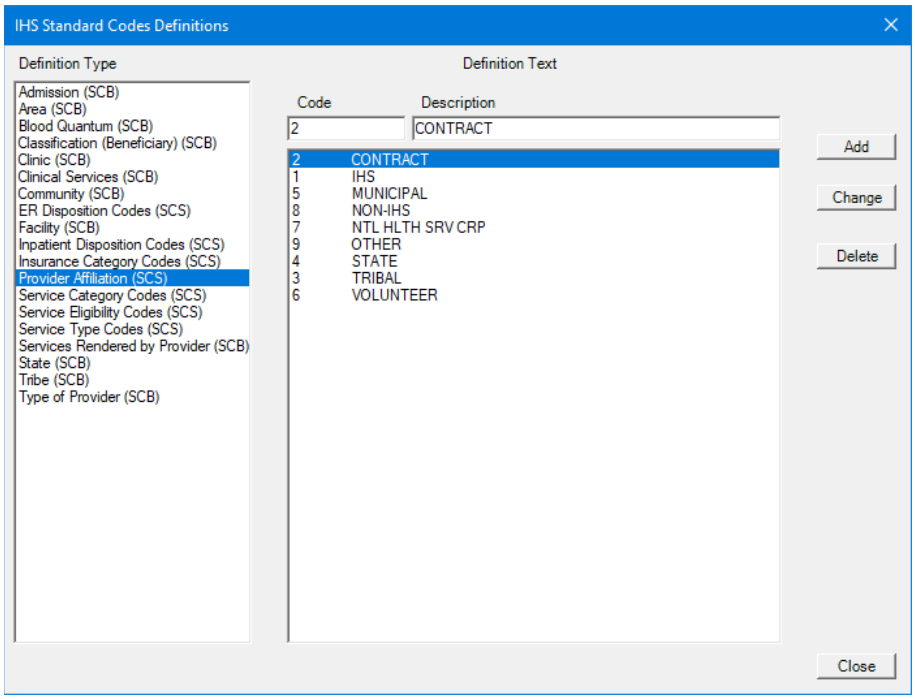
Provider Affiliation

You can customize provider affiliation codes as needed.

To customize Provider Affiliation

1. In the **IHS Standard Codes Definitions** dialog box, in the **Definition Type** list, select P**rovider Affiliation (SCS)**.

   The corresponding definitions appear in the list to the right.



2. Do any of the following:

   - To add a definition, do the following:

     a. With any definition selected, under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and the existing text in the **Description** box (which can be up to 100 characters in length).

     b. Click **Add**.

   - To edit a definition, do the following:

     a. Select a definition.

     b. Under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and/or the existing text in the **Description** box (which can be up to 100 characters in length).

     c. Click **Change**.

   - To delete a definition, do the following:

     a. Select a definition.

     b. Click **Delete**.

     A confirmation message appears.

     c. Click **Yes**.

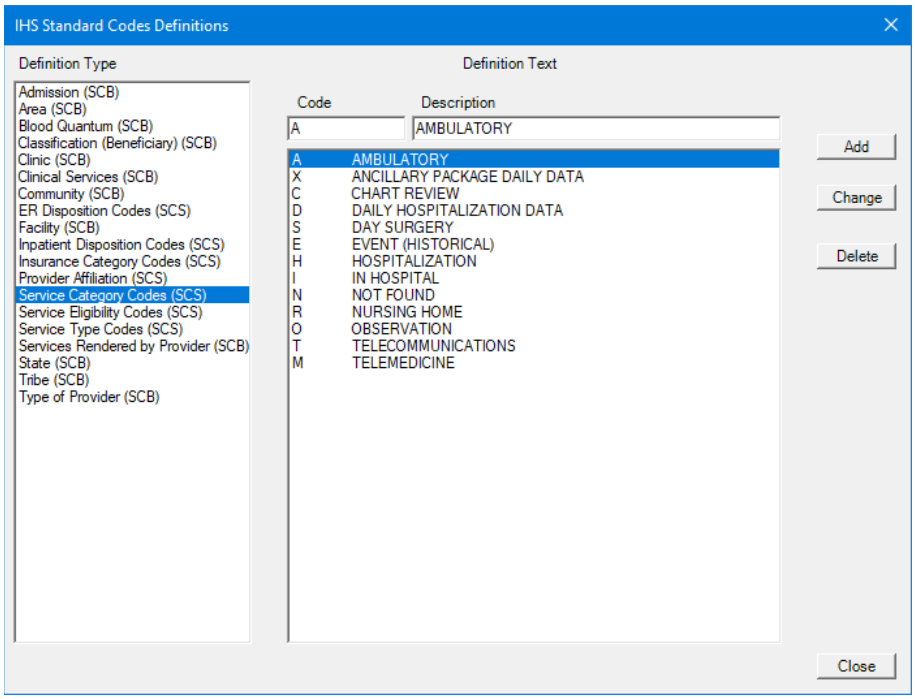
Service Category Codes

You can customize service category codes as needed.

To customize Service Category Codes

1. In the **IHS Standard Codes Definitions** dialog box, in the **Definition Type** list, select **Service Category Codes (SCS)**.

   The corresponding definitions appear in the list to the right.



2. Do any of the following:
   - To add a definition, do the following:
     a. With any definition selected, under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and the existing text in the **Description** box (which can be up to 100 characters in length).
     b. Click **Add**.
   - To edit a definition, do the following:
     a. Select a definition.
     b. Under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and/or the existing text in the **Description** box (which can be up to 100 characters in length).
     c. Click **Change**.
   - To delete a definition, do the following:
     a. Select a definition.
     b. Click **Delete**.

        A confirmation message appears.
     c. Click **Yes**.

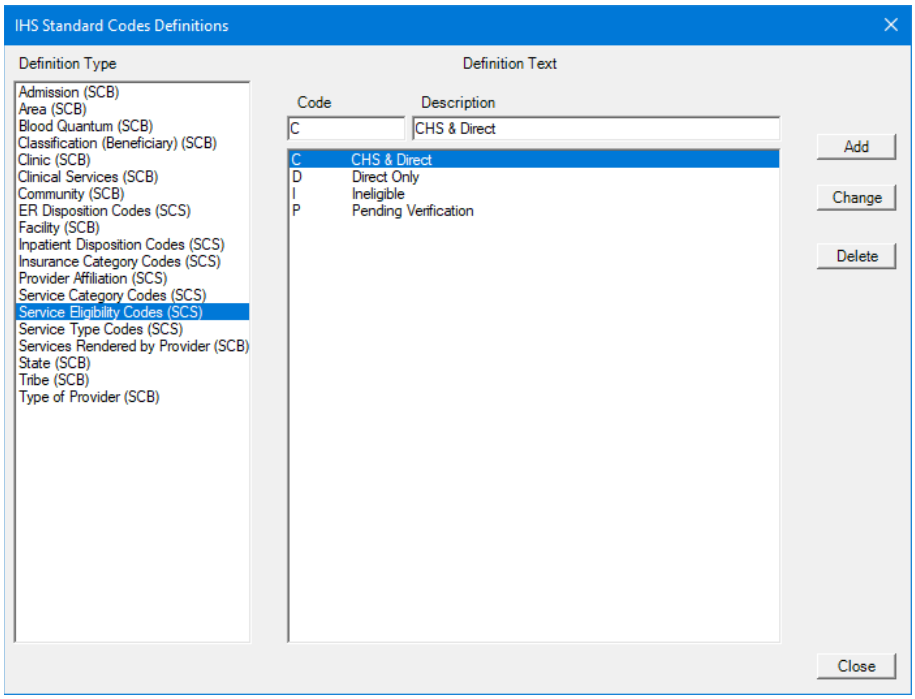
Service Eligibility Codes

You can customize service eligibility codes as needed.

To customize Service Eligibility Codes

1. In the **IHS Standard Codes Definitions** dialog box, in the **Definition Type** list, select **Service Eligibility Codes (SCS)**.

   The corresponding definitions appear in the list to the right.



2. Do any of the following:
   - To add a definition, do the following:
     a. With any definition selected, under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and the existing text in the **Description** box (which can be up to 100 characters in length).
     b. Click **Add**.
   - To edit a definition, do the following:
     a. Select a definition.
     b. Under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and/or the existing text in the **Description** box (which can be up to 100 characters in length).
     c. Click **Change**.
   - To delete a definition, do the following:
     a. Select a definition.
     b. Click **Delete**.

        A confirmation message appears.

     c. Click **Yes**.

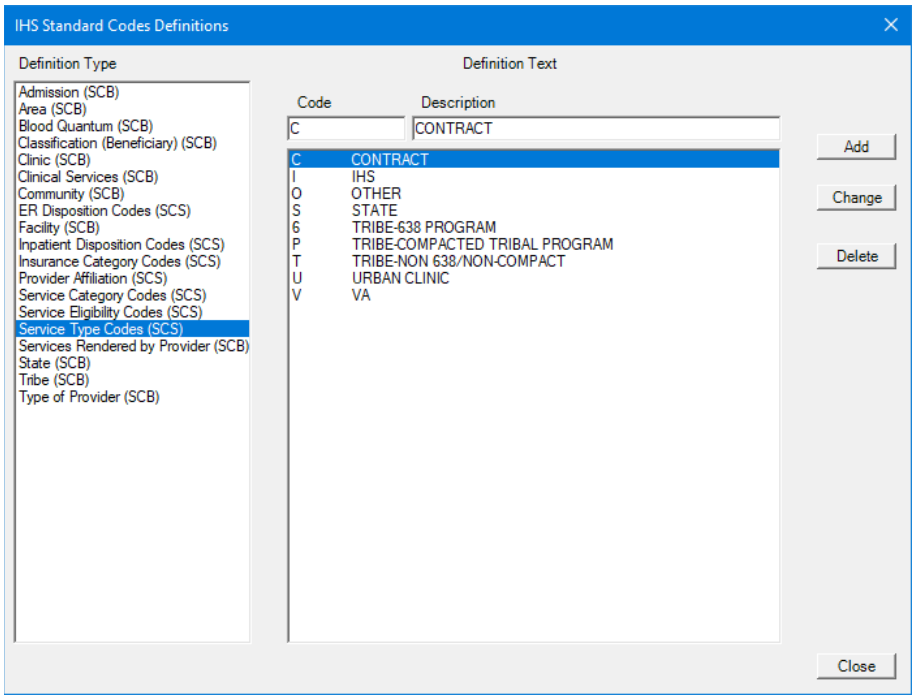
Service Type Codes

You can customize service type codes as needed.

To customize Service Type Codes

1. In the **IHS Standard Codes Definitions** dialog box, in the **Definition Type** list, select **Service Type Codes (SCS)**.

   The corresponding definitions appear in the list to the right.



2. Do any of the following:
   - To add a definition, do the following:
     a. With any definition selected, under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and the existing text in the **Description** box (which can be up to 100 characters in length).
     b. Click **Add**.
   - To edit a definition, do the following:
     a. Select a definition.
     b. Under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and/or the existing text in the **Description** box (which can be up to 100 characters in length).
     c. Click **Change**.
   - To delete a definition, do the following:
     a. Select a definition.
     b. Click **Delete**.

        A confirmation message appears.

     c. Click **Yes**.

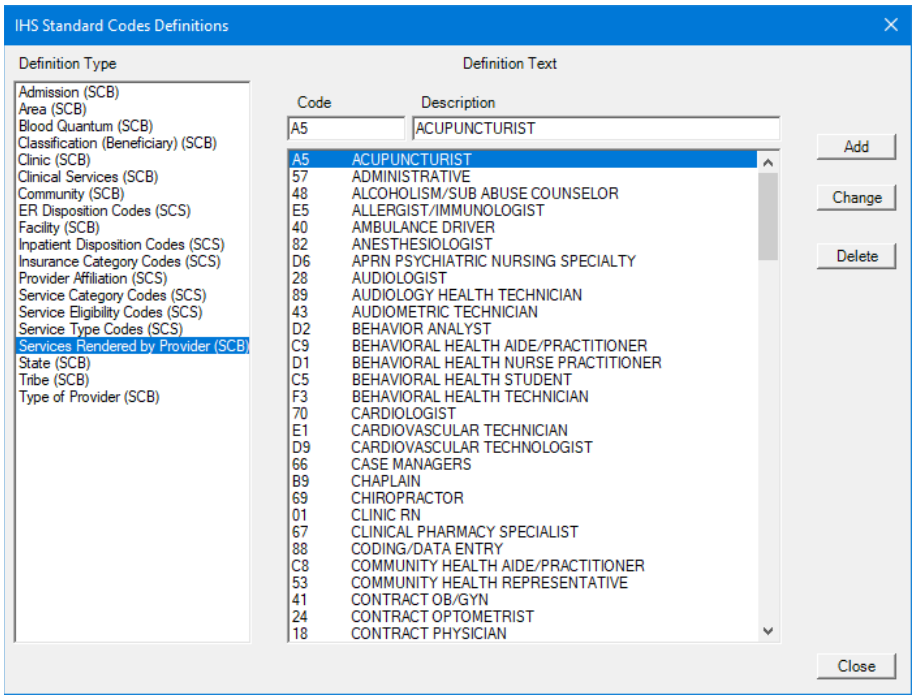
Services Rendered by Provider

You can customize codes for services rendered by providers as needed.

To customize Services Rendered by Provider

1. In the **IHS Standard Codes Definitions** dialog box, in the **Definition Type** list, select **Services Rendered by Provider (SCB)**.

   The corresponding definitions appear in the list to the right.



2. Do any of the following:

   - To add a definition, do the following:
     a. With any definition selected, under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and the existing text in the **Description** box (which can be up to 100 characters in length).
     b. Click **Add**.
   - To edit a definition, do the following:
     a. Select a definition.
     b. Under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and/or the existing text in the **Description** box (which can be up to 100 characters in length).
     c. Click **Change**.
   - To delete a definition, do the following:
     a. Select a definition.
     b. Click **Delete**.

        A confirmation message appears.

     c. Click **Yes**.

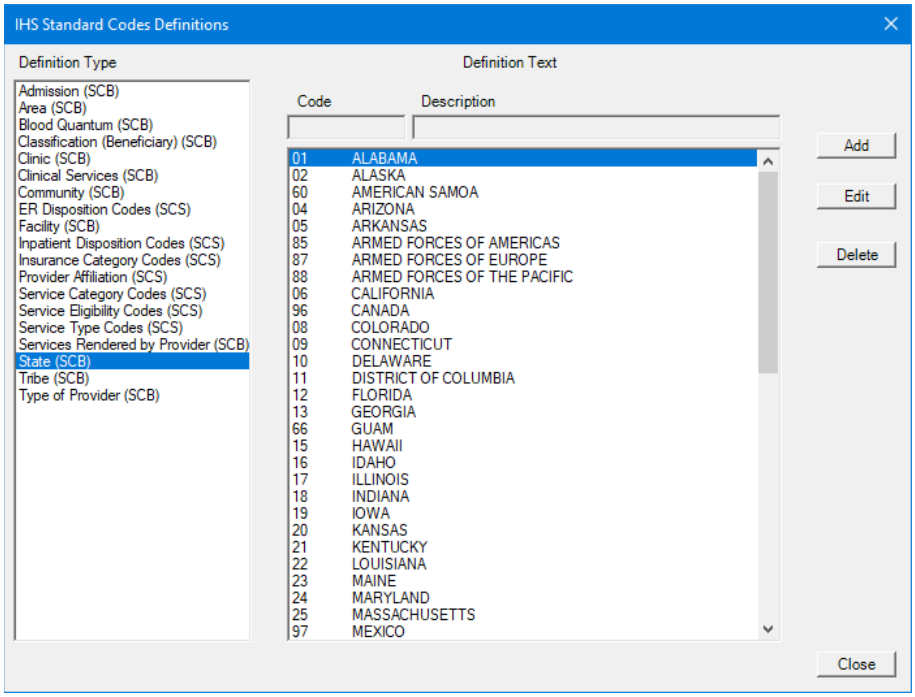
State

You can customize state codes as needed.

To customize State

1. In the **IHS Standard Codes Definitions** dialog box, in the **Definition Type** list, select **State (SCB)**.

   The corresponding definitions appear in the list to the right.



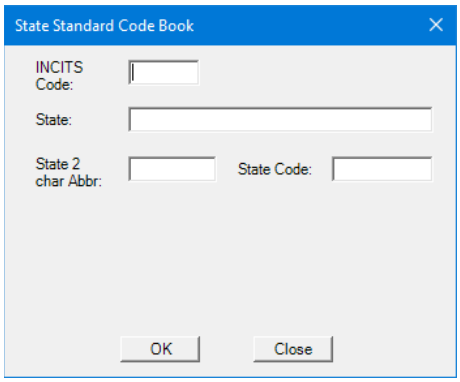
2. Do any of the following:

   - To add a definition, do the following:

     a. Verify that the desired definition does not already exist.

     b. Click **Add**.

     The **State Standard Code Book** dialog box appears.



     c. Set up the following options:

     - **INCITS Code** – The state's INCITS code (up to seven characters in length).
     - **State** – The state's description (up to 100 characters in length).
     - **State 2 char Abbr** – The state abbreviation of the state (up to two characters in length).

- **State Code** – The state's code (up to two characters in length).

d. Click **OK**.

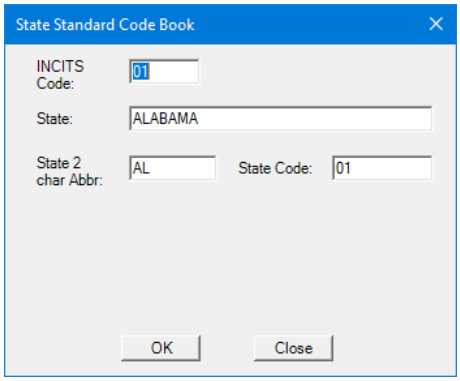
Note: The new definition appears in the list alphabetically by area.

- To edit a definition, do the following:

a. Select a definition.

b. Click **Edit**.

The **State Standard Code Book** dialog box appears.



c. Change any of the following options as needed:

- **INCITS Code** – The state's INCITS code (up to seven characters in length).
- **State** – The state's description (up to 100 characters in length).
- **State 2 char Abbr** – The state abbreviation of the state (up to two characters in length).
- **State Code** – The state's code (up to two characters in length).

d. Click **OK**.

- To delete a definition, do the following:

a. Select a definition.

b. Click **Delete**.

A confirmation message appears.

c. Click **Yes**.

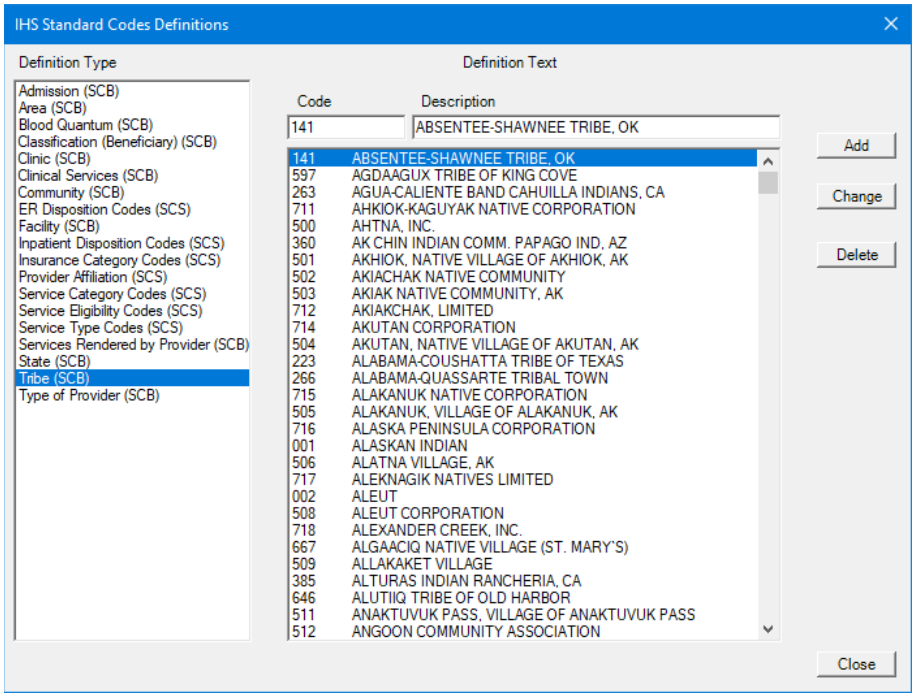
Tribe

You can customize tribe codes as needed.

To customize Tribe

1. In the **IHS Standard Codes Definitions** dialog box, in the **Definition Type** list, select **Tribe (SCB)**.

   The corresponding definitions appear in the list to the right.



2. Do any of the following:
   - To add a definition, do the following:
     a. With any definition selected, under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and the existing text in the **Description** box (which can be up to 100 characters in length).
     b. Click **Add**.
   - To edit a definition, do the following:
     a. Select a definition.
     b. Under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and/or the existing text in the **Description** box (which can be up to 100 characters in length).
     c. Click **Change**.
   - To delete a definition, do the following:
     a. Select a definition.
     b. Click **Delete**.

        A confirmation message appears.
     c. Click **Yes**.

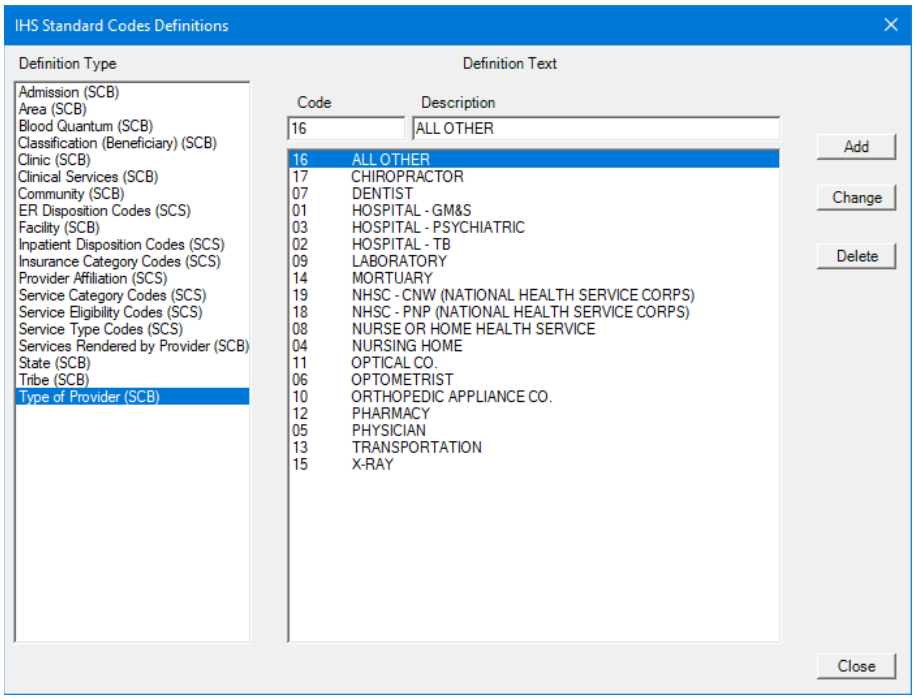
Type of Provider

You can customize the codes for provider types as needed.

To customize Type of Provider

1. In the **IHS Standard Codes Definitions** dialog box, in the **Definition Type** list, select **Type of Provider (SCB)**.

   The corresponding definitions appear in the list to the right.



2. Do any of the following:

   - To add a definition, do the following:

     a. With any definition selected, under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and the existing text in the **Description** box (which can be up to 100 characters in length).

     b. Click **Add**.

   - To edit a definition, do the following:

     a. Select a definition.

     b. Under **Definition Text**, replace the existing code in the **Code** box (which can be up to seven characters in length) and/or the existing text in the **Description** box (which can be up to 100 characters in length).

     c. Click **Change**.

   - To delete a definition, do the following:

     a. Select a definition.

     b. Click **Delete**.

     A confirmation message appears.

     c. Click **Yes**.

Setting Up Auto Chart Numbering

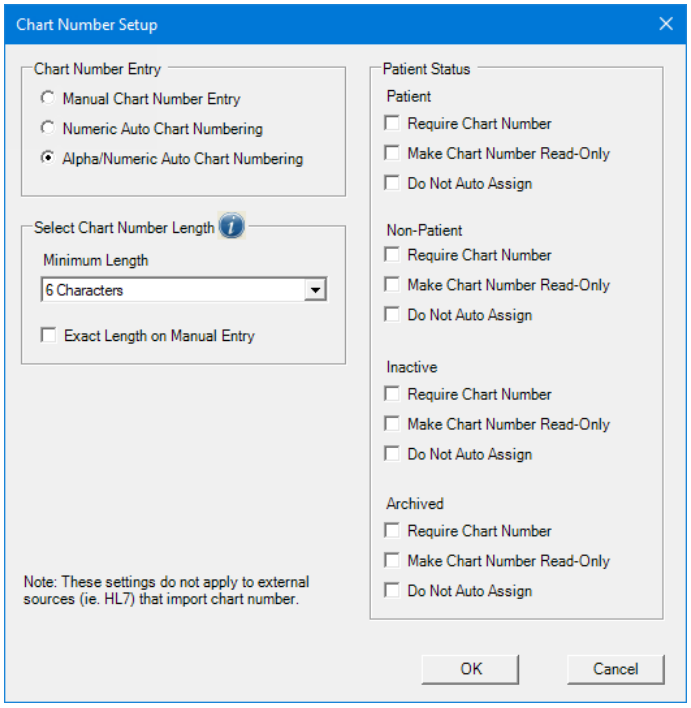
You can specify how Dentrix Enterprise handles chart numbers for your patients. The chart number settings can help you eliminate duplicate chart numbers, speed data entry for new patients, and maintain the integrity of your chart numbering system.

Note: If your office uses the HL7 interface to connect Dentrix Enterprise with a medical practice management system (PMS), chart numbers will likely be generated in the medical PMS and transferred to Dentrix Enterprise.

To set up chart numbers

1. In Office Manager, from the **Maintenance** menu, point to **Practice Setup**, and then click **Chart Number Setup**.

   The **Chart Numbering Setup** dialog box appears.



2. Set up the following options to suit your preferences:
   - **Chart Number Entry** – Select one of the following options:
     - **Manual Chart Number Entry** – Select this option to not use chart numbers in your office or to assign chart numbers manually.
     - **Numeric Auto Chart Numbering** – Select this option to have Dentrix Enterprise automatically assign a numeric chart number to each new patient.
     - **Alpha/Numeric Auto Chart Numbering** – Select this option to have Dentrix Enterprise automatically assign a combination alpha and numeric chart number to each new patient. This option will create a chart number using the initial two characters of the patient's last name and then a unique numeric ID. For example, John Smith might be assigned the chart number SM0001.

- **Select Chart Number Length**:
  - **Minimum Length** – Select the minimum length that chart numbers must be from the list. Chart numbers can have a minimum length of anywhere from 5 to 10 characters or not have minimum length (if you select **None**).
  - **Exact Length on Manual Entry** – To require that chart numbers be exactly as long as the selected **Minimum Length** when someone enters chart numbers manually, select this check box.

  Note: A chart number's length may differ from these settings in either of the following cases: if a prefix or suffix is added to the chart number, or if the chart number is not required and a value is not entered.

- **Patient Status** – For each of the patient statuses (**Patient**, **Non-Patient**, **Inactive**, and **Archived**), select any of the following check boxes:
  - **Require Chart Number** – A chart number is required for a patient record with the given patient status selected.
  - **Make Chart Number Read-Only** – The chart number is read-only when editing a patient's record with the given patient status selected. However, a user with the "Chart, Override Read-Only Setting" right selected can edit the chart number in such a patient's record.
  - **Do Not Auto Assign** – Dentrix Enterprise does not automatically assign a chart number to a patient's record with the given patient status selected. This option is not available for any patient status if **Manual Chart Number Entry** is selected.

3. Click **OK**.

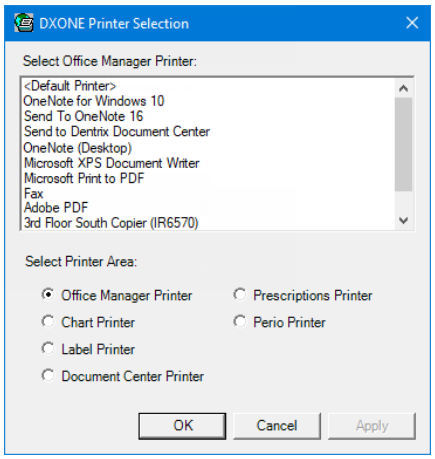
Setting Up Default Printers

You can set up a default printer for printing from the Office Manager and other areas throughout Dentrix Enterprise. However, before printing from the Office Manager or other modules, the printer to which you want to print must first be selected.

To select a default printer

1. In the Office Manager, from the **File** menu, click **Setup Printer**.

   The **DXONE Printer Selection** dialog box appears.



2. Under **Select Printer Area**, select the area of Dentrix Enterprise to which you want to assign a default printer:
   - **Office Manager Printer** – To print reports from the Office Manager module.
   - **Chart Printer** – To print from the Patient Chart module.
   - **Label Printer** – To print labels.
   - **Document Center Printer** – To print documents from the Document Center module.
   - **Prescriptions** – To print prescriptions from the Prescriptions module.
   - **Perio Printer** – To print periodontal examinations from the Perio module.
   - **Presenter Printer** – To print treatment plan presentations from the Treatment Planer module.
3. In the list box of printers, select the printer that will be used to print from the selected area.
4. Click **OK**.

Setting Up Security

Passwords in Dentrix Enterprise serve many different functions. First, you can use passwords to prevent an unauthorized person from performing certain sensitive tasks, such as changing information, deleting transactions, and accessing financial information. Second, you can have the extra security of flagging certain operations to require additional user verification—the password must be re-entered—to perform those operations.

You can create user groups to group users by role or some other method that suits your needs. Having users in groups allows you to manage security rights for all users in a given group at the same time instead of having to manage rights per user.

The enhanced security rights feature of Dentrix Enterprise provides you with the flexibility to implement and manage security rights to suit your preferences. You can choose whether to use user groups or not use them. You can choose whether to assign all or only some users to groups. You can assign a user to multiple groups. Also, on a user-by-user basis, you can customize a user's rights whether or not those rights have been assigned to that user by a group.

In Dentrix Enterprise, each user is assigned "rights" to the tasks they need to complete. Dentrix Enterprise then allows access to each password-protected operation, according to the security rights assigned to the logged-on user. If a user does not have rights to perform a certain function, they cannot access that particular area of the program or perform that particular task.

Assigned rights are clinic-specific. Each user will need to be given rights for each clinic to which they have access.

Note: It is recommended that the doctor read this section carefully and be aware of who is given "Password Administration" rights in the office.

This section covers the following topics on setting up passwords:

- Password Requirements
- Database Encryption
- Adding User Groups
- Assigning Users to Groups
- Customizing Security Rights
- Copying Security Rights
- Setting Up Secure Passwords
- Assigning User Verification to Tasks

Password Requirements

The passwords for user accounts must adhere to the following criteria:

- **Complexity** – The password must be at least 8 (for standard users) or 15 (for administrative users) characters in length and meet the following requirements: have at least one uppercase letter, have at least one lowercase letter, have at least one number, and have at least one special character (for example, #, %, or &).
- **Changes** – When the password is changed, at least 75% of the characters must be different in the new password than in the old password.
- **Storage and transmittal** – Passwords must encrypted when being stored or transmitted.
- **Expiration** – A password can be valid for one to up to 60 days. Then, it expires and must be changed.
- **Reuse** – When changing a password, any of a given user's previous six passwords cannot be reused.
- **Temporary passwords** – A temporary password can be provided for a given user to log on to a system, but a permanent password must be created by the user immediately upon logging on.

Database Encryption

Employ at least 128-bit encryption to protect data at rest in the EDR SQL database. Bit Locker encryption that is implemented at the operating system level does not suffice for this control.

Employ encryption to protect the confidentiality and integrity and availability of data during transit. Though EDR and RPMS servers are usually collocated, information is still vulnerable from attackers seeking to hijack information in transit. Encryption is required because EDR and RPMS are both High systems. DIS-SOP-06-11a:8.3 recommends a FIPS 140-2 certified encryption solution when transmitting and receiving PHI.

Encrypting Data at Rest

Enabling transparent data encryption (TDE) protects data at rest. Backup files are also protected. Refer to https://msdn.microsoft.com/en-us/library/bb934049(v=sql.110).aspx.

Notes:

- TDE requires decryption after data is retrieved from the disk, which will slow down the server. Data in memory is not encrypted.
- To restore the database from a backup, the certificate protecting the database encryption key must also be available, so you must maintain backups of the server certificates to prevent data loss.

For information about creating and using SQL server certificates and asymmetric keys, refer to https://msdn.microsoft.com/en-us/library/bb895327(v=sql.110).aspx.

Encrypting Data During Transit

Protect data during transit by doing the following:

- Enabling Secure Sockets Layer (SSL) protects data during transit. Refer to https://technet.microsoft.com/en-us/library/ms189067(v=sql.110).aspx. SSL requires some configuration changes on the SQL server.
- Using Internet Protocol Security (IPSec). Refer to https://en.wikipedia.org/wiki/IPsec. IPSec does not require any configuration changes on the SQL server.

Adding User Groups

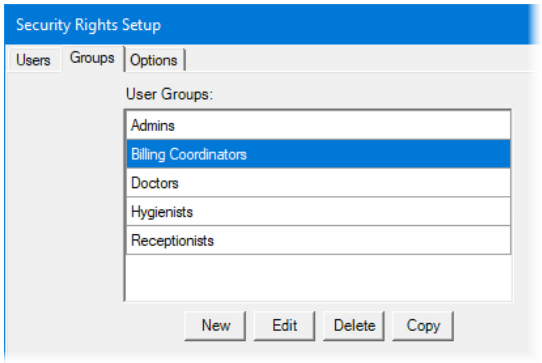
You can create user groups as needed to group users by role or some other method.

To add a user group

1. In Office Manager, from the **Maintenance** menu point to **Practice Setup** > **Security Setup**, and then click **Security Rights Setup**.

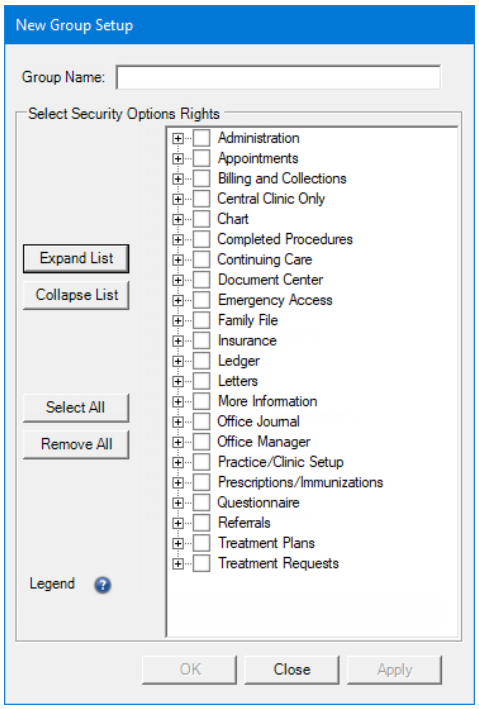
   The **Security Rights Setup** dialog box appears.

2. Click the **Groups** tab.



3. Under **User Groups**, click **New**.

   The **New Group Setup** dialog box appears.



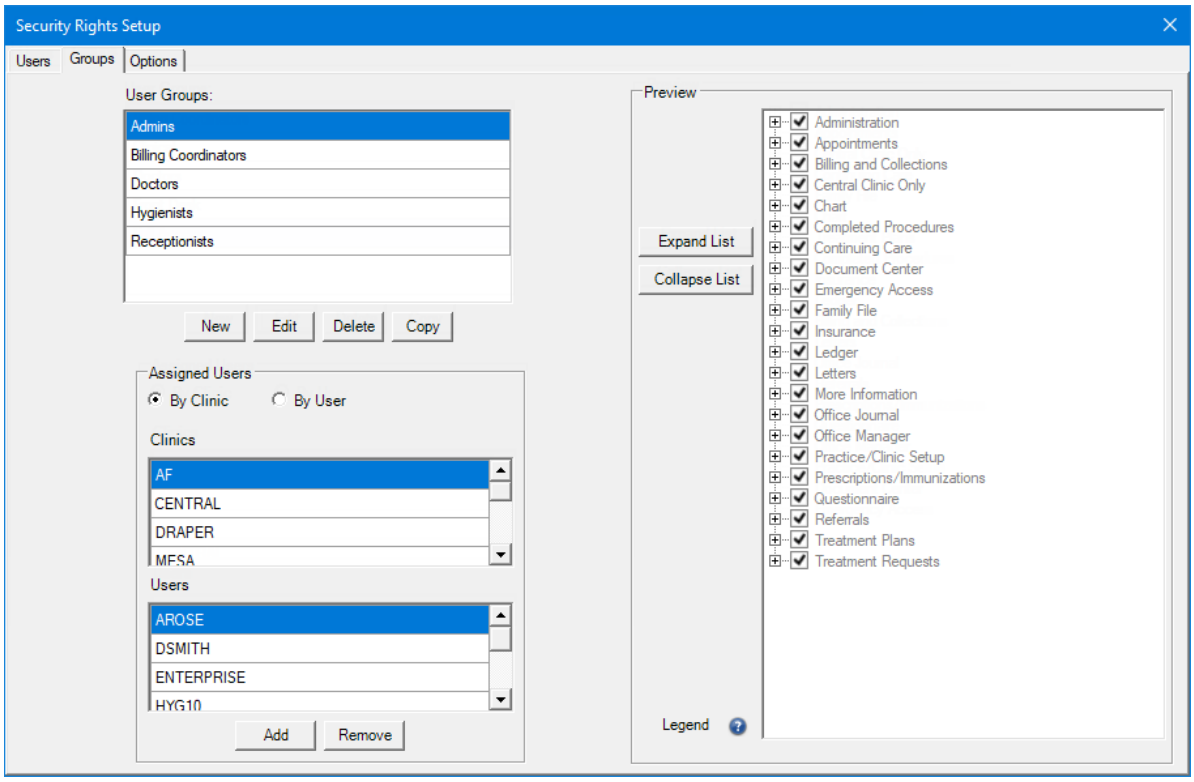
4. Set up the following options:
   - **Group Name** – Enter a name to identify the group.
   - **Rights** – Select the check boxes of the rights (categories and/or individual rights) that users in this security group should have by default.
5. Click **OK**.

Assigning Users to Groups

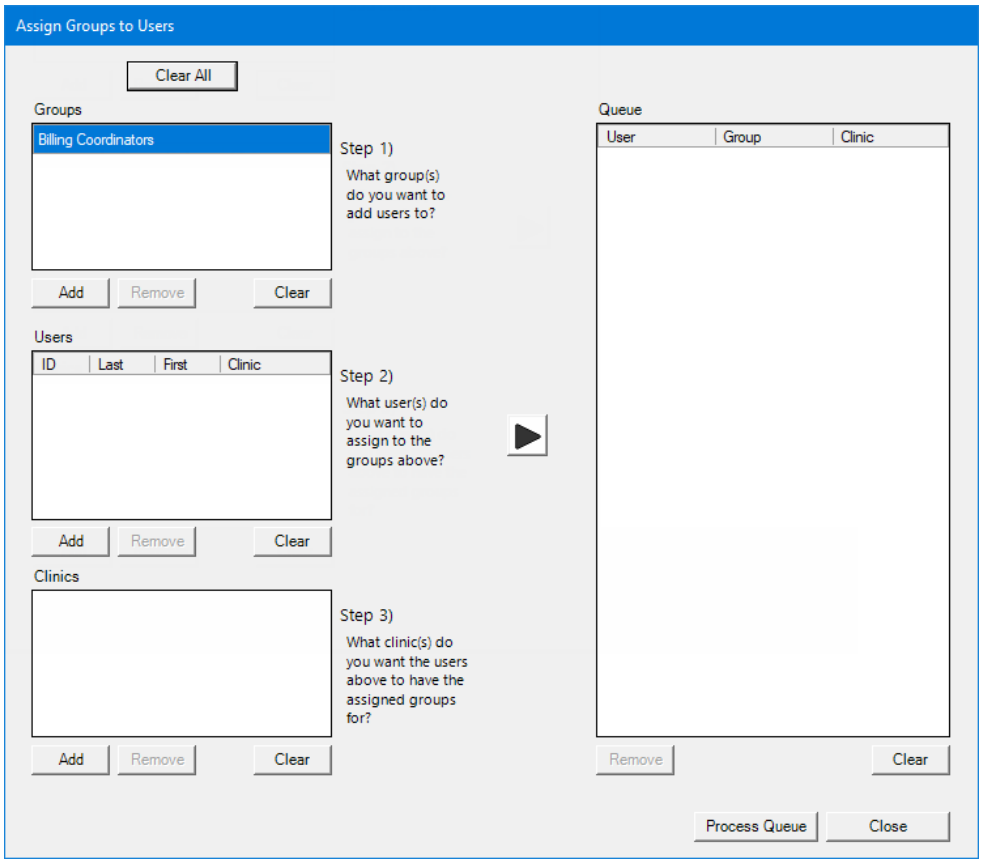
After you have created the necessary user groups, you can assign users to those groups as needed. A user can be assigned to multiple groups.

To assign users to a group

1. On the **Groups** tab of the **Security Rights Setup** dialog box, with a group sselected, under **Assigned Users**, click **Add**.



The **Assign Groups to Users** dialog box appears.



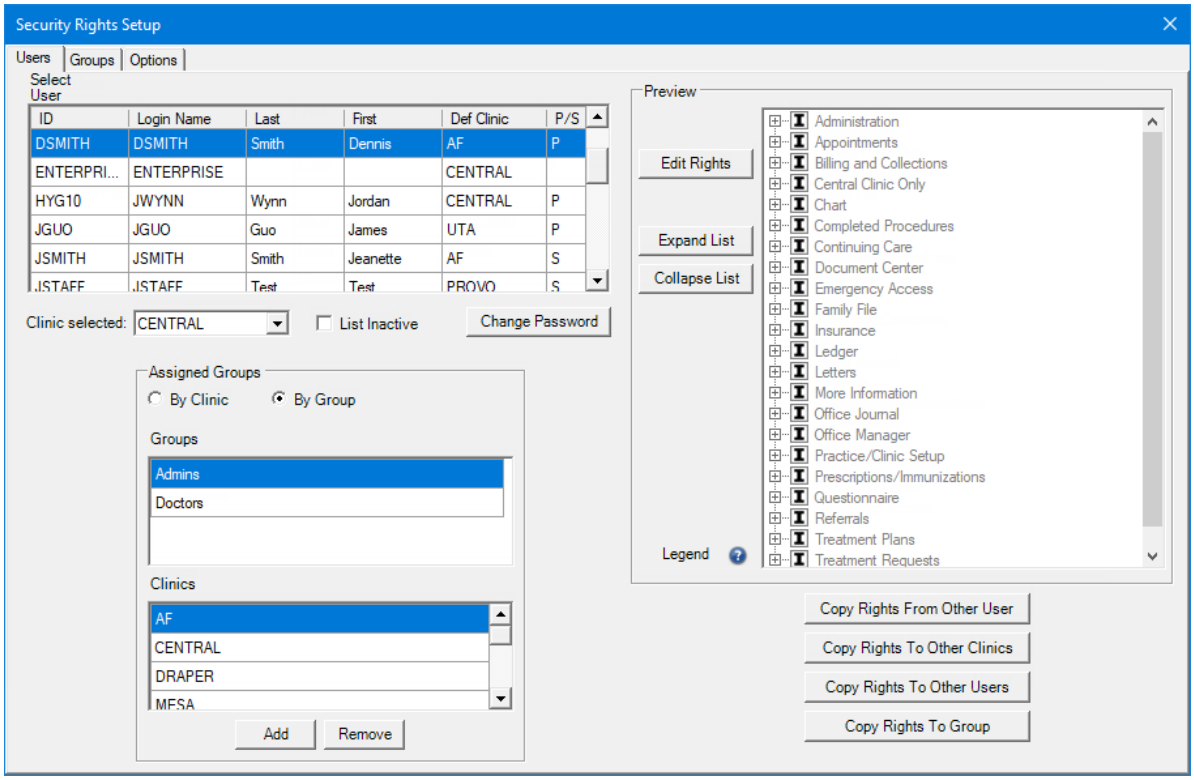
2. Set up the following options:
   - **Groups** – To select other groups that you want to add users to, click **Add**.
   - **Users** – To select the users that you want to add to the selected groups, click **Add**.
   - **Clinics** – To select the clinics that you want the selected user groups to have rights in, click **Add**.
3. Click the **Add to Queue** button ▶.
4. Click **Process Queue**.
5. Click **Close**.

Customizing Security Rights

You can customize a user's rights whether or not those rights were assigned to that user due to that user being part of a group.

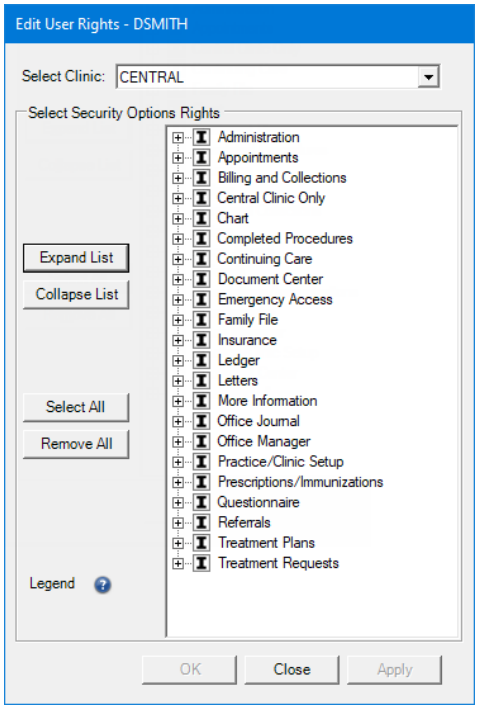
To customize a user's rights

1. On the **Users** tab of the **Security Rights Setup** dialog box, under **Select User**, select a user.



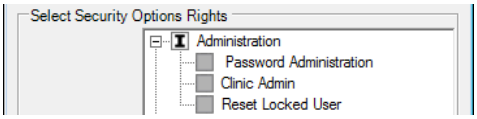
2. From the **Clinic selected** list, select the clinic that you want to customize rights for.
3. Under **Preview**, click **Edit Rights**.

   The **Edit User Rights** dialog box appears.

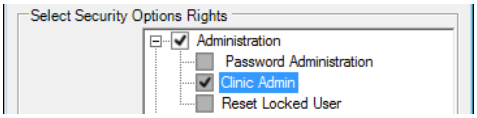


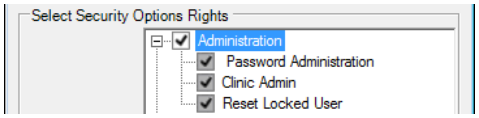
4. Change the assigned rights as needed by selecting and/or clearing the desired check boxes:

   - If the check box of a category has a black X, the rights in that category are assigned by a security group. All the check boxes of the rights in that category have gray backgrounds.

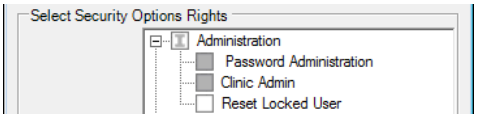


     If you clear all the check boxes in a category, the check boxes of the rights in that category will still have gray backgrounds, and if you then select a check box, the background stays gray.

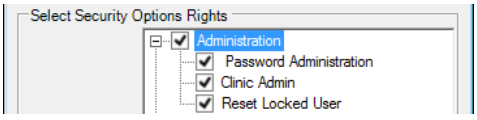




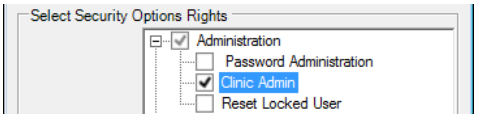
   - If the check box of a category has a gray X, the rights in that category are assigned by a security group. The check boxes of only the rights in that category that are assigned to the user have gray backgrounds. The check boxes of unassigned rights are clear.



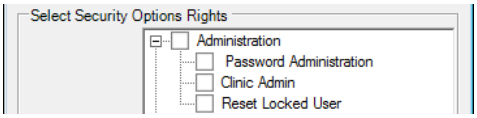
   - If the check box of a category has a black check mark, the rights in that category are not assigned by a security group. All the check boxes of the rights in that category are selected.



- If the check box of a category has a gray check mark, the rights in that category are not assigned by a group. The check boxes of only the rights in that category that are assigned to the user are selected. The check boxes of unassigned rights are clear.



If you clear all the check boxes in a category, the category check box will be cleared automatically.



5. Click **OK**.

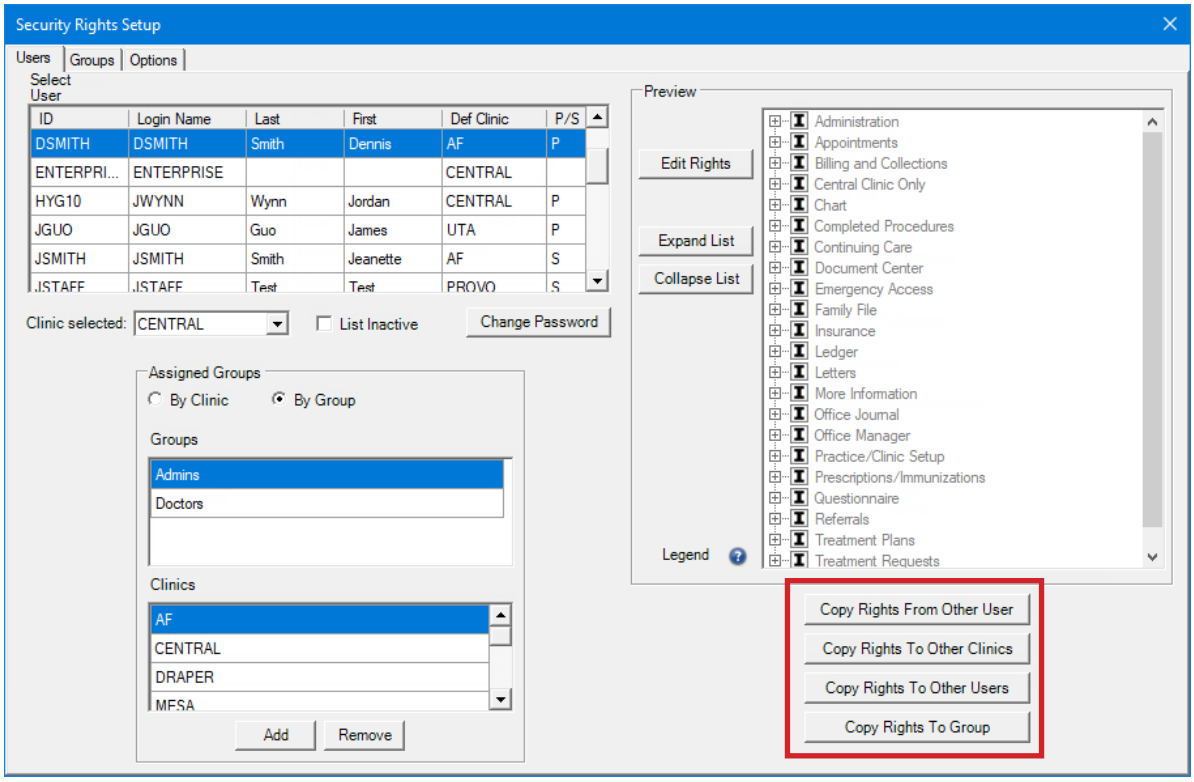
For a comprehensive list of all security options and their corresponding descriptions, see the "Security rights list" topic in the Dentrix Enterprise Help.

Copying Security Rights

If different users will have the same security rights selected, or if a user works at more than one clinic, you can save time by copying the rights to different users and clinics and to a user group.

To copy security rights

1. From the **Security Rights Setup** dialog box, select a user.

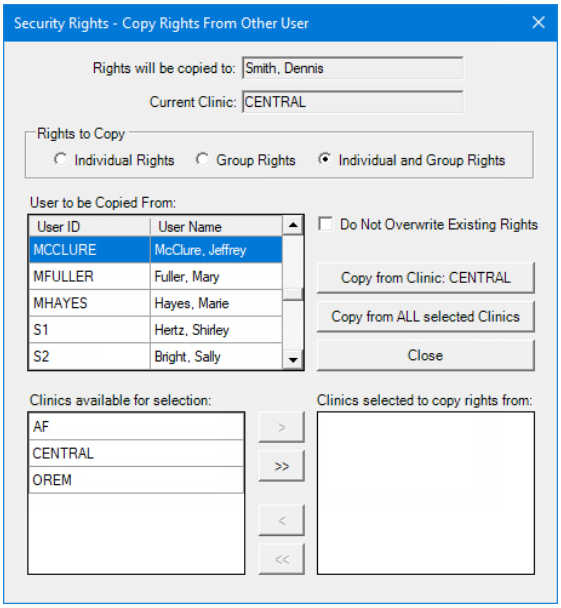


2. From the **Clinic selected** list, select a clinic.

Note: To show active and inactive users or show only active users in the **Select User** list, select or clear the **List Inactive** check box.

3. Do any of the following:

- **Copy Rights From Other User**:



To copy rights from a specified user to the selected user, do the following:

a. Click **Copy Rights From Other User**.

The **Security Rights - Copy Rights From Other Users** dialog box appears.

b. Under **Rights to Copy** specify if you want to copy **Individual Rights** (rights assigned to a user individually), **Group Rights** (rights assigned to a user due to being part of a group), or **Individual and Group Rights**.

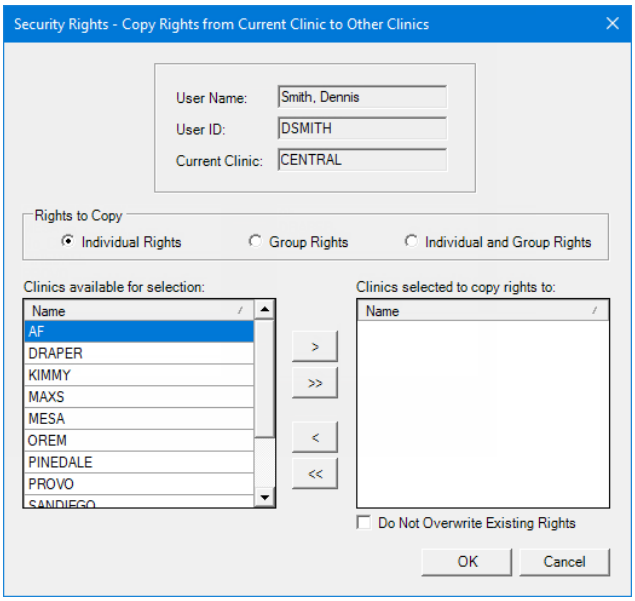
c. Under **User to be Copied From**, select the user from whom you want to copy rights.

d. To prevent disabling the rights that the user who the **Rights will be copied to** has enabled for the **Current Clinic**, select the **Do Not Overwrite Existing Rights** check box.

e. Do one of the following:

- From the **Clinics available for selection** list, select the clinics that you want to copy rights from, and then click the right arrow button to move them to the **Clinics selected to copy rights from** list box. Then, click **Copy from ALL selected clinics**.
- To copy rights from the **Current Clinic** only, click **Copy from Clinic: [Current Clinic]**.

- **Copy Rights To Other Clinics**:



To copy rights for the selected user from the selected clinic to specified clinics, do the following:

a. Click **Copy Rights To Other Clinics**.

The **Security Rights - Copy Rights from Current Clinic to Other Clinics** dialog box appears.

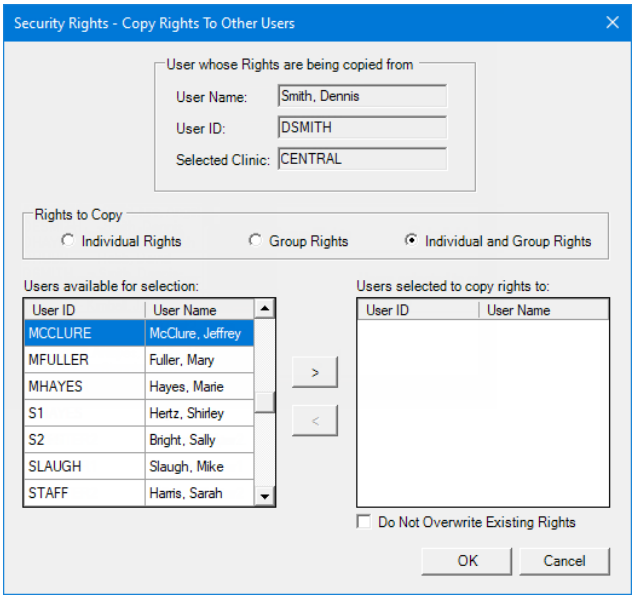
b. Under **Rights to Copy** specify if you want to copy **Individual Rights** (rights assigned to a user individually), **Group Rights** (rights assigned to a user due to being part of a group), or **Individual and Group Rights**.

c. From the **Clinics available for selection** list, select the clinics that you want to copy rights to, and then click the right arrow button to move them to the **Clinics selected to copy rights to** list box.

d. To prevent disabling the rights that the user has enabled for the **Clinics selected to copy rights to**, select the **Do Not Overwrite Existing Rights** check box.

e. Click **OK**.

- **Copy Rights To Other Users**:



To copy rights of the selected user for the selected clinic to other users, do the following:

a. Click **Copy Rights To Other Users**.

The **Security Rights - Copy Rights To Other Users** dialog box appears.

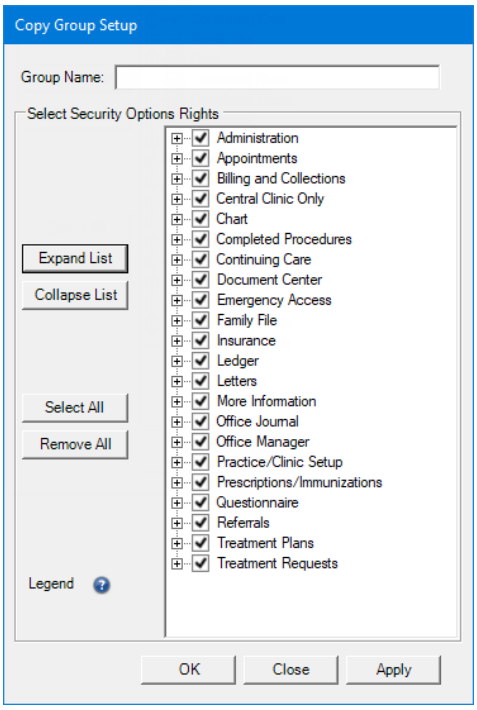
b. Under **Rights to Copy** specify if you want to copy **Individual Rights** (rights assigned to a user individually), **Group Rights** (rights assigned to a user due to being part of a group), or **Individual and Group Rights**.

c. From the **Users available for selection** list, select the users who you want to copy rights to, and then click the right arrow button to move them to the **Users selected to copy rights to** list box.

d. To prevent disabling the rights that the **Users selected to copy rights to** have enabled, select the **Do Not Overwrite Existing Rights** check box.

e. Click **OK**.

- **Copy Rights To Group**:



To copy the selected user's rights to other users, do the following:

a. Click **Copy Rights To Group**.

The **Copy Group Setup** dialog box appears.

b. Enter a **Group Name**, .

c. Select the check boxes of the rights (categories and/or individual rights) that users in this security group should have by default.

d. Click **OK**.

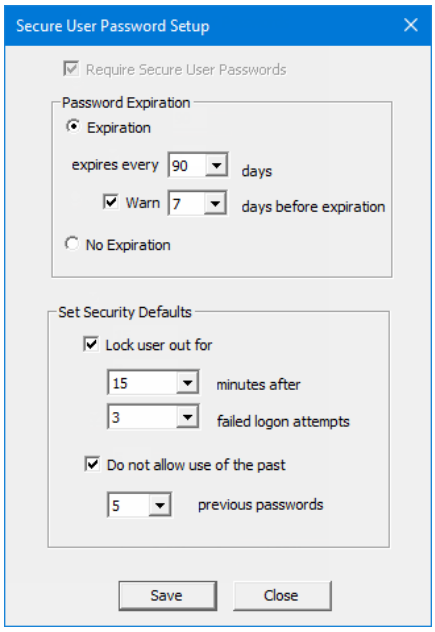
Setting Up Secure Passwords

A clinic can set up a time interval that forces users to change their passwords regularly. For instance, an office may want to enforce a change of password every three months. In conjunction with this, your office can set a requirement that users cannot reuse any of their previous passwords.

To set up secure user passwords

1. While logged on to the Central clinic, in Office Manager, from the **Maintenance** menu point to **Practice Setup** > **Security Setup**, and then click **Secure User Password Setup**.

   The **Secure User Password Setup** dialog box appears.



2. Set up the following options:
   - **Password Expiration** – If you want passwords to expire so that users have to change their passwords after a certain length of time, click **Expiration**, and then select a password expiration date in days. If you want users to be forewarned of a pending password change, check **Warn**, and then select the days before the expiration date that you want the notification to appear. If you do not want passwords to expire (users will never have to change passwords), click **No Expiration**.
   - **Set Security Defaults**
     - **Lock user out for** – To select how many logon attempts a user has before that user is locked out of the system for a specific period of time, check this option, select the time interval for which a user will be locked out in minutes, and select the number of logon attempts users have.

       Note: When a user is locked out, an administrator can reset any and all locked out users.

     - **Do not allow use of the past** – If you want to prevent users from reusing a specific number of old passwords, check this option, and then select how many previous passwords you want to block.
3. Click **Save**.

Assigning User Verification to Tasks

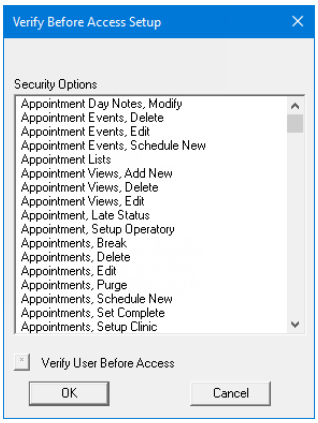
Once a user has logged on to Dentrix Enterprise, the user may perform all tasks to which they have rights. There can be certain situations for which additional protection is desired. In these cases, the security options can be flagged to "Verify User Before Access." With this security flag enabled for a task, users will be prompted to re-enter a user name and password when attempting to perform that task.

Tip: Consider how frequently the security task is performed before assigning the "Verify Users Before Access" flag. This flag will always prompt users to enter their passwords before they can continue working; a lot of interruptions might not be worth the added security.

To assign user verification

1. In the Office Manager, from the **Maintenance** menu point to **Practice Setup** > **Security Setup**, and then click **Verify User Before Access**.

   The **Verify User Before Access** dialog box appears.



2. Select one or more tasks.
3. Click **Verify User Before Access**.

   The selected tasks are flagged and moved to the bottom of the list. An asterisk (*) appears before a security option that is flagged to require re-entry of a password every time users attempt to perform that task.
4. Click **OK**.

Setting Up Program Preferences

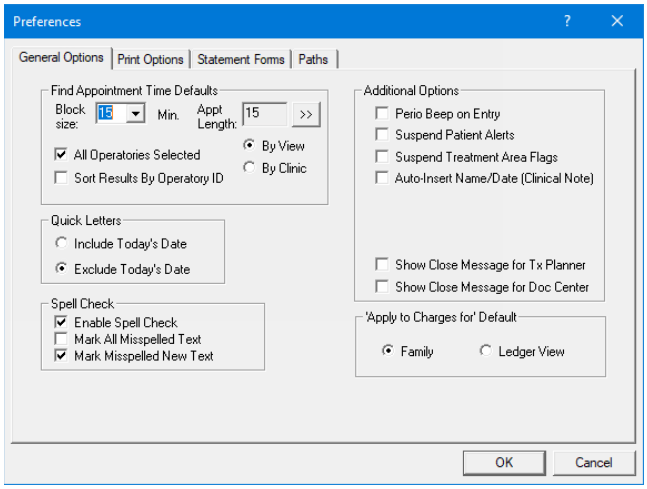
You can customize Dentrix Enterprise to the way your practice works. Each computer can have different preference settings.

To set up preferences

1. In the Office Manager, from the **Maintenance** menu, point to **Practice Setup**, and then click **Preferences**.

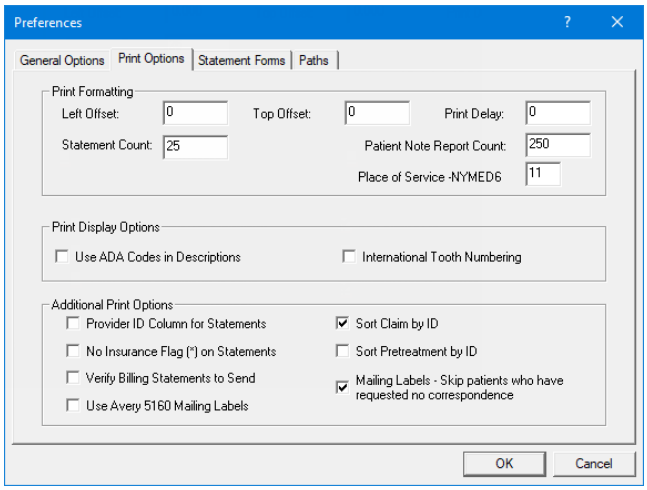
   The **Preferences** dialog box appears.

2. On the **General Options** tab, set up the following preferences:



- **Find Appointment Time Defaults** – Set the defaults for the Find Appointment Time button in the Appointment Book. Select the **Block size** in minutes and an **Appt Length**. Select **All Operatories Selected** to search all operatories and/or **Sort by Operatory ID** to sort the results by operatory ID. Select whether to search by the current Appointment Book view or by the current clinic.
- **Apply to Charges for' Default** – To have charges default to the family of the selected patient when making a payment or credit adjustment, click **Family**. Or, to have charges default to whomever's account is being viewed in the Ledger, click **Ledger View**.

3. On the **Print Options** tab, set up the following preferences:



- **Use ADA Codes in Descriptions** – To have ADA codes print with their descriptions, select this check box.

- **Provider ID Column for Statements** – To have the provider ID printed next to each transaction description on walkouts and billing statements, select this check box.
- **No Insurance Flag(*) on Statements** – To remove the text "*Indicates this procedure has been billed to Insurance" from billing statements, select this check box.
- **Verify Billing Statements to Send** – To preview billing statements before printing them or sending then electronically, select this check box.
- **Sort Claim by ID** – To print procedures on insurance claims in the order the procedures were posted in the Patient Chart or Ledger, select this check box.
- **Sort Pretreatment by ID** – To print procedures on pre-estimate claims in the order the procedures were posted in Patient Chart or Ledger, select this check box.

4. Click **OK**.

Chapter 2: Family File

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. Dentrix Enterprise organizes patients by family in Family File.

This chapter covers the following topics about using Family File:

- The Family File Window
- Selecting a Patient
- Adding Families and Patients
- Working with Employers
- Working with Insurance
- Assigning Continuing Care
- Working with Patient Notes
- Working with Referrals
- Assigning Medical Alerts
- Archiving Patients
- Editing Family Relations
- Merging Duplicate Patients

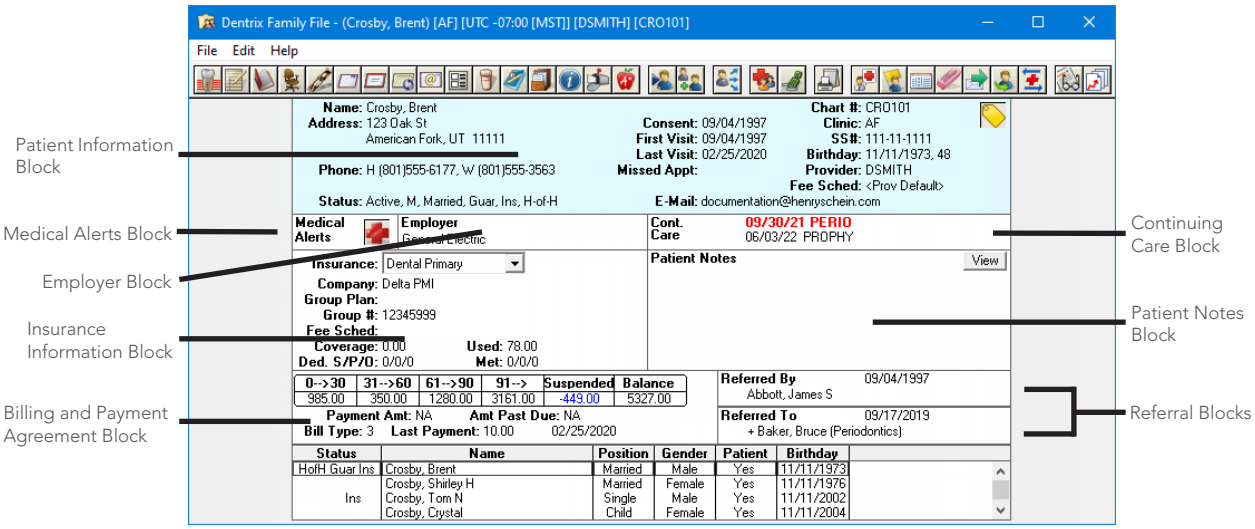
The Family File Window

This section covers the following topics to help you understand how to use the Family File window:

- The Family File Blocks
- The Family Member List
- The Family File Toolbar

The Family File Blocks

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.



Note: From the Billing and Payment Agreement block in Family File, you can change a family's billing type, set up payment agreements, and manage guarantor notes. These functions are discussed in Chapter 7: Ledger.

The Family Member List

The Family Member List displays all members of the family. Double-click a family member to quickly access that family member's information in Family File.

Status	Name	Position	Gender	Patient	Birthday
HofH Guar Ins	Crosby, Brent	Married	Male	Yes	11/11/1973
	Crosby, Shirley	Married	Female	Yes	11/11/1975
	Crosby, Crystal	Child	Female	Yes	11/11/2002
Ins	Crosby, Tom	Single	Male	Yes	11/11/2002

The Family File Toolbar

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



The function of the buttons specific to Family File are explained in the following table.

	Click the **Select Patient** button to select a patient whose record you want to view in Family File.
	Click the **Add New Family Member** button to create a patient record in the family currently being viewed in Family File.
	If the patient currently being viewed in Family File has referred any patients to your practice, click the **Referral Analysis** button to monitor referrals or enter gratuities.
	Click the **Patient Notes Report** button to print patient notes and other types of notes in Dentrix Enterprise for the patient currently being viewed in Family File.
	Click the **Patient Alerts** button to enter or manage the alerts for the patient currently being viewed in Family File.
	Click the **Clinical Notes** button to manage clinical notes regarding the treatments for the patient currently being viewed in Family File.
	Click the **Patient Referrals** button to enter or manage referrals to and from your practice for the patient currently being viewed in Family File.

For a comprehensive explanation of all the buttons on the toolbar, see the “Using the Family File toolbar” topic in the Dentrix Enterprise Help.

Selecting a Patient

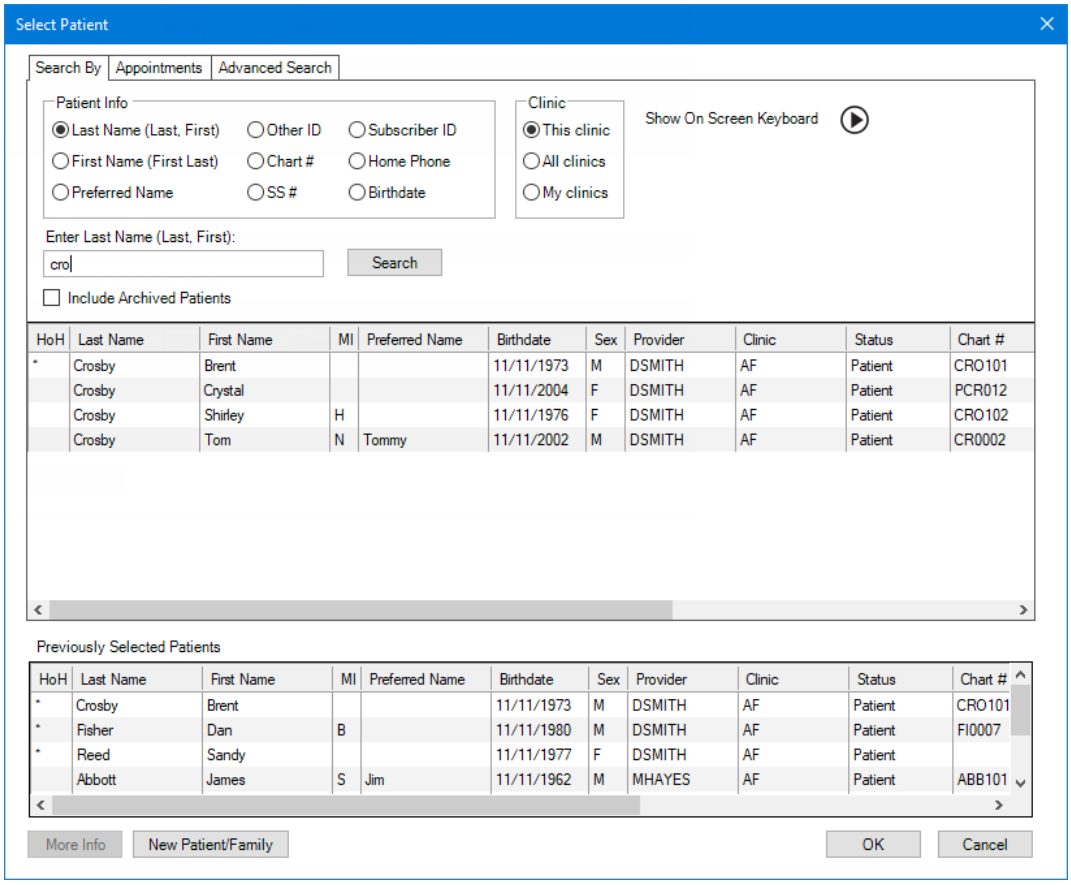
To view or edit a patient's information in Family File (or any other patient-specific module), you must select the patient. By default, you search for patients by lastname; however, you can search for patients using other information, such as first name, a home phone number, chart number, or Social Security number.

Note: When you first install Dentrix Enterprise, no patients are in the database. Patient information must be entered manually or through an electronic data conversion.

To select a patient

1. Click the **Select Patient** button 

   The **Select Patient** dialog box appears.



2. Enter all or the first few letters of the patient's last name in the **Enter Name** box to view a list of patients that match the search criteria. If the clinic setting to allow instant patient searches is not enabled, or if you have entered only one or two letters, click **Search** to view the patients that match your search criteria.

   Tips: To include archived patients in your search, select **Include Archived Patients**. Also, you can use the wildcard character (%) when performing searches.

3. In the list, double-click the patient.

Adding Families and Patients

This section covers the following topics about how to add patient records into Dentrix Enterprise:

- Viewing Patient Records
- Adding Family Members
- Adding a New Patient with an Appointment

Viewing Patient Records

Before you can work with a patient in Dentrix, such as charting a procedure and submitting a claim, a patient record in the database is needed. For billing and communication, patient records are grouped by "family," even for a single patient who lives alone. A family in Dentrix Enterprise must hve at least one person, the head of household (guarantor), even if that person is not a patient. When you register a patient in RPMS, the patient and corresponding demographics are pushed to Dentrix Enterprise. If you want to add a patient in Dentrix Enterprise, contact Dentrix Technical Support.

Important: The current functionality of an HL7 interface is to transfer data from a "host" system (RPMS) to a "secondary" system (Dentrix Enterprise). This means that any changes to some patient demographic boxes you make in Dentrix Enterprise may be overridden the next time the HL7 interface is processed and an update message comes across.

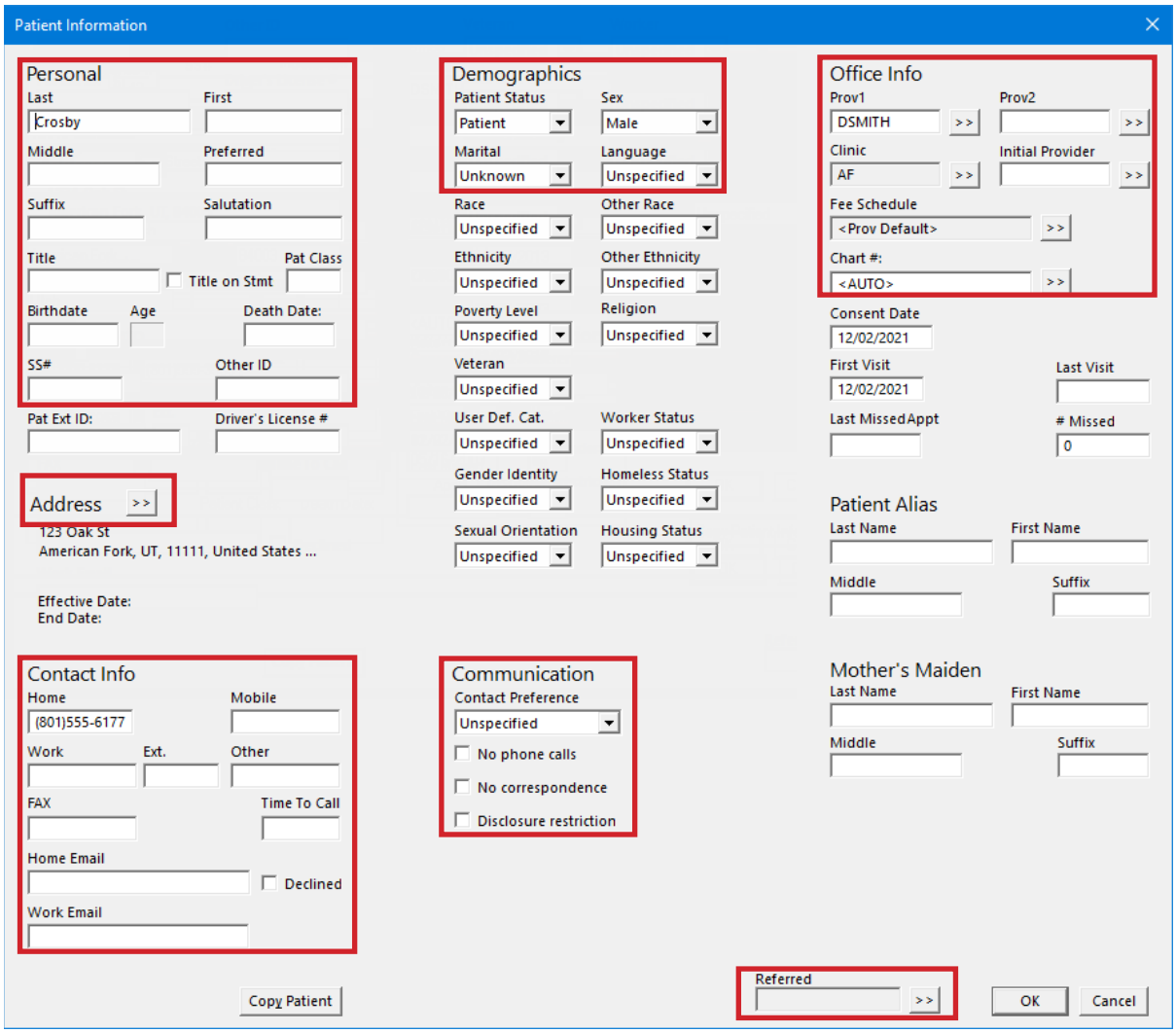
Adding Family Members

Since all patients in Dentrix Enterprise come from RPMS, the only time you may need to add a family member to a family is for insurance purposes.

To add a family member

1. With a family account being viewed in Family File, click the **Add New Family Member** button  .

The **Patient Information** dialog box appears.



2. The last name, primary provider, and address of the head of household are already entered for this patient. However, you can change any of that information as needed and enter the rest of the patient's information.
3. Click **OK**.

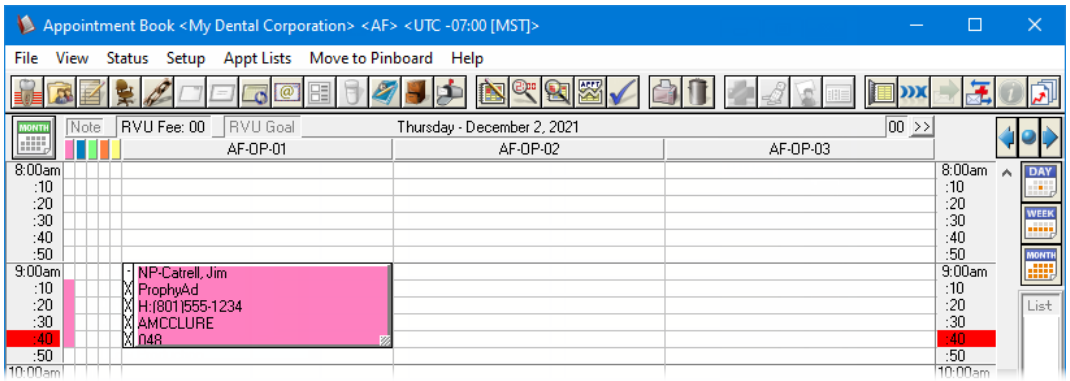
Adding a New Patient with an Appointment

When you schedule an appointment for a new patient, a patient record does not exist for that patient. It's not until the patient arrives for his or her appointment that you want to create a record for him or her in your patient database, but you don't want to have to re-enter any of the patient information you entered when you scheduled the appointment. That's why Dentrix Enterprise provides a way for you to quickly create a patient record based on information recorded for a new-patient appointment.

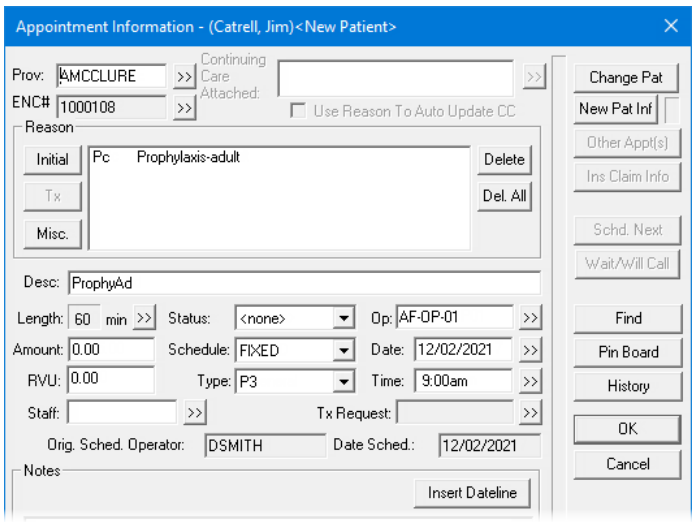
Important: All demographics for the patient come from RPMS. Do not add a patient or change patient information in Dentrix Enterprise.

To add a new patient with an appointment

1. Once the patient has been registered in RPMS and pushed across to Dentrix Enterprise, double-click the new patient's appointment in Appointment Book. (A new-patient appointment has an "NP" preceding the patient's name.)



The **Appointment Information** dialog box appears.



2. Click **Change Pat**, and then select the patient.
3. Click **OK**.

   The Appointment Book now shows the appointment as a regular appointment (the "NP" is gone), and you can now post treatment for this patient.

Working with Employers

This section covers the following topics about how to manage patients' employers:

- Assigning Employers
- Changing an Employer

Assigning Employers

You can attach an employer to an insurance plan to make it easier to find the correct insurance plan (in a long list of plans) to assign to a patient. You can generate a report that lists employers and employees if you have a need to see this information in one place. Employers attached to patients can appear on several reports. Having employer information on hand can also be beneficial in case you need to contact the patient's employer.

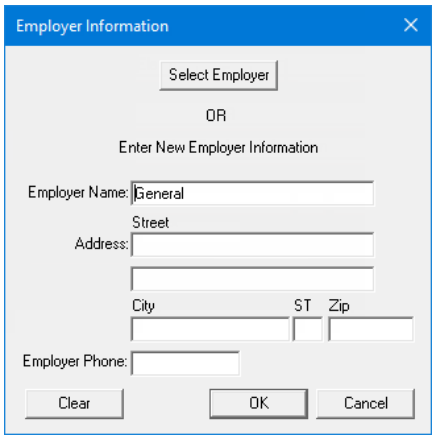
Additionally, to make the process of assigning an employer faster, Dentrix Enterprise compiles a database of employers that you can choose from when assigning an employer to any patient, so you only have to enter information for each employer once. Also, you can add, edit, and delete any of the employers in your database from the Office Manager.

To assign an employer to a patient

1. In Family File, with a patient selected, double-click the **Employer** block.

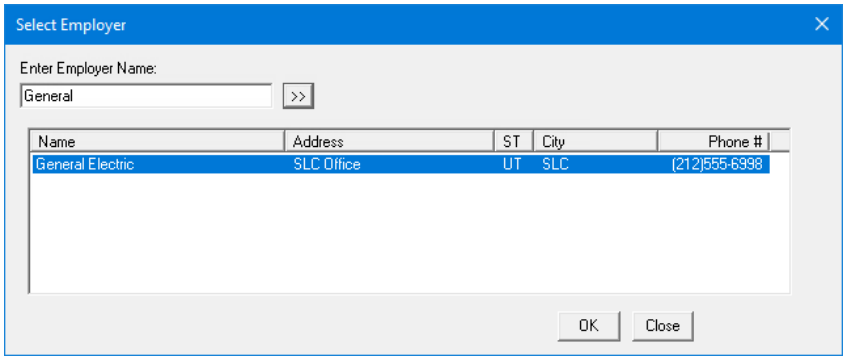


   The **Employer Information** dialog box appears.

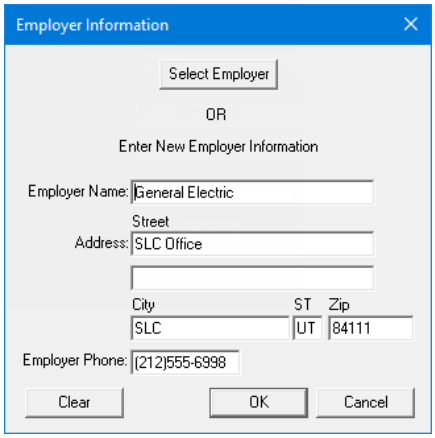


2. Enter the first few characters of the employer's name in the **Employer Name** box, and then click **Select Employer**.

   The **Select Employer** dialog box appears so that you can verify that the employer does not already exist in Dentrix Enterprise.



3. Do one of the following:
   - If the employer already exists, select it, and then click **OK**. You are returned to the **Employer Information** dialog box.
   - If the patient's employer does not already exist, click **Cancel** to return to the **Employer Information** dialog box, and then enter the employer's name, address, and phone number.



4. Click **OK**.

For information about adding an employer from the Office Manager, see the "Adding and editing employers" topic in the Dentrix Enterprise Help.

Changing an Employer

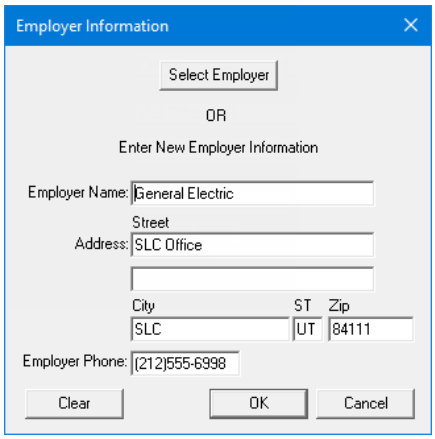
When a patient changes employers, or a patient's current employer changes its name, address, and/or phone number, you can change or clear the employer that is attached to a patient's record as needed. Any changes you make to an employer's information affects other patients who have that same employer.

To change the employer assigned to a patient

1. In Family File, with a patient selected, double-click the **Employer** block.



   The **Employer Information** dialog box appears.



2. Do one of the following:
   - To remove the patient's employer from his or her record, click **Clear**.
   - If the patient's current employer has changed its name, address, or phone number, make the necessary changes.
   - To assign a different employer to the patient, click **Clear**, and then select the correct employer as explained in "Assigning Employers" in this chapter.
3. Click **OK**.

   If you have changed the information in any box (not cleared the employer and not selected or entered a new employer), a message appears and states that the changes to this employer will affect the employer information for all patients with this employer. To apply the changes to the employer, click **OK**.

Working with Insurance

You can add insurance coverage to a head of household or patient in Family File. This section covers the following topics about how to add and remove dental insurance for a patient or head of household:

- Attaching Dental Insurance to a Subscriber
- Attaching Dental Insurance to a Non-subscriber
- Updating a Dental Insurance Plan
- Changing the Coverage Table for a Dental Insurance Plan
- Changing the Coverage Order of Dental Insurance Plans
- Clearing Dental Insurance Coverage

Attaching Dental Insurance to a Subscriber

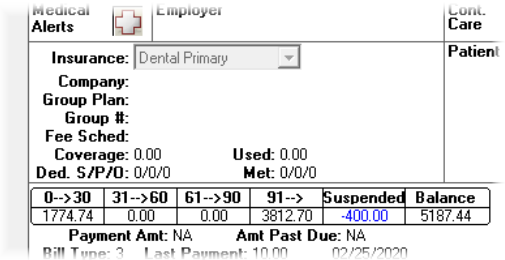
To ensure that you can submit claims for patients covered by insurance plans to the correct insurance carriers, and to ensure that those claims have the correct information on them, you need to properly attach insurance to each patient's record. Before you attach insurance to dependents, make sure that the insurance plan has been attached to the subscriber and that the subscriber is part of the same family as the patient to whom you are attaching the insurance plan. If the dental insurance plan that you want to attach to a subscriber doesn't already exist, you can create a new dental insurance plan, and attach it to the subscriber.

Notes:

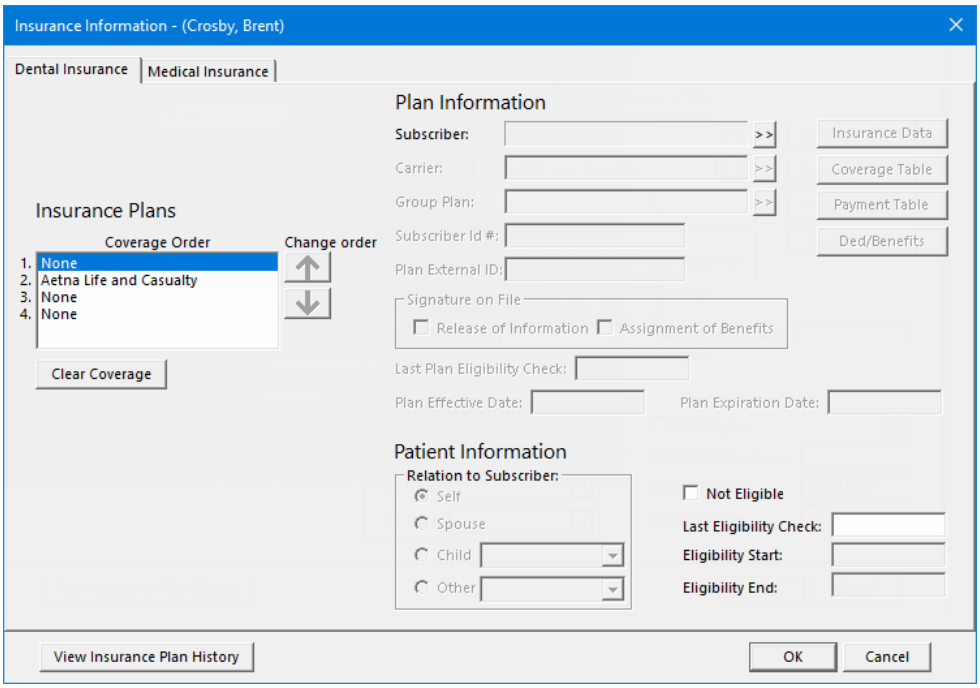
- By default, when you add a family member to a family with a subscriber that already has insurance plans attached to his or her record as a subscriber, Dentrix Enterprise automatically attaches the subscriber's insurance plans to that family member as a dependent, but you can change the family member's insurance as needed.
- If an insurance subscriber is not one of your patients, create a Family File record with a "Non-patient" status for the subscriber within the applicable family record. With insurance attached to the subscriber's record as a subscriber, you can attach insurance to the family members who are your patients as dependents.

To attach dental insurance to a subscriber

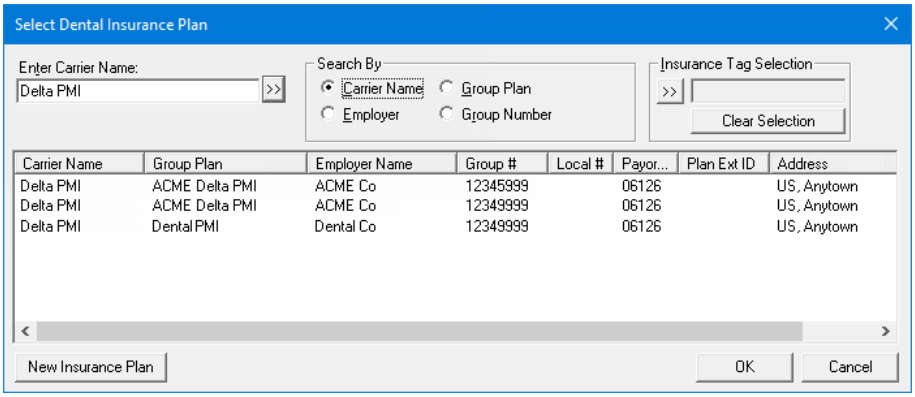
1. In Family File, with a patient selected, double-click the **Insurance Information** block.



The **Insurance Information** dialog box appears.

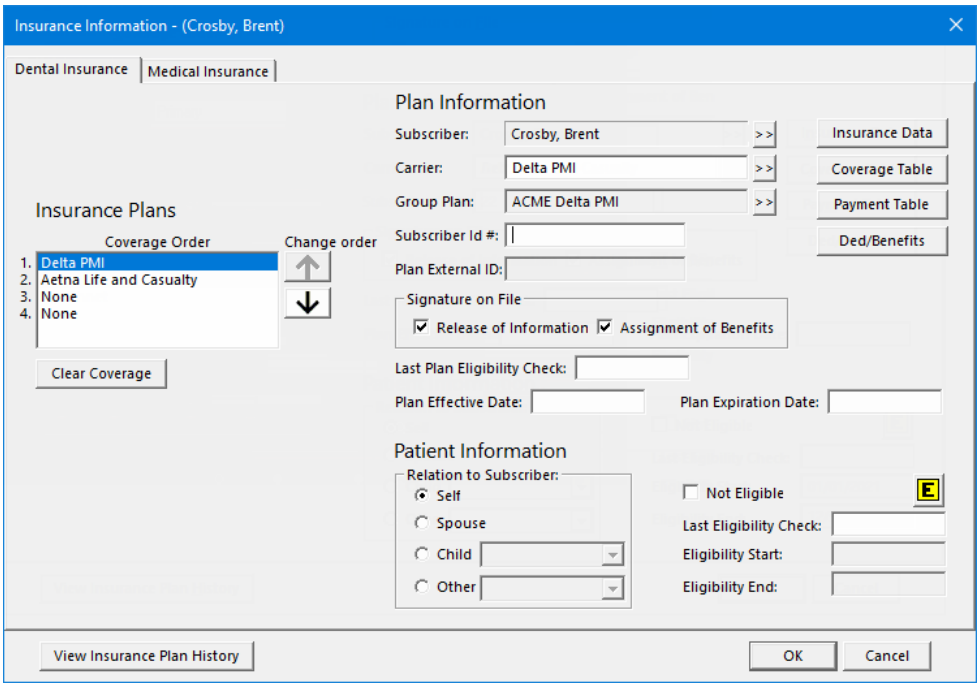


2. From the **Coverage Order** list, select the **None** option that corresponds to the enter of plan that you want to add to the subscriber: 1 (primary), **2** (secondary), **3** (tertiary), or **4** (quaternary).
3. If the current patient is not already selected as the **Subscriber**, click the search button [>>], and then click **Current Patient**.
4. Click the **Carrier** search button [>>] to verify that the insurance plan you want to add does not already exist. In the **Select Dental Insurance Plan** dialog box, enter the first few characters of the carrier's name (you can also search by employer, group plan, or group number), and then click the search button [>>] to view a list of all the carriers that match your search criteria.



Important: It is very important to search for existing insurance plans before adding a new insurance plan to prevent adding duplicate insurance plans to your database.

5. Do one of the following:
   - If the carrier already exists, select it, and then click **OK** to return to the **Insurance Information** dialog box.
   - If the carrier does not already exist, click **New Insurance Plan** to add the insurance plan and return to the **Insurance Information** dialog box. For an explanation about setting up the options for a new insurance plan, see "Updating a Dental Insurance Plan" in this chapter.



6. Set up the following options:
   - **Subscriber Id #** – Enter the subscriber's ID number.
   - **Signature on File** – If you want the words "Signature on File" to print on insurance claims for the subscriber to authorize the release of information, select **Release of Information**. If you want to authorize payments directly to the provider instead of the subscriber, select **Assignment of Benefits**.

     Important: If your office accepts assignment of benefits from insurance carriers, you must select the **Assignment of Benefits** check box; if you do not, insurance checks will be mailed to the subscriber, not the office.

   - **Relation to Subscriber** – Make sure **Self** is selected to indicate that the current patient is the subscriber.
7. Click **OK**.

Attaching Dental Insurance to a Non-subscriber

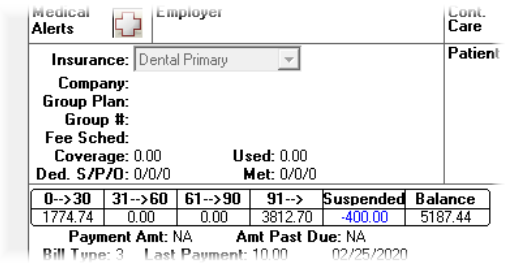
To ensure that you can submit claims for patients covered by insurance plans to the correct insurance carriers, and to ensure that those claims have the correct information on them, you need to properly attach insurance to each patient's record. Before you attach insurance to dependents, make sure that the insurance plan has been attached to the subscriber and that the subscriber is part of the same family as the patient to whom you are attaching the insurance plan.

Notes:

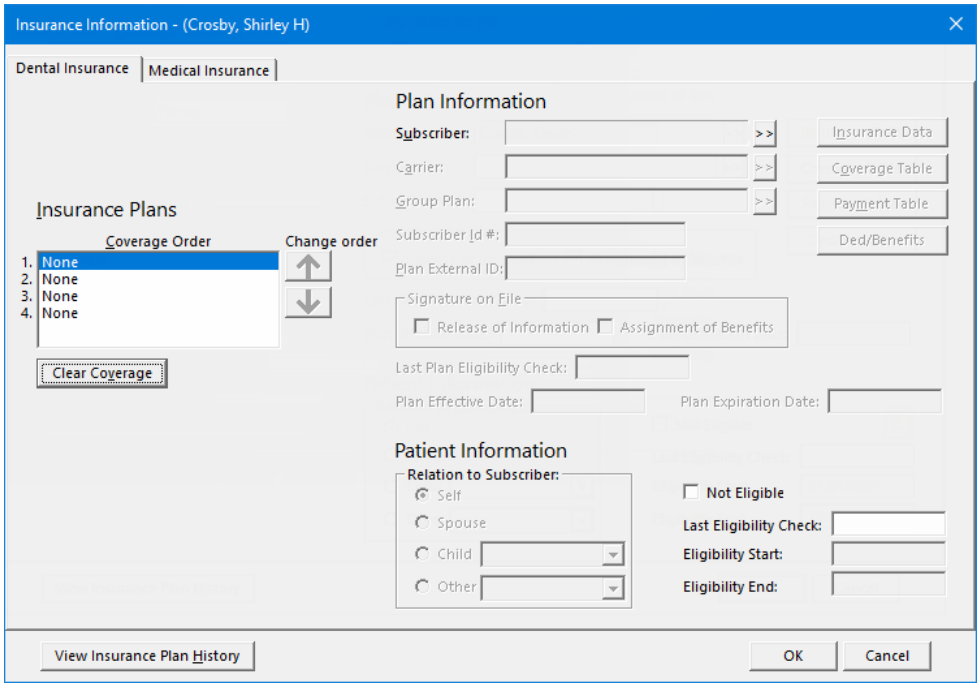
- By default, when you add a family member to a family with a subscriber that already has insurance plans attached to his or her record as a subscriber, Dentrix Enterprise automatically attaches the subscriber's insurance plans to that family member as a dependent, but you can change the family member's insurance as needed.
- If an insurance subscriber is not one of your patients, create a Family File record with a "Non-patient" status for the subscriber within the applicable family record. With insurance attached to the subscriber's record as a subscriber, you can attach insurance to the family members who are your patients as dependents.

To attach dental insurance to a non-subscriber

1. In Family File, with a patient selected, double-click the **Insurance Information** block.



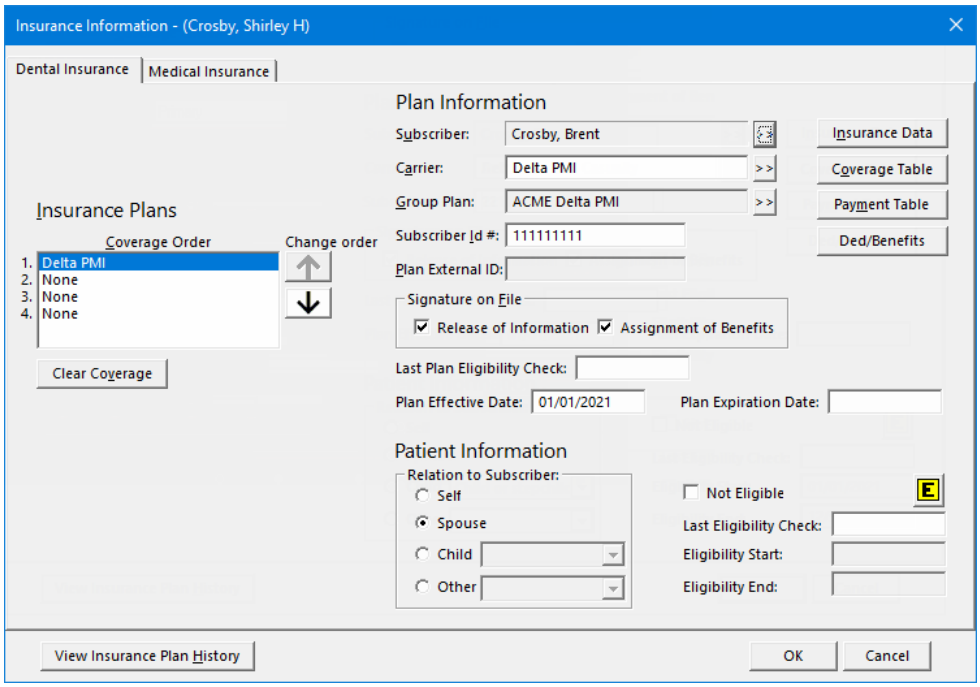
   The **Insurance Information** dialog box appears.



2. From the **Coverage Order** list, select the **None** option that corresponds to the type of plan that you want to add to the patient: 1 (primary), **2** (secondary), **3** (tertiary), or **4** (quaternary).
3. If the correct subscriber's name is not in the **Subscriber** box, click the search button >> to select the correct subscriber (with the correct plan).

   Under **Plan Information**, Dentrix Enterprise automatically populates the following subscriber options for the corresponding insurance plan:

   - Subscriber
   - Carrier
   - Group Plan
   - Subscriber Id #
   - Signature on File



Notes:

- Changing any of the **Plan Information** options affects the subscriber for this plan and all patients who are covered under the subscriber's plan.
- Changing any of the **Coverage Table** options affects all subscribers and patients who are covered under this plan.

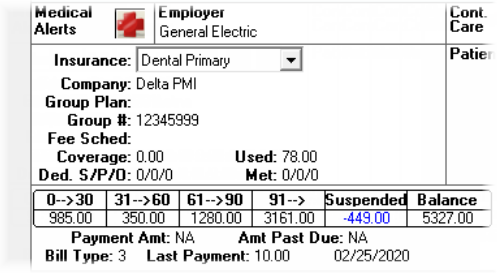
4. Make sure the patient's **Relation to Subscriber** is correct: **Spouse**, **Child**, or **Other**.
5. Click **OK**.

Updating a Dental Insurance Plan

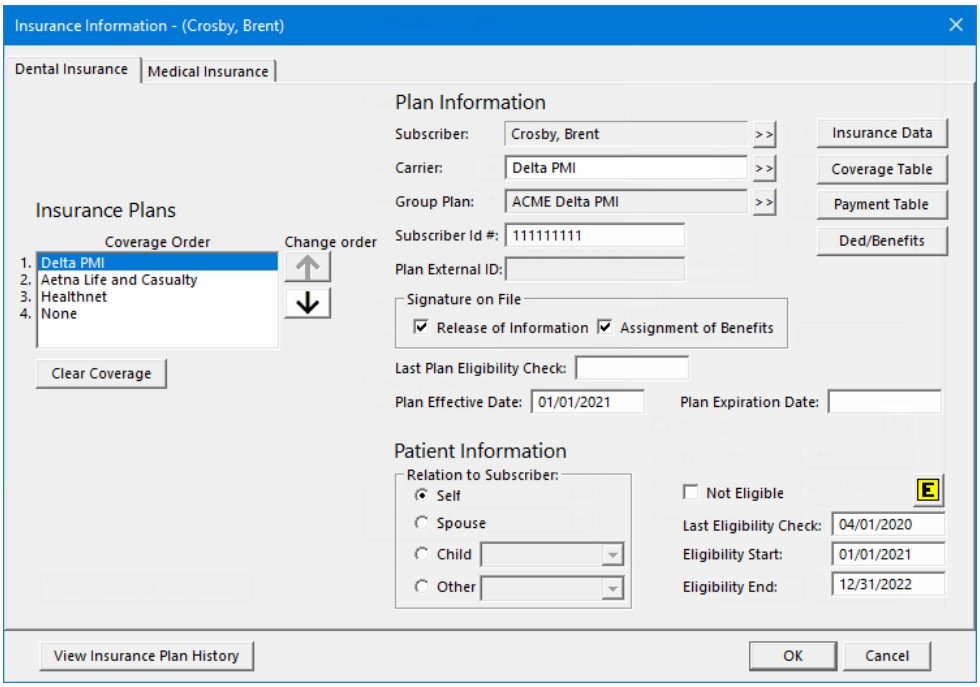
You can change information for a dental insurance carrier at any time. You can edit this information from Family File or Office Manager.

To update a dental insurance plan

1. In Family File, with a patient selected, double-click the **Insurance Information** block.

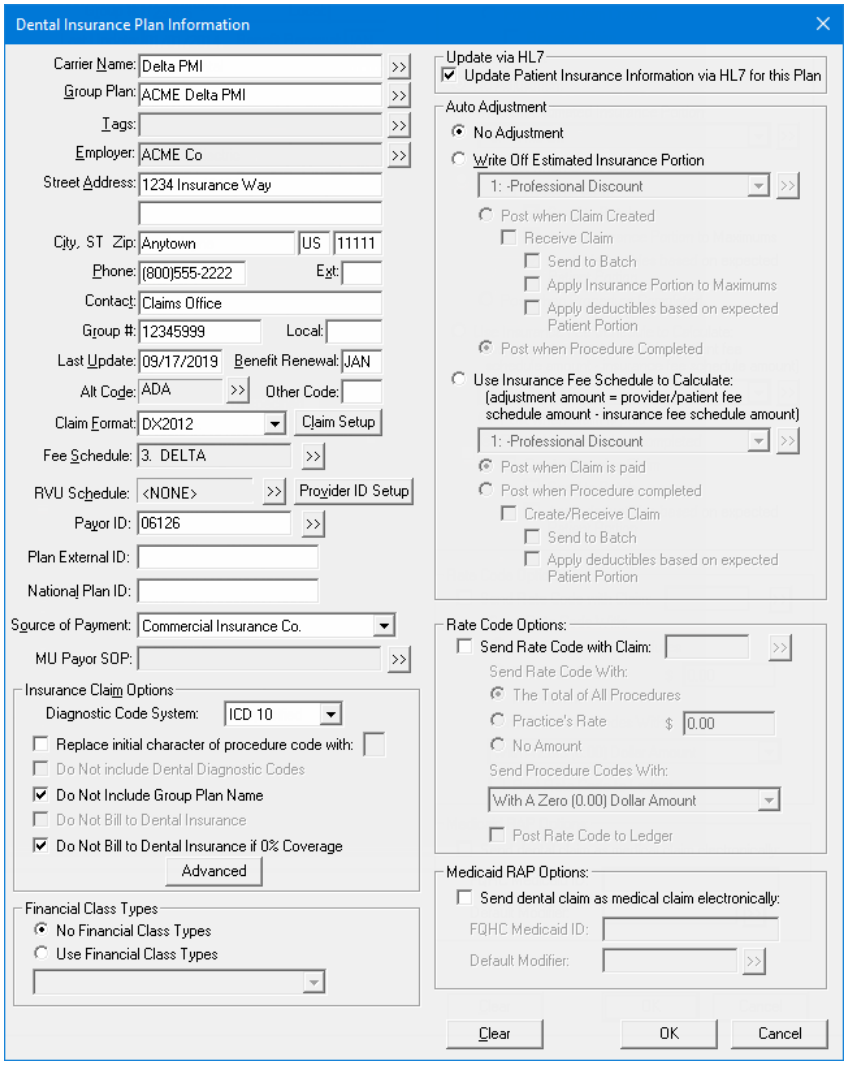


The **Insurance Information** dialog box appears.



2. From the **Coverage Order** list, select the plan with the carrier that you want to edit.
3. Click **Insurance Data**.

   The **Dental Insurance Plan Information** dialog box appears.



4. Change any of the following options as needed:

- **Carrier Name** – Enter the insurance carrier's name.
- **Group Plan** – Enter the group plan name. If you do not have a group plan name, enter the employer name as the group plan name; this will assist you later on when you are assigning previously entered insurances to patients.
- **Employer** – Click the search button [>>] to select the employer that administers the group plan.
- **Contact Information** – Enter the address where insurance claims are to be mailed for this carrier. Also, enter the contact phone number and extension (if applicable), and the contact person.
- **Group #** – Enter the group number for this plan.
- **Benefit Renewal** – Enter the month that the yearly insurance benefits renew for the insured patients.
- **Claim Format** – The claim format defaults to the first claim format listed in Practice Definitions, but you can select a different one if applicable.
- **Claim Setup** – If the selected Claim Format is DX2012, this button is available so that you can customize the options for claims for this plan.
- **Fee Schedule** – (Optional) Click the search button [>>] to select a fee schedule to attach to this insurance carrier.

  Note: If you attach a fee schedule to an insurance plan, Dentrix Enterprise uses that fee schedule

instead of the fee schedule attached to the patient's primary provider. A fee schedule assigned to a patient overrides any other fee schedule attached to the patient's insurance plan or provider.

- **RVU Schedule** – Click the search button >> to select an RVU fee schedule to attach to this insurance carrier.
- **Payor ID –** Enter the payor ID that is to be used with electronic claims, or click the search button >> to find and select a payor ID.
- **Auto Adjustment** – Choose from the following automatic adjustment options:
  - **No Adjustment** – If you do not want an automatic adjustment posted for this insurance carrier.
  - **Write Off Estimated Insurance Portion** – To automatically make an adjustment for the estimated insurance portion in the Ledger.

    Select the credit adjustment type you want to use for the adjustment.
    - If you want to post an adjustment after a claim is created, click **Post when Claim Created**. This option should be used if claims will always be created for the insurance. Select **Receive Claim** to change the claim status to "Received" with a zero payment after the adjustment is made. If **Receive Claim** is selected, you can set up further actions you want to occur automatically after a claim is received – **Send to Batch**, **Applying Ins. Portions to Maximums**, and **Apply deductibles based on expected Patient Portion**.
    - If you want to post an adjustment when a procedure is completed, click **Post when Procedure Completed**. This option should be used if no claims will be created for the insurance. With this option selected, any changes made to the coverage table after the procedure has been set complete will not be reflected in the adjustment.
  - **Use Insurance Fee to Calculate** – To have the adjustment calculated using the following formula: **Provider or patient fee schedule amount** - **Insurance fee schedule amount** = **Adjustment amount**.

    The following will happen with this option selected:
    - If the patient has been assigned a fee schedule in Family File, an adjustment will be posted that equals the difference between the patient fee schedule amount and the insurance fee schedule amount.
    - If the patient does not have a fee schedule assigned to him or her, the patient's primary provider's assigned fee schedule will be used. An adjustment will be posted that equals the difference between the provider's fee schedule and the insurance fee schedule amount. To use this option, a fee schedule must be selected for the insurance carrier.

    Select the credit adjustment type that you want to use for the adjustment:
    - If you want to post the adjustment using this calculation when the claim has been received, click **Post when Claim is Paid**.
    - If you want to post the adjustment using the formula previously mentioned when a procedure is set complete, **Post when Procedure completed**. Select **Create/Receive Claim** to have the following occur automatically: create a claim, post the adjustment, and then change the status of the claim to "Received" with a zero payment. If **Create/Receive Claim** is selected, you can set up further actions you want to occur automatically after a claim is received: **Send to Batch** and **Apply deductibles based on expected Patient Portion**.

- **Rate Code Options** – Some insurance companies (usually state Medicaid) pay a practice a set dollar amount per visit no matter how many or how few procedures were performed on a patient during that visit. The "rate code," also known as an "encounter code" or "visit code," is a procedure code that tells the insurance company how much that amount is. You can choose to include and under what conditions to include an encounter, rate, or visit code on a claim:

  a. Select **Send Rate Code with Claim**, and then click the search button ›› to select the appropriate code.

  b. Under **Send Rate Code With**, select one of the following options:

  - **The Total of All Procedures** – The selected rate code will be used as the first procedure on the claim (printed or electronic), and the amount of the rate code will be the sum of all the procedures on the claim.

    The fee used for this calculation will be the default fee schedule (with the ID number "1") for the billing provider for the claim. This is the same fee schedule that is used for an "F" claim format.
  - **Practice's Rate** – The selected rate code will be used as the first procedure on the claim (printed or electronic), and the amount of the rate code will be the rate entered in the box. By default, the box has the insurance plan's fee schedule, but you can change it to specify the rate code that you want to be used on the claim.
  - **No Amount** – The selected rate code will be used as the first procedure on the claim (printed or electronic), but the amount or charge on the claim for the rate code will be blank.

  c. From the **Send Procedure Codes** list, select one of the following options:

  - **With A Zero (0.00) Dollar Amount** – The procedures will be listed after the rate code on the insurance claim (printed or electronic) with a zero dollar amount (0.00).
  - **With The Procedure's Fee** – The procedures will be listed after the rate code on the insurance claim (printed or electronic) with each procedure's fee as the amount charged.
  - **No Amount** – The procedures will be listed after the rate code on the insurance claim (printed or electronic) with each procedure's charged amount being blank.
  - **Do Not Send Procedures** – Only the rate code will be listed on the insurance claim (printed or electronic).

  d. If you want the rate code to be posted in the Ledger, select **Post Rate Code to Ledger**. The rate code will not appear in the Patient Chart. The fee shown in the Ledger will be the same fee that appears on the claim.

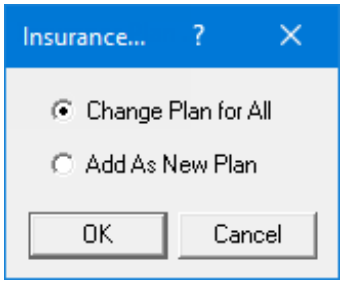
  Important: The fee schedules for the procedure code(s) and rate code on the claim must not conflict or double the account balance in the Ledger.

  Notes:

  - Since the rate code has to be medically crossed coded to be placed on a medical claim, Dentrix Enterprise will post the rate code and automatically edit the rate code to select the appropriate AMA CPT and ICD-9-CM diagnostic code (with the installation of Dentrix Enterprise, a "Rate Code" has been added to the AMA CPT list and ICD-9-CM diagnostic code list) as long as the rate procedure code is cross coded with the AMA CPT "Rate Code" and ICD-9-CM "Rate Code".
  - The AMA CPT "Rate Code" and ICD-9-CM "Rate Code" tied to the procedure rate code will not appear on the claim (printed or electronic).
  - If the AMA CPT "Rate Code" and ICD-9-CM "Rate Code" tied to the procedure rate code are deleted, the rate code option for the claim will not work properly, and you will have to cross code the rate code again.

5. Click **OK** to save the insurance plan and return to the **Insurance Information** dialog box.
6. Click **OK**.

   If the insurance plan is being used by more than one person (subscriber or non-subscriber in any family), the **Insurance Plan Changed** dialog box appears.



7. Do one of the following:
   - If you want the changes to affect all other subscribers who have the same insurance plan, which will, in turn, affect the family members of the those subscribers, select **Change Plan for All**, and then click **OK**.
   - If you want the changes to affect only the current subscriber and the changed insurance plan to be added as a new insurance plan without changing the original plan, select **Add as New Plan**, and then click **OK**.

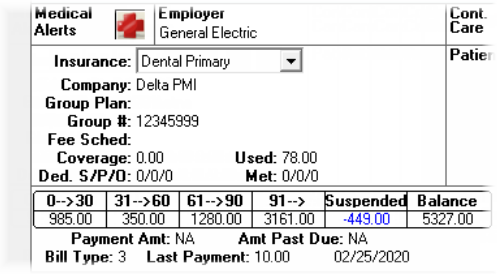
Changing the Coverage Table for a Dental Insurance Plan

Most insurance companies provide the patient with a schedule of benefits, which declares the maximum annual benefits for the individual and entire family. The schedule of benefits also states the deductible amounts, plan maximums, and the percentage of the usual and customary fee that the insurance company will pay. You can add this information to an insurance plan as a coverage table. You can also specify the deadline for submitting any claim and select the applicable method to calculate insurance co-payments. A coverage table helps you create treatment plan estimates that accurately reflect the benefits that an insurance carrier will pay.

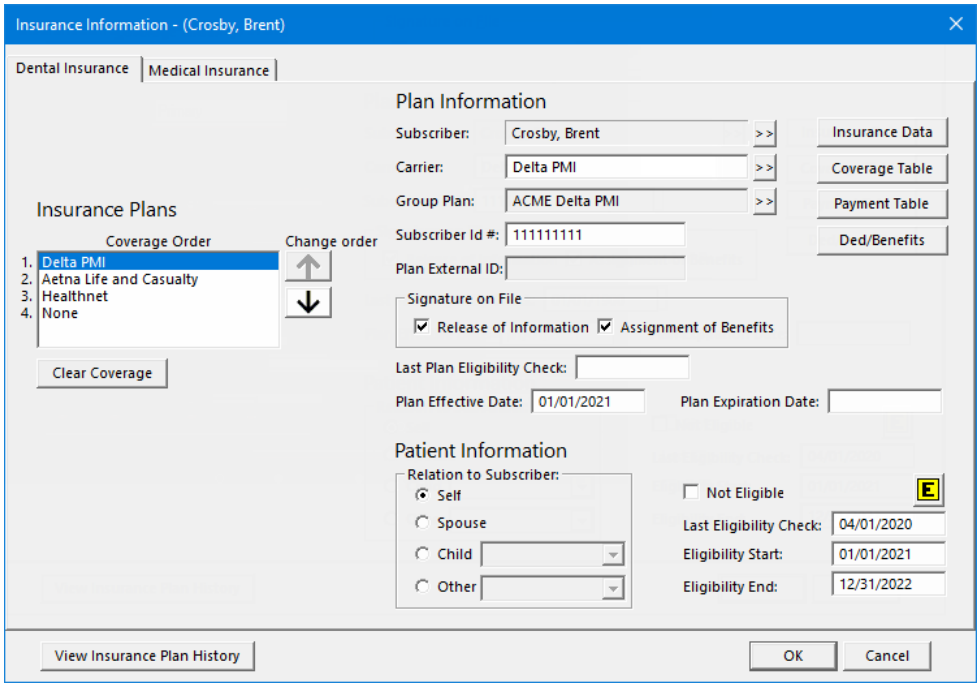
Note: Changing an insurance plan's coverage affects all other subscribers and patients who are covered under the plan.

To change the coverage table for a dental insurance plan

1. In Family File, with a patient selected, double-click the **Insurance Information** block.

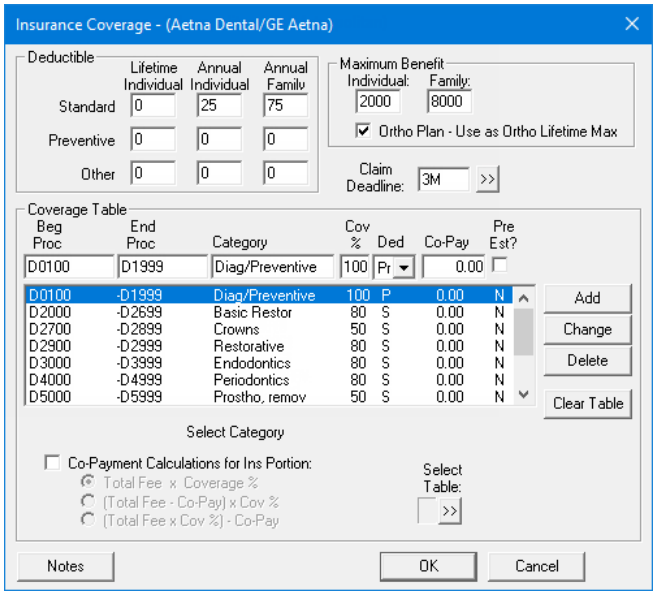


   The **Insurance Information** dialog box appears.



2. From the **Coverage Order** list, select the plan whose coverage you want to edit.
3. Click **Coverage Table**.

   The **Insurance Coverage** dialog box appears.



4. Set up the following options:
   - **Deductible** – You can assign each range of procedure codes in your coverage table its own deductible type. The following types of deductibles are available:
     - **Standard (S)** – Used for most insurance coverage tables.
     - **Preventive (P)** – Used if an insurance carrier's coverage has a separate deductible for preventive/diagnostic procedures.
     - **Other (O)** – Used if an insurance carrier's coverage has a separate deductible for specific procedures other than preventive/diagnostic.

For each type of deductible, you can specify the following amounts:

- **Lifetime Individual** – Used for insurance carriers that require subscribers to pay one deductible for the life of the policy for the patient.
- **Annual Individual** – Used for insurance carriers that require patients to pay a deductible amount each benefit year.
- **Annual Family** – Used for insurance carriers that require a maximum deductible amount for the entire family each benefit year.

Tip: When Dentrix Enterprise calculates the patient's portion of charges, the appropriate deductible amounts will be added to the patient's payment due amount. This figure will appear in the Ledger as the **Est. Patient Portion**.

- **Maximum Benefit** – Enter maximum amount of benefits that will be paid by the insurance carrier for the **Individual** patient and **Family** annually.
- **Coverage Table** – A coverage table allows you to group several procedures into ranges and assign the percentage the insurance will pay. Dentrix Enterprise provides five standard coverage tables that you can modify from the Office Manager to fit your specific insurance plan needs. When you assign a new insurance plan to a subscriber, Dentrix Enterprise automatically assigns the first standard coverage table to the plan. If you do not have or know the insurance company's schedule of benefits, as you make insurance payments and estimates in the Ledger, Dentrix Enterprise will provide you the option to automatically update a payment table for the insurance plan, storing what the insurance company actually pays for a procedure. Insurance estimate calculations will reflect the payment table amounts whenever possible, making your estimates very accurate.

  You can use one of the standard coverage tables as is or create a custom coverage table (for this plan only) based on one of the standard coverage tables.

  - To select a different coverage table, click the **Select Table** search button ››, select the table that is most like the coverage for the current insurance plan you are adding or editing, and then click **OK** to copy the selected table to this plan's coverage table. You can modify the coverage table as needed.

    Note: If you need to modify the plan's coverage table, keep the following in mind:

    - You must use ADA Procedure Codes.
    - You may not overlap the beginning and ending procedure codes in any given range.
    - A procedure code can be in only one range at a time.

  - To modify the coverage table, do the following:

    a. Select a procedure code range (either to change it or to add a new range based on it), and then do the following:change any of the following options for the selected range:

    b. Change any of the following options for the selected range:

    - **Beg Proc** – The beginning procedure code in the range.
    - **End Proc** – The ending procedure code in the range. If you are assigning only one procedure to a range, enter that procedure code as the **Beg Proc** and leave the **End Proc** box blank. The box will automatically be filled in with the beginning procedure code.
    - **Category** – The name you assign to represent the range of procedure codes.
    - **Cov %** – The percentage the insurance plan will pay for all of the procedures in the range.
    - **Ded** – The deductible type for the range of procedure codes.

- **Co-Pay** – If you are setting up a capitation plan, enter the patient's co-pay amount.
- **Pre Est?** – If the insurance company requires you to submit a pre-treatment estimate for a procedure in the range, select this option.

c. Do one of the following:

- To add the selected range to the coverage table, click **Add**.
- To apply the changes to the selected range, click **Change**.

d. Repeat steps a – c for any other ranges you want to add or modify.

Note: To delete a selected procedure code range from the coverage table, click **Delete**.

- **Co-Payment Calculations for Ins Portion** – If the plan requires that specific co-pay amounts be paid by the patient for each procedure, select this check box, and then select the method that will be used to calculate the amount the insurance company will pay:
  - **Total Fee x Coverage %**
  - **(Total Fee - Co-Pay) x Cov %**
  - **(Total Fee x Cov%) - Co-Pay**

  Important: If the plan you are setting up is not a capitation type plan with specific co-payment amounts for each procedure, do not select the **Co-Payment Calculation for Ins Portion** box.

5. Click **OK**. When a message appears and states that the changes you have made will affect all patients assigned to this insurance carrier., click **OK**.

You are returned to the **Insurance Information** dialog box to make other changes as needed.

6. Click **OK**.

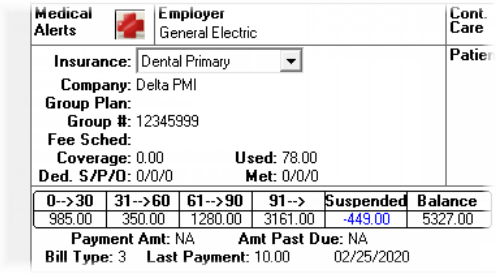
Changing the Coverage Order of Dental Insurance Plans

You can quickly change the coverage order of insurance plans that are attached to a patient's record as needed.

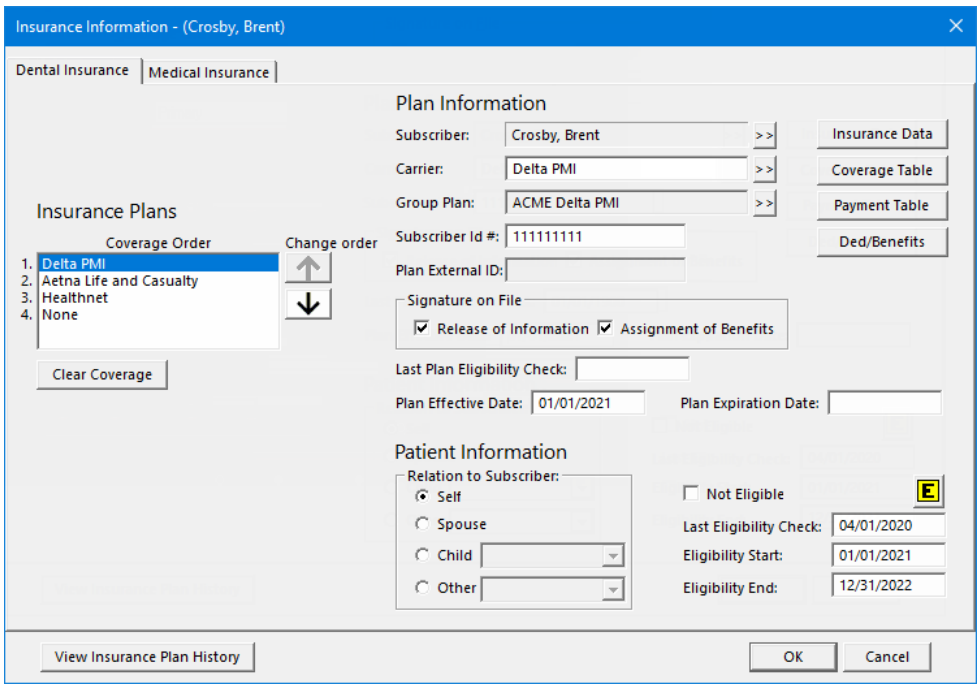
Note: Changing the coverage order of a plan for a subscriber or non-subscriber does not affect the covrage order for other family members who are covered under that plan.

To change the coverage order of a dental insurance plan

1. In Family File, with a patient selected, double-click the **Insurance Information** block.



The **Insurance Information** dialog box appears.



2. In the **Coverage Order** list, select a plan.
3. Click the **Move Up** button ↑ or the **Move Down** button ↓ as needed to move the plan to the desired position. As the selected plan's position in the coverage order changes, the other plans' positions in the coverage order shift accordingly.
4. Click **OK**.

5. If you have changed the coverage order of a plan with outstanding claims, on the message that appears, reminding you that each unpaid claim that is affected by the coverage change can be updated manually, click **OK**.

   The following information for a patient's insurance plan is preserved when you move that plan to a different position in the coverage order: subscriber, insurance plan data, carrier, subscriber ID, signature-on-file preferences, date of the last plan eligibility check, effective date, expiration date, coverage table, payment table, patient's relation to subscriber, patient's eligibility status, state of the **Not Eligible** check box, date of the last patient eligibility check, patient's eligibility start date, and patient's eligibility end date.

   However, the met deductibles and used benefits are linked to the coverage order instead of a plan, so changing a plan's position in the coverage order does not transfer the amounts for the met deductibles and used benefits automatically; you must modify those amounts manually as needed.

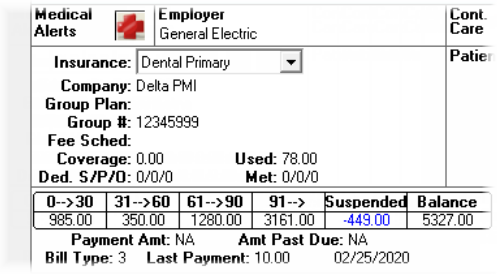
Clearing Dental Insurance Coverage

The following circumstances may require you to remove a patient's insurance coverage:

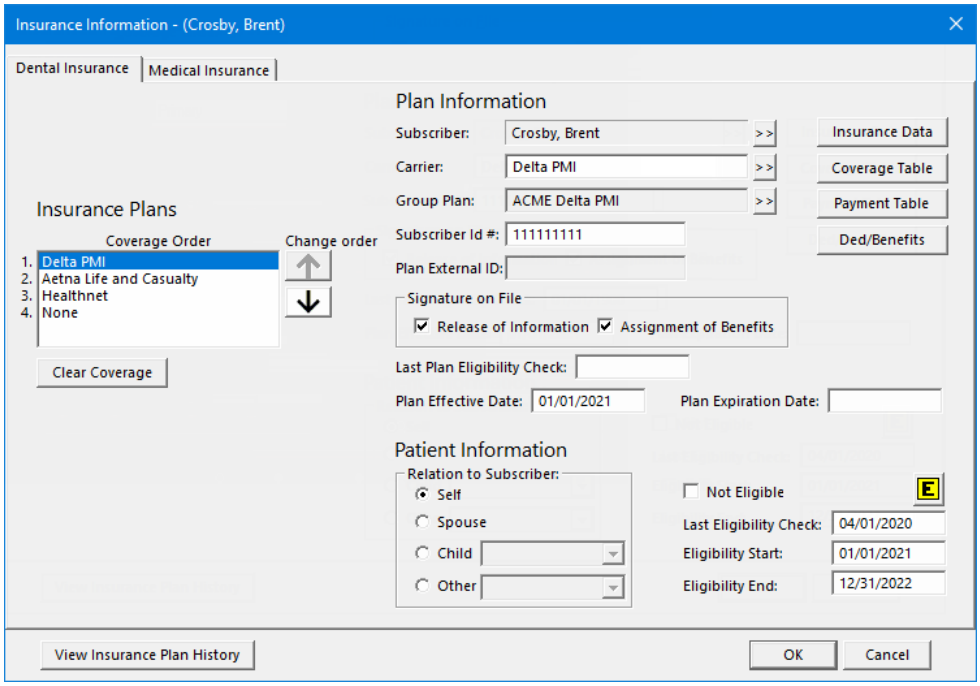
- To move the patient from one family to another, you must first clear the patient's insurance information.
- To switch the patient's primary and secondary coverage, you can clear the primary and secondary insurance. However, you can quickly switch the coverage order of any plan without clearing coverage.
- The primary, secondary, tertiary, and/or quaternary insurance was assigned to the patient in error, so you must clear the applicable insurance information.

To clear a patient's insurance coverage

1. In Family File, with a patient selected, double-click the **Insurance Information** block.



   The **Insurance Information** dialog box appears.



2. From the **Coverage Order** list, select the plan whose coverage you want to clear.
3. Click **Clear Coverage**.

   Notes:

   - Repeat steps 2–3 to clear any of the patient's other coverage as needed.
   - If you are switching the coverage, specify the **Subscriber** and **Carrier** for the primary insurance plan and then for the secondary insurance plan.

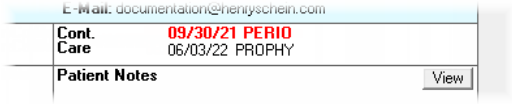
4. Click **OK**.

Assigning Continuing Care

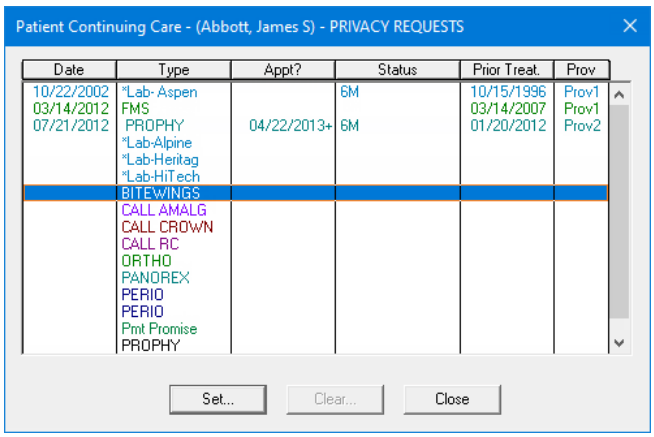
Having continuing care (recare or recall) assigned to patients is key to achieving your goal of keeping patients coming back for routine, scheduled maintenance. As you schedule and reschedule a patient for a specific type of continuing care (such as an exam, a cleaning, or X-rays) that continuing care type gets attached to the patient and updated automatically. However, you can assign a continuing care type to a patient's record manually, such as to get the patient's record ready before their appointment or to correct a situation where continuing care is not attached to the patient's record after their appointment.

To assign a continuing care type to a patient

1. In Family File, with a patient selected, double-click the **Continuing Care** block.



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

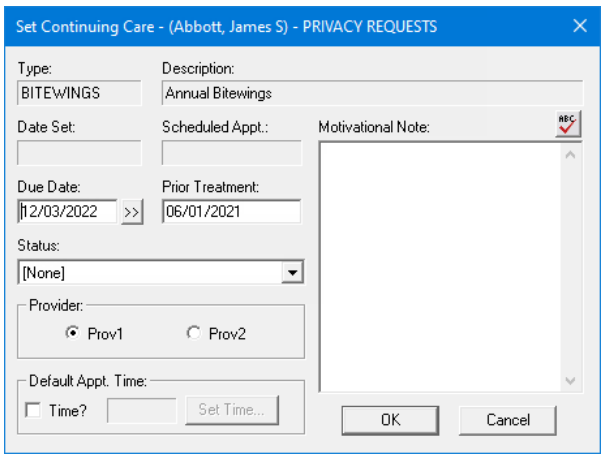


2. Select the continuing care type you want to set.

   Note: If the selected continuing care type is already set for the patient, the **Date** column for the continuing care type contains a date, and the **Set** button is labeled "Edit."

3. Click **Set**.

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



4. Customize the following options as needed:
   - **Due Date** – To set the interval for the patient's continuing care, click the search button >>. 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.
   - **Status** – To assign a continuing care status to the patient, select the desired status. Statuses are relevant primarily when you generate continuing care lists.
   - **Provider** – To assign the patient's primary or secondary provider as the provider of appointments for this continuing care type, select **Prov1** or **Prov2**.
   - **Default Appt. Time** – To enter the amount of time this patient will need for appointments with this continuing care type attached, select **Time?**. Drag the slider to set the number of units, and then set up the time pattern for each unit (chair time ⌜, assistant's time /, or provider's time X) to help you make use of all operatories when scheduling appointments and maximize your productivity.
5. Click **OK**.

For comprehensive details about all the options available when assigning continuing care types, see the "Assigning continuing care" topic in the Dentrix Enterprise Help. Also, for more information about setting up continuing care types and their default settings, see "Setting Up Continuing Care Types" in Chapter 1: Introduction and Initial Setup.

Working with Patient Notes

You can enter internal notes about a patient in Dentrix Enterprise that will not be seen by the patient as patient notes. A patient note can contain a patient's interests, hobbies, dislikes, and personal situations or events to remember. A patient note is appropriate for documenting financial or insurance information that you don't want in an account note or insurance plan note or create apatient alert for. A patient note can include this and any other information you want to be available internally in your office, which may help you build a relationship with the patient or serve them better.

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.

This section covers the following topics about how to use patient notes in Family File:

- Viewing and Hiding Patient Notes
- Adding and Editing Patient Notes
- Generating the Patient Notes Report

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 Family File of a patient with a patient note, the patient note is hidden by default. Afterwards, for each patient that you select in Family File, the notes are viewed or hidden depending on the state of the previously selected patient's notes.

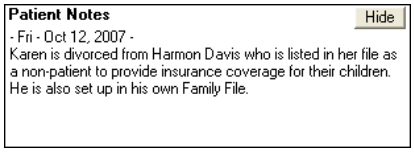
Note: If no notes have been entered for the patient, the block displays "No Note," and the **View/Hide** option is not available.

To view and hide 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.")



- 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.")



Adding and Editing Patient Notes

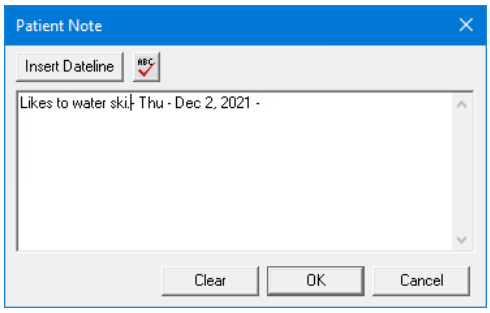
You can add notes to an individual patient's record. Also, you can edit those notes at any time.

To add or edit notes for a patient

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



The **Patient Note** dialog box appears.



2. Enter the patient's hobbies, interests, financial arrangements, or any other notes useful to your practice. A patient note is limited to 4,000 characters.

   Tip: If you want to delete the patient notes for this patient, click **Clear**. The notes will not be deleted until you click **OK**, so if you click **Clear** accidentally, you can restore the notes to how they were before you opened the dialog box by clicking **Cancel** instead of **OK**.

3. Click **OK**.

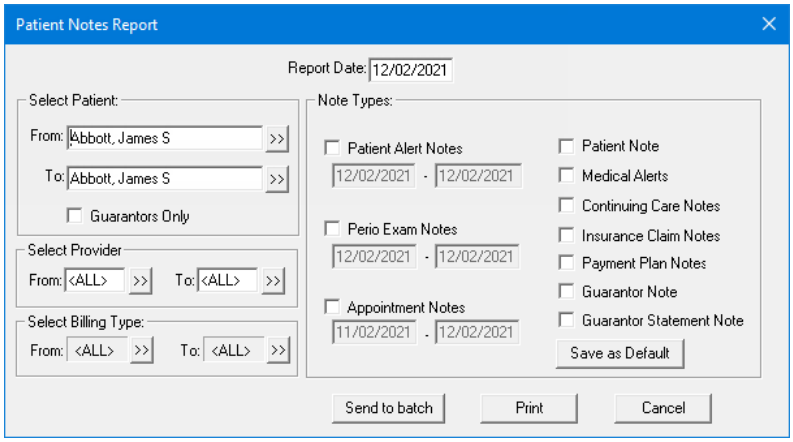
Generating the Patient Notes Report

You can generate a report of all notes entered for a patient from Family File. You can also run this report from the Office Manager.

To print the Patient Notes Report

1. In Family File, with a patient selected, click the **Patient Notes Report** button  .

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



2. Set up the following options:
   - **Filters** – You can include notes for the current patient or a range of patients and for only guarantors. If you run the report for a range of patients, you can further filter the report by patients' providers and/or billing types.
   - **Note Types** – Select the types of notes you want to include on the report:
     - **Patient Alert Notes** – Notes entered in the Patient Alert system. You can also specify a date range to include notes that were entered within that time period.
     - **Perio Exam Notes** – Notes entered in the **Perio Clinical Notes** dialog box (which is accessed from the **Diagnostics** menu in the Perio Chart). You can also specify a date range to include notes that were entered within that time period.
     - **Appointment Notes** – Notes attached to appointments. You can also specify a date range to include notes that were entered within that time period.
     - **Patient Notes** – Notes entered in the Patient Notes block of Family File.
     - **Medical Alerts** – Medical alerts for patients.
     - **Continuing Care Notes** – Motivational notes added from the **Set (or Edit) Continuing Care** dialog box.
     - **Insurance Claim Notes** – Notes entered for insurance claims.
     - **Payment Plan Notes** – Notes attached to a future due payment plan set up for the patient.
     - **Guarantor Note** – Guarantor note entered in the Ledger.
     - **Guarantor Statement Note** – Guarantor billing statement note entered in the Ledger.

     Tip: If you want the selected note types to be selected the next time you run the report, click **Save As Default**.

3. Click either **Send to batch** or **Print**.

Working with Referrals

To track the effectiveness of your referral sources, you need to first add them to your Dentrix Enterprise database. Once you have added sources to the database, you can assign them to patients as they are referred to your office. From the **Referred By** block in Family File, you can view and enter information about the individual or source that referred the current patient to your practice. There are Referred by Patient and Referred by Doctor/Other referral types.

You can also add other dental providers, professionals, and specialists to whom you refer treatment or services as referrals. Then, you can attach those outbound referrals to patients and treatment-planned procedures. Dentrix Enterprise can help you track the patients who have been referred to another doctor or specialist. From the **Referred To** block, you can see to whom you have referred a patient.

This section covers the following topics about patient referrals and referrals out to specialists:

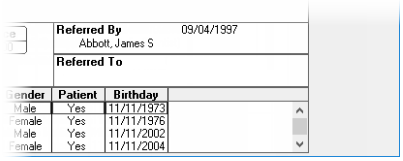
- Entering Patient Referrals
- Entering Doctor/Specialist Referrals
- Sending Correspondence to Referrals

Entering Patient Referrals

To track the effectiveness of your referral sources, you need to first add them to your Dentrix Enterprise database. Once you have added sources to the database, you can assign them to patients as they are referred to your office. You can enter a referral from a patient who referred another patient to your practice.

To enter a patient referral

1. In Family File, with a patient selected, double-click the **Referred By** block.

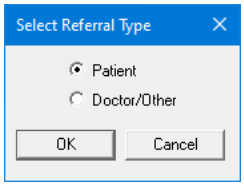


   The **Patient Referrals** dialog box appears.



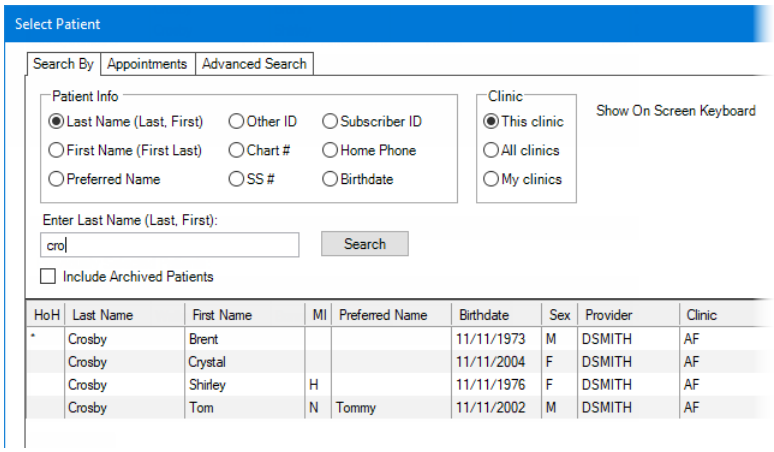
2. Next to the **Referred By** list box, click **Add Referral**.

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



3. Select **Patient**, and then click **OK**.

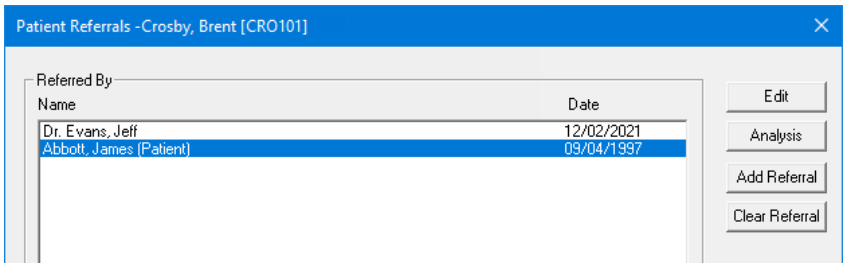
The **Select Patient** dialog box appears.

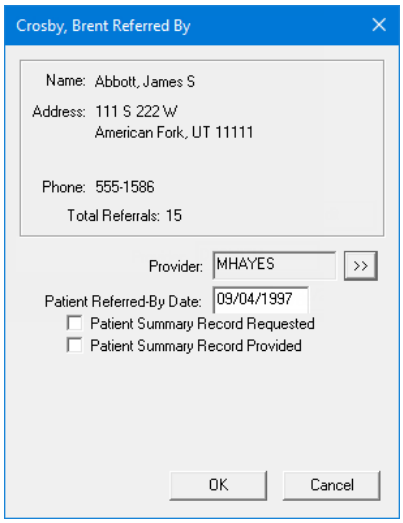


4. Select the person who referred the patient.

   Tip: If you cannot find the referring patient's name, first check the spelling; then, if you still cannot locate the patient's name, he or she has not been entered in Family File yet, or the referring party is not one of your patients and must be entered as a non-patient referral (Referred by Doctor/Other).

5. To change the date the patient was referred to your practice or to change the provider to associate with this referral, with the referring patient selected in the **Referred By** list box, click **Edit**. In the dialog box that appears, enter the correct date in the **Patient Referred-By Date** box, and then click **OK**.





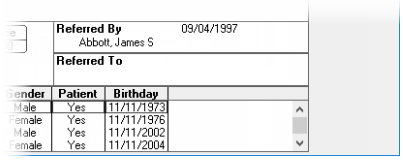
For more information on referral sources, clearing referrals, and referral analysis, see the "Working with referrals" topic and its subtopics in the Dentrix Enterprise Help.

Entering Doctor/Specialist Referrals

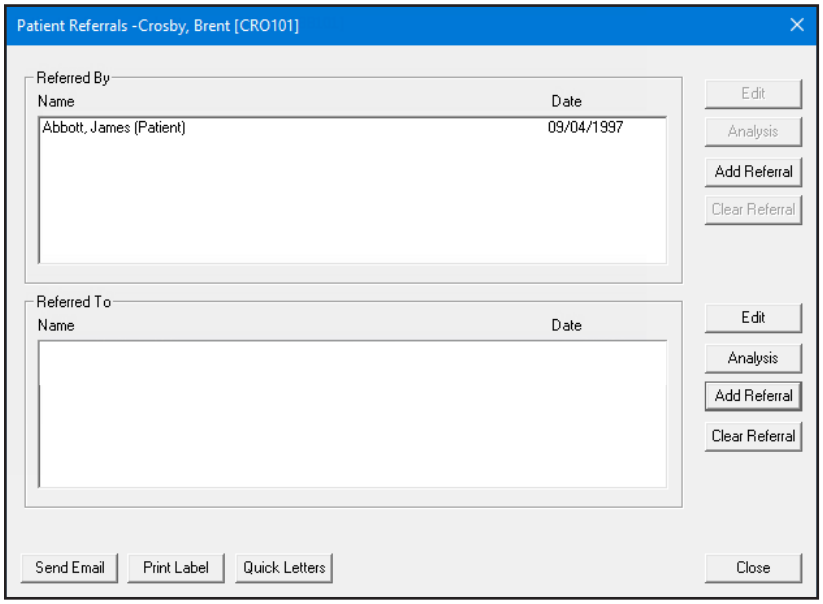
You can add other dental providers, professionals, and specialists to whom you refer treatment or services as referrals. Then, you can attach those outbound referrals to patients and treatment-planned procedures. Dentrix Enterprise can help you track the patients who have been referred to another doctor or specialist.

To enter a referral to a doctor/specialist

1. In Family File, with a patient selected, double-click the **Referred By** block.

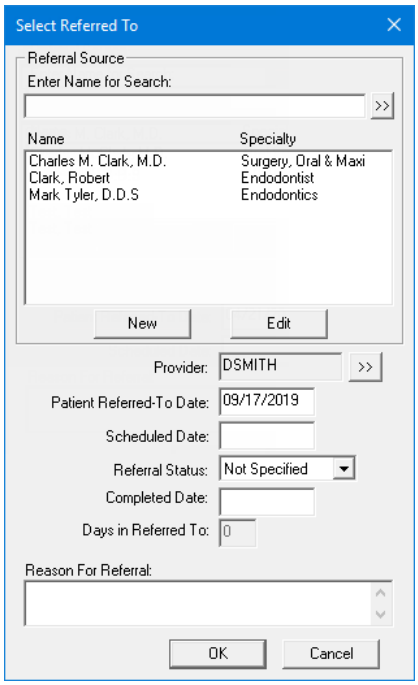


   The **Patient Referrals** dialog box appears.



2. Next to the **Referred To** list box, click **Add Referral**.

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



3. Initially, all doctors/specialists are listed. To narrow the search, enter the first few characters of the doctor/specialist's name in the **Enter Name for Search** box, and then click the search button >> to view the doctors/specialists that begin with those letters.

   Tip: If the doctor/specialist is not listed, click **New** to add the doctor/specialist. In the **Referred To Information** dialog box, enter the referral information, and then click **OK**.

4. Select the doctor/specialist.
5. Set up any of the following options:
   - **Provider** – Click the search button >> to select the provider you want to associate with this referral.
   - **Patient Referred-To Date** – If necessary, change the date to reflect the correct date that you referred the patient to a doctor or specialist.
   - **Scheduled Date** – Enter the date of the patient's next scheduled appointment, relating to this referral, at your office.
   - **Referral Status** – Select the current status of this referral.
   - **Completed Date** – Enter the date that the referral was completed. The value in the **Days in Referred To** box is updated automatically; it is the number of days since the **Patient Referred-To Date** up to the **Completed Date** (if one is entered).
   - **Reason for Referral** – Enter any notes regarding the purpose of this referral.
6. Do one of the following:
   - Click **OK** to return to the **Patient Referrals** dialog box. Ignore the steps that follow.
   - Click **Edit** to edit the referral information. The **Referral To Information** dialog box appears. Proceed to the next step.



7. Edit any of the following referral information as needed:
   - **Name** – The doctor/specialist's name, title (if applicable), specialty, and salutation (for letters you send to the doctor/specialist).

     Tip: Do not put a doctor's credentials in the **Title** box, as that appears before the doctor's name; instead, add credentials after the name in the **Last/Referral Name** box.

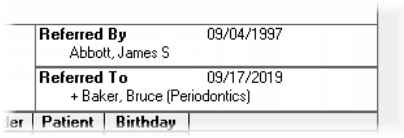
   - **Address** – The address, email address, and contact numbers for the doctor/specialist.
   - **Notes** – Any notes or useful information regarding the doctor/specialist.
8. Click **OK** to save the changes and return to the **Referred To** dialog box.
9. Click **OK** to return to the **Patient Referrals** dialog box.

Sending Correspondence to Referrals

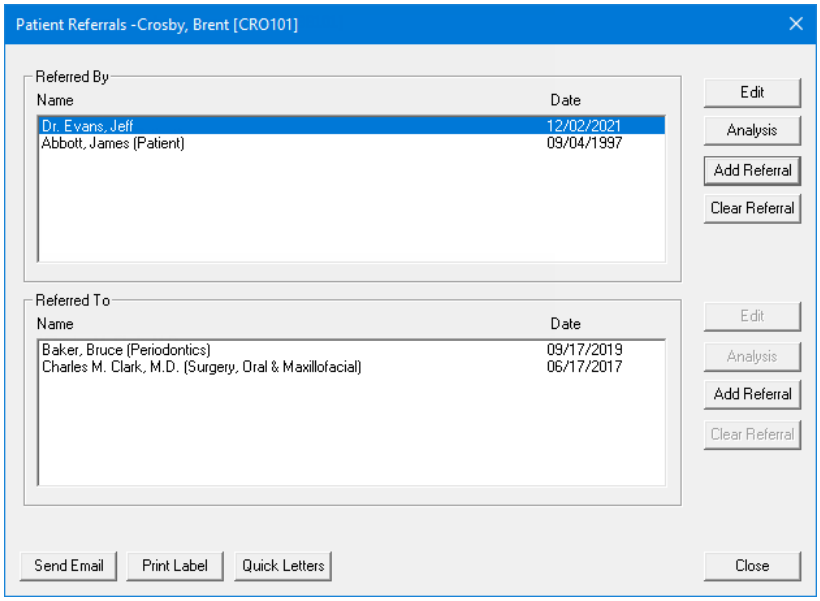
You can quickly send correspondence to a referral.

To send correspondence to a referral

1. In Family File, with a patient selected, double-click the **Referred By** or **Referred To** block.



The **Patient Referrals** dialog box appears.



2. Select the referral you want to correspond with.
3. Click any of the following buttons:
   - **Send Email** – To compose and send an email message to the referral.
   - **Print Label** – To print a single address label for the referral.
   - **Quick Letters** – To quickly print a letter for the referral. In the **Quick Letters** dialog box, select the appropriate letter, and then click **Print**.

Assigning Medical Alerts

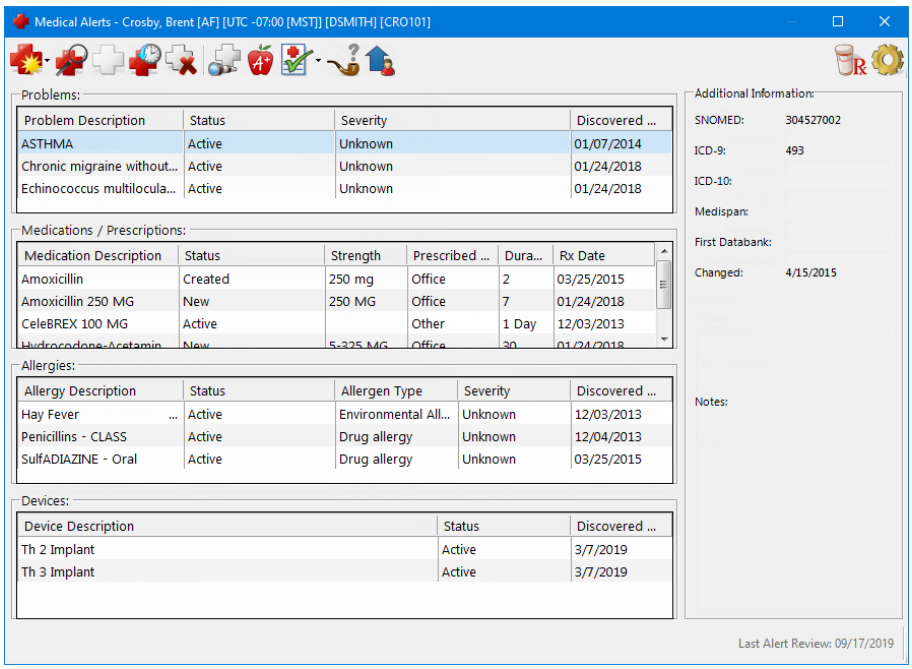
You can add alerts for problems, medications, allergies, and implantable devices to a patient's account. You can customize the list of available problems, medications, and allergies in Practice Definitions. For information about setting up medical alerts, see the "Customizing Medical Alerts" topic in the Dentrix Enterprise Help.

To add a medical alert to a patient

1. In Family File, with a patient selected, double-click the **Medical Alerts** block, or click the button in that block.



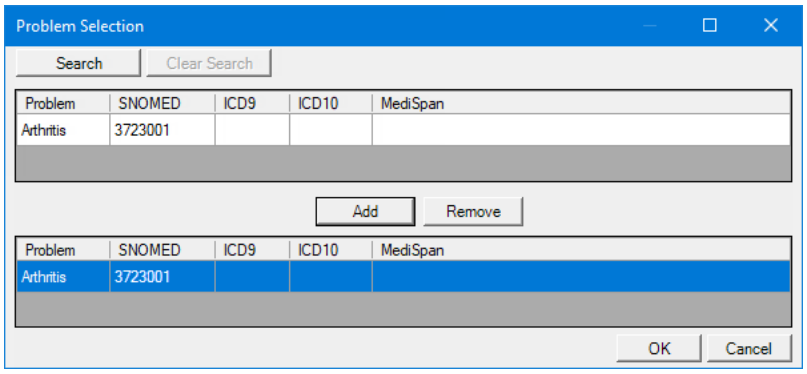
The **Medical Alerts** dialog box appears. Any existing problems, medications, and/or allergies are listed.



Note: You can also view a patient's medical alerts from the Patient Chart, the Treatment Planner, and the Appointment Book.

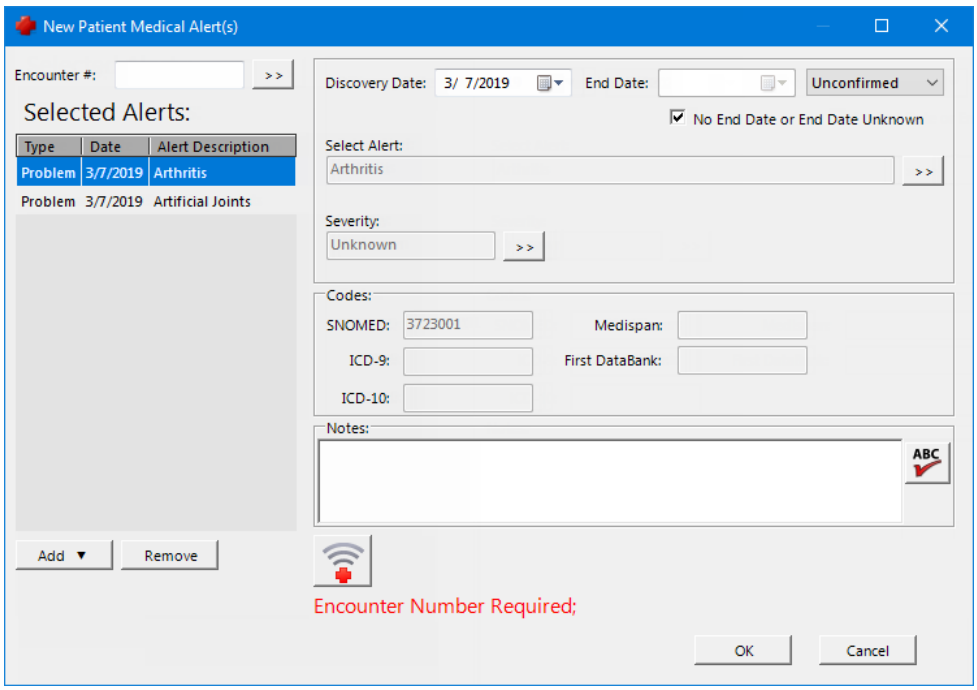
2. Click the **New Medical Alert** button, and then click one of the following options on the menu:
   - **Problem**
   - **Medication**
   - **Allergy**
   - **Implantable Device**

The selection dialog box that appears varies according to the type of medical alert selected.



3. Add the problem, medication, or allergy, and then click **OK**. Or, for a device, search for the UDI, or click **No UDI**.

   The **New Patient Medical Alert(s)** dialog box appears.



4. Specify the date of discovery and other details as needed, and then click **OK**.

For comprehensive information about all the available options, see the "Assigning medical alerts" topic in the Dentrix Enterprise Help.

Archiving Patients

If a patient becomes deceased, or there is no possibility that they will be seen in your office again, you can archive the patient in Dentrix Enterprise to effectively "hide" them but preserve the clinical, financial, administrative, and other records. You cannot post new procedures or treatment plans, set treatment-planned procedures complete, or create new prescriptions for archived patients.

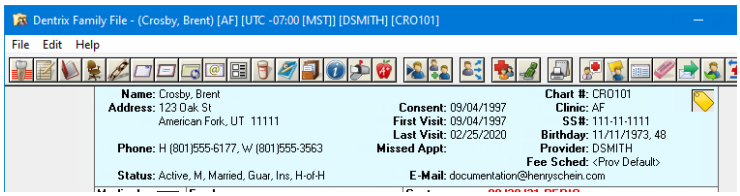
Note: Archived patients appear in the following areas:

- The Family Member List and the Ledger with "<A>" preceding their names.
- The **View** menu in the Ledger with "(Archived)" preceding their names.
- The **Appointment Information** dialog box title bar with "<A>" preceding their names,
- The Ledger, Office Journal, and Document Center title bars with "<A>" preceding their names.

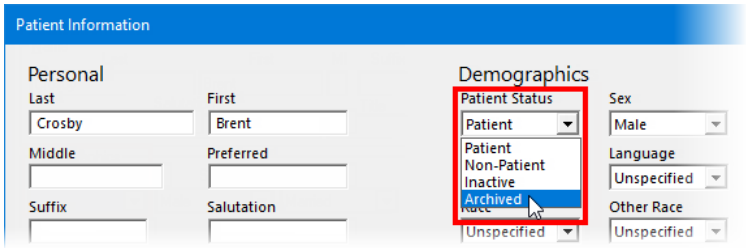
Important: Although you can reactivate an archived patient, archiving a patient should be considered a permanent action, as this will significantly change that patient's data in the database, and some data will not be able to be easily restored later.

To archive a patient

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



The **Patient Information** dialog box appears.



2. Under **Demographics**, from the **Patient Status** list, select **Archived**.
3. Click **OK**.

For information on changing a patient's status, see "Viewing Patient Records" in this chapter.

Editing Family Relations

In Family File, you can change the head of household, delete a patient, delete a family, and combine or separate families. For detailed information on completing these tasks, refer to the "Changing the head of household," "Deleting patients," "Deleting families," and "Combining and separating families" topics in the Dentrix Enterprise Help.

Merging Duplicate Patients

Sometimes someone will add a patient record, and maybe even post some treatment in that record, without realizing that a record has already been created for that patient. You don't want to have to re-enter data into the correct patient's record and delete the wrong record. Or, maybe a long time has passed since the duplicate record was created, and you can't delete the wrong patient. So, Dentrix Enterprise provides a way for you to merge the two patient records into one, using specified criteria, such as last name, birth date, and gender.

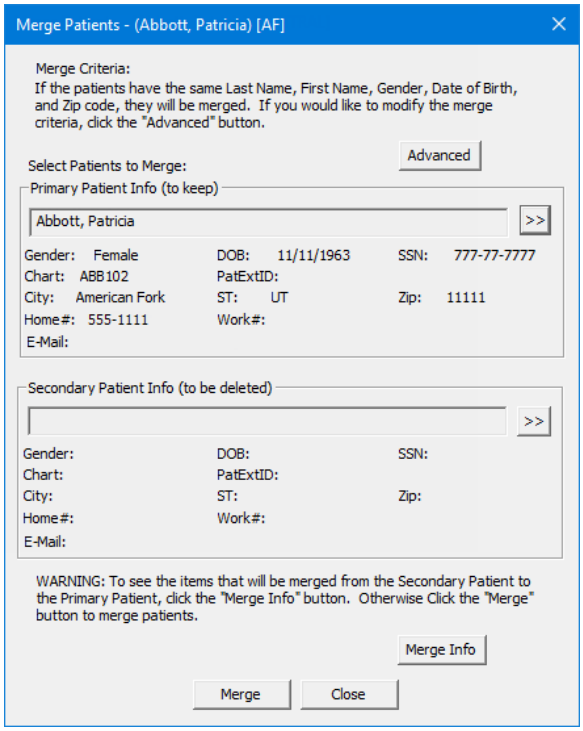
Notes:

- Do not have either of the patients you are going to merge selected in any Dentrix Enterprise module on any computer on the network except in Family File on your computer.
- The patients being merge must have a status of Active or Non-patient; but, even if the patients do not have to have the same status, you cannot merge an active record into a non-patient record.
- Duplication of patients can occur as a result of a data conversion from another dental practice management software to Dentrix Enterprise. Duplication can also occur if you have an HL7 interface (used for communication between Dentrix Enterprise and your medical software), and a patient record is entered manually into Dentrix Enterprise and your medical software.

To merge patients

1. In Family File, with a patient selected, from the **Edit** menu, click **Merge Patients**.

   The **Merge Patients** dialog box appears.



2. The primary patient is the patient record you want to keep. The secondary patient's information will be transferred into the primary patient's record. By default, the patient currently selected in Family File is the primary patient. To select a different primary patient, click the the **Primary Patient Info** search button >>.

3. The secondary patient is the patient record you do not want to keep. The secondary patient's information will be merged into the primary patient's record. To select a secondary patient, click the **Secondary Patient Info** search button >>.

   Note: If the secondary patient is a guarantor, all family members of the secondary patient will be moved to family of the primary patient.

4. To change the merge criteria, click **Advanced**. In the **Advanced Merge Patients Criteria** dialog box, select the patient information that must all match for both the primary and secondary patient for Dentrix Enterprise to perform the merge: **Last Name**, **First Name**, **Gender**, **Date of Birth**, **Zip**, **Social Security #**, **City**, **State**, **E-Mail**, **Home Phone #**, and/or **Work Phone #**. Then, click **OK**.

   Note: If you want to view the merge information, click **Merge Info**. The patient information that will be transferred from the secondary patient to the primary patient is listed on the left; the information that will not be merged, on the right. Be aware that the only exceptions to what will and won't be merged happen when joining a head of house (secondary) with a head of house (primary):

   - Medical alerts, medications, and allergies are moved from the secondary head of house to the primary head of house.
   - If the primary head of house does not have a referral, but the secondary head of house does, the secondary head of house's referral information is moved to the primary head of house.
   - If the primary head of house does not have continuing care, but the secondary head of house does, the secondary head of house's continuing care information is moved to the primary head of house.

5. Click **Merge**. On the confirmation message that appears, click **Yes**.

Chapter 3: Appointment Book

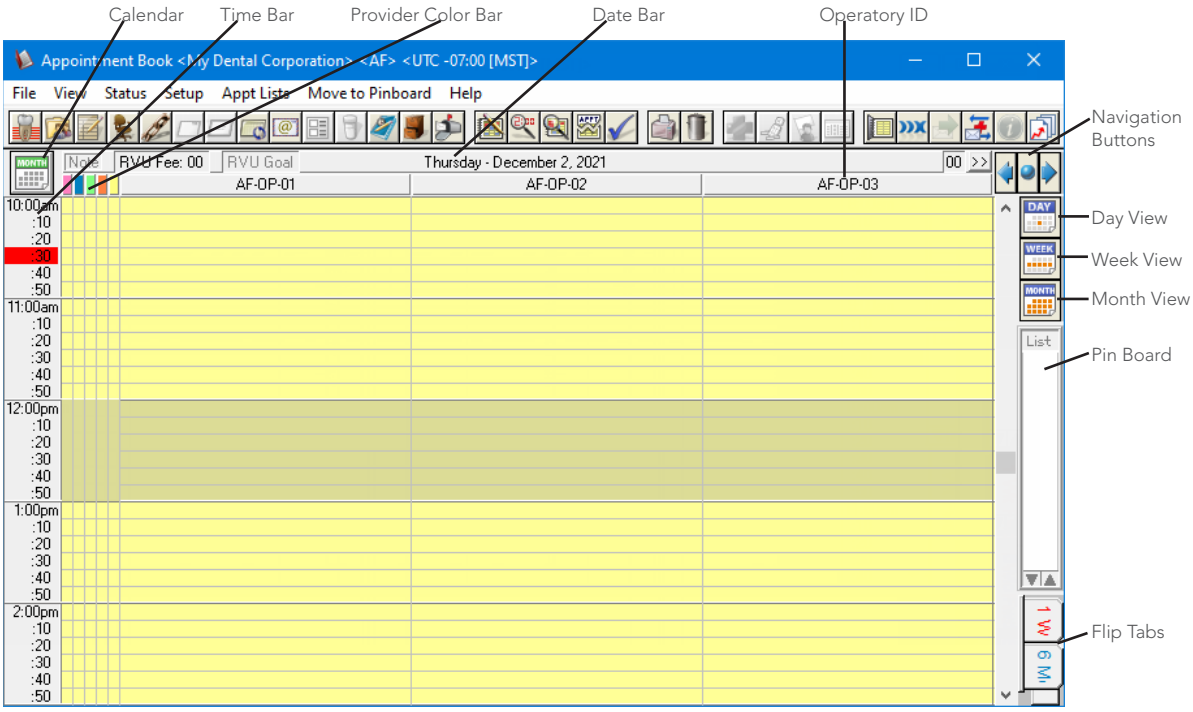
The Dentrix Enterprise Appointment Book was created to facilitate "productivity scheduling." Convenient toolbars and exclusive flip tabs help you navigate through the schedule, search for open times, organize appointments and notes, and handle all the common tasks you need to perform throughout the day. You can schedule appointments, record broken appointments, and print route slips.

This chapter covers the following topics:

- The Appointment Book Window
- Changing a Clinic's Schedule
- Changing a Provider's Schedule
- Changing an Operatory's Schedule
- Switching Between Views
- Finding Open Appointment Times
- Scheduling Appointments for Existing Patients
- Scheduling Appointments for New Patients
- Scheduling Events
- Managing Appointment Book Lists
- Using the Scheduling Assistant
- Managing Appointments
- Managing Events
- Generating Appointment Book Reports
- Working with Notes in Appointment Book
- Using Perfect Day Scheduling

The Appointment Book Window

The **Appointment Book** window 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.



This section covers the following topics to help you understand how to use the **Appointment Book** window:

- The Appointment Book Toolbar
- Using the Month Calendar
- The Time Bar
- Provider Colors
- Operatory IDs
- Understanding Appointments
- Using the Navigation Buttons
- Using the Day View
- Using the Week View
- Using the Month View
- Using the Pinboard
- Using the Flip Tabs

The Appointment Book Toolbar

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



The function of the buttons specific to Appointment Book are explained in the following table.

	Click the **Schedule Appointment** button to choose the patient for whom you want to schedule an appointment, and then enter the appointment information.
	Click the F**ind New Appointment Time** button to find an available appointment time by entering search criteria.
	Click the **Locate Appointment** button to choose a patient so that you can locate any existing appointments for that patient.
	With an appointment selected, click the **Break Appointment** button to remove the appointment from the schedule and place it on the Unscheduled List.
	Click the **Set Complete** button to post the scheduled treatment for the selected appointment as complete to the Ledger and Patient Chart.
	Click the **Print Route** slip button to print a route slip for the selected appointment.
	Click the **Delete Appointment** button to delete the selected appointment.
 	Click the **Perfect Day Scheduling** button to turn Perfect Day Scheduling on and off. If the button has red and blue rectangles, this feature is turned on. If the button does not have red and blue rectangles, this feature is turned off. Perfect Day Scheduling must be turned on to see the Perfect Day Scheduling time blocks.

For a comprehensive explanation of all the buttons on the toolbar, see the "Using the Appointment Book toolbar" topic in the Dentrix Enterprise Help.

Using the Month Calendar

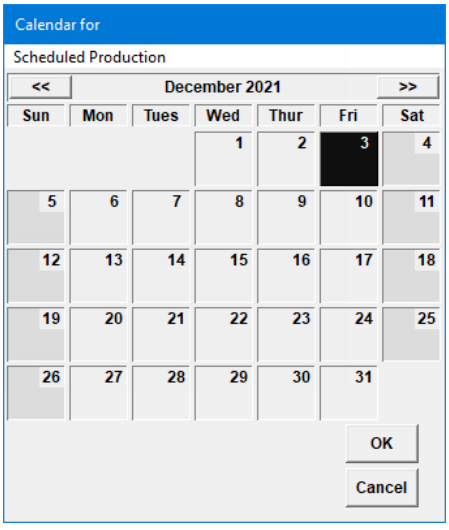


Click the **Calendar** button to open a monthly calendar. From the calendar you can view production goals, scheduled production, and actual production, making it easy to quickly evaluate your progress in meeting production objectives.

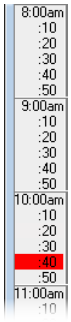
The following options are available:

- Click the double left and right arrow buttons to navigate to the desired month.
- Click **Scheduled Production** on the menu bar to view scheduled production for each day.

  Totals for Scheduled, Production, and New Patients are displayed at the bottom of the calendar.
- Click a date square to go to that date in Appointment Book.



The Time Bar

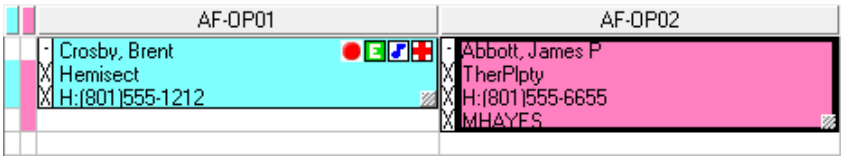


The time bar on the left and right sides of Appointment Book splits up hour intervals into your selected time block size. The red bar indicates the current time of day For information about changing the time block size, see “Setting Up a Clinic” in Chapter 1: Introduction and Initial Setup.

Provider Colors

You can assign a unique color to each treatment provider in your office. These colors will be used to flag each appointment so that you can tell which provider the patient is seeing by the color of the appointment.

On the left side of Appointment Book, a color column for each treatment provider appears. The color depends on the unique color assigned to that provider. A colored block in a column indicates that the corresponding provider is scheduled to be working on a patient during that time.



For example, in the blue column you see a blue block from 9:10am to 9:30am, indicating that the “blue” provider will be involved with a patient during that time. If a provider has been double-booked, the color block will be white with stripes in the color assigned to that provider. If the provider column is gray, this indicates that the provider is not available at that time.

For information about changing provider colors, see “Setting Up a Provider” in Chapter 1: Introduction and Initial Setup.

Operatory IDs

The Appointment Book displays a column for each operatory added to Dentrix Enterprise.

Operatories are displayed in alphabetical order using operatory IDs. There is a limit of 10 operatories per Appointment Book view. For information about views, see “Setting Up Views” in Chapter 1: Introduction and Initial Setup.

Understanding Appointments

Every scheduled appointment is assigned to an operatory and a provider and has a length.



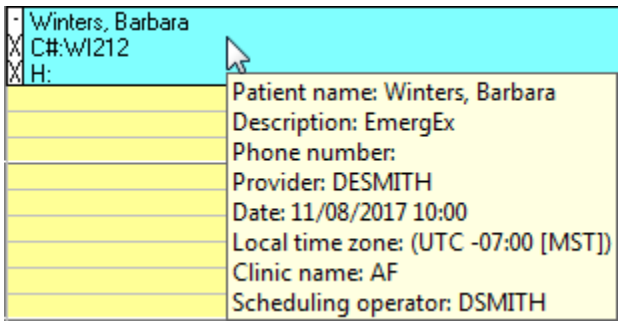
- The color of the appointment depends on the unique color assigned to the provider who has been selected as the treating/rendering provider for the appointment.
- The markings in the white column on the left side of the appointment correspond to the chair (blank), assistant (/), and provider (X) times specified for the appointment.
- Depending on the length of the appointment, Dentrix Enterprise displays up to nine lines of customizable information, such as the patient's name and the appointment reason.
- To quickly change the length of the appointment, click the gray square in the lower-right corner of the appointment so that the cursor turns into double-headed arrow, and then drag the bottom edge of the appointment up or down.



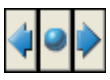
- The appointment can have one or more icons on it in the upper-right corner.



  - A yellow flag indicates that the patient has a patient alert.
  - A blue musical note indicates that the appointment has a note.
  - A red plus sign indicates that the patient has a medical alert.
- To quickly view appointment information, position your mouse pointer over an appointment.



Using the Navigation Buttons



The navigation buttons are used to move from day to day in Appointment Book. Click the left arrow button to move back one day. Click the right arrow to move forward one day. Click the circle button to quickly return the current system date.

The navigation buttons function differently for views other than the day view: if you are displaying the week view, the navigation buttons will move you forward or backward a week at a time; if you are displaying the month view, the navigation buttons will move you forward or backward a month at a time.

Using the Day View



Opening Appointment Book in the day view allows you to see detailed information pertaining to an individual day and its scheduled appointments. You can schedule appointments by double-clicking at an available time. If you are on the week or month view, click the **Day View** button to switch to the day view.

Using the Week View



A time-saver when looking for an available appointment time, the week view allows you to see a week's worth of appointments at one time. Click the **Week View** button to switch to the week view. The week view displays large columns for each day of your work week. Each day column is further divided into operatory columns that show provider color blocks, which indicate appointments that have already been scheduled, making it easy to see free scheduling opportunities. To schedule an appointment, double-click at an available time.

Tip: To see details about an appointment, while pressing the Shift key on your keyboard, right-click the appointment. A pop-up box appears and displays the patient name, appointment reason, phone number, provider, appointment date and time, and status.

Using the Month View

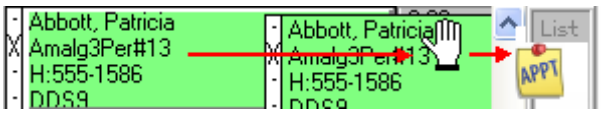


If your schedule is packed weeks in advance, then the month view will make finding a free appointment time much easier. Click the **Month View** button to display an entire month's worth of appointment times for each provider. On the left side of Appointment Book, each provider is listed by ID and in color for each work day in the month. On the top of Appointment Book, the time of day is shown. To view the appointments on a particular day, click in that date's row to move to that date in the day view.

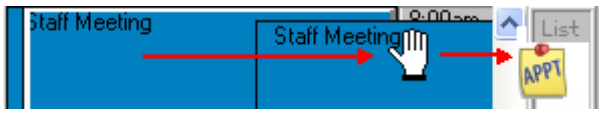
Note: Only appointments that have been scheduled using provider time ("X"s will appear on the left side of each appointment) appear in the month view. See "Scheduling Appointments" in this chapter.

Using the Pinboard

Similar to a real pin board, the Appointment Book Pinboard can temporarily store appointment or event information until you can find a new appointment or event time. You can have multiple appointments and events on the Pinboard at any given time.



Dragging an appointment to the pin board



Dragging an event to the pin board

Using the Flip Tabs



Flip tabs act as bookmarks allowing you to jump forward or backward several days, weeks, or months in Appointment Book according to a specified length of time, such as seven days, two weeks, or six months. No flip tabs are set up with the initial installation of Dentrix Enterprise. For information about defining flip tabs, see "Setting Up Flip Tabs" in this chapter.

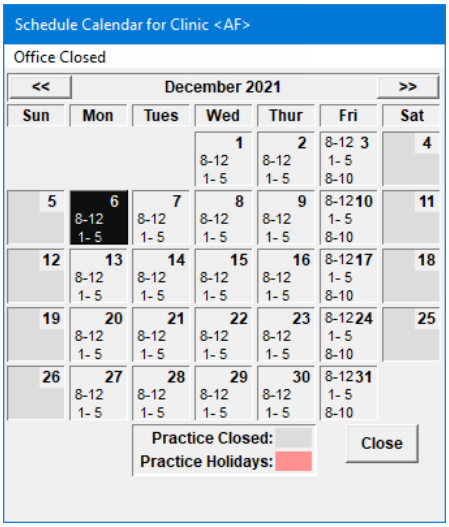
Changing a Clinic's Schedule

Occasionally you will need to change the hours your office is open for a particular date. Dentrix Enterprise allows you to change your working hours for a single day or to close the office completely on a single day. Changing the hours of operation for a day or closing the office on a day does not make changes to any previously scheduled appointments. For example, if you have scheduled patients for March 5th, and then you close March 5th, those patients remain scheduled on March 5th.

To set up when a clinic is closed for vacation days and holidays

1. In Appointment Book, from the **Setup** menu, click **Clinic Schedule**.

   The **Schedule Calendar for Clinic** dialog box appears.



2. Click the double left or right arrows to navigate to the correct month, and then select the day you want to close or open the office.
3. From the **Office Closed** menu, click one of the following options:
   - **Close Office on selected date** – Closes the office on the selected day. The cell for that day will become light gray. Use this option to close the office for yearly holidays that do not occur on the same day of the month every year (for example, Thanksgiving).
   - **Open Office** – Opens the office on the selected day if it was previously closed.
   - **Set Yearly Holiday on selected day** – Closes the office on the selected day. The cell for that day will become pink. Use this option to close the office for yearly holidays that fall on the same day of the month every year (for example, Christmas is always on December 25).
   - **Delete Holiday** – Opens the office on the selected day if it was previously closed for a yearly holiday.
4. Click **Close**.

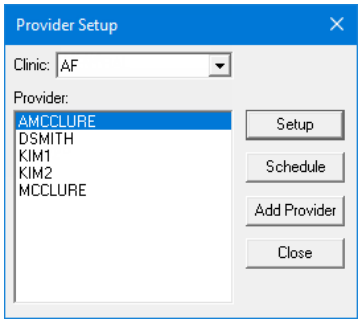
Changing a Provider's Schedule

Occasionally, you may need to change the hours a particular provider is available. In Dentrix Enterprise, you can change a single provider's hours for one day or to schedule the provider to be out of the office for one day. Changing a provider's hours for a day or scheduling a provider out of the office on a certain day does not make changes to any previously scheduled appointments. For example, if you have scheduled patients for March 5th and then set a vacation day for a provider who has patients on March 5th, those patients remain scheduled on March 5th..

To change a provider's schedule

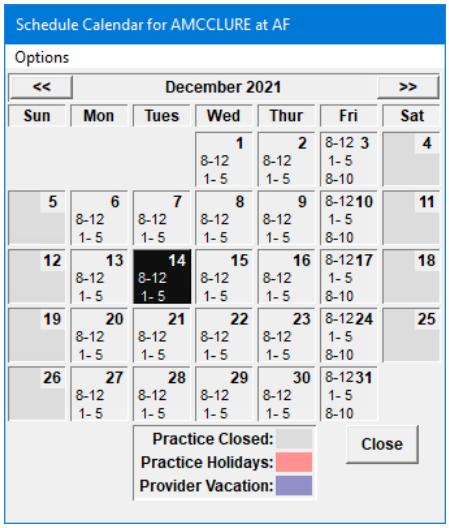
1. In Appointment Book, from the **Setup** menu, click **Provider Setup**.

   The **Provider Setup** dialog box appears.



2. Select a **Clinic**.
3. Select the desired **Provider**.
4. Click **Schedule**.

   The **Schedule Calendar for** dialog box appears.



5. Click the double left or right arrows to navigate to the correct month, and then select the day you want to set or remove a vacation day.
6. From the **Option** menu, click one of the following options:
   - **Set Vacation on selected date** – Makes the provider not available on the selected day. The cell for that day will become purple.
   - **Delete Vacation day** – Removes the provider's vacation day for the selected day if it was previously set.

- **Reset Hours to default on selected date** – Returns the selected day to the provider's default work day for that day of the week.

7. Click **Close** to return to the **Provider Setup** dialog box.
8. Click **Close**.

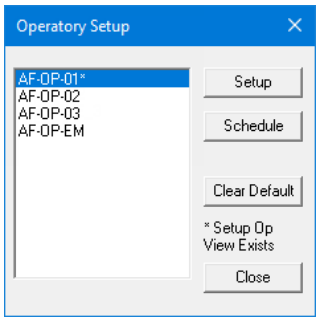
Changing an Operatory's Schedule

Occasionally, you may need to change the hours a particular operatory is available. In Dentrix Enterprise, you can change a single operatory's hours for one day. This does not make changes to any previously scheduled appointments or events. For example, if you have scheduled patients for March 5th and then change an operatory's hours, and that operatory has patients scheduled on March 5th outside of the operatory's availability, those patients remain scheduled in that operatory on March 5th.

To change an operatory's schedule

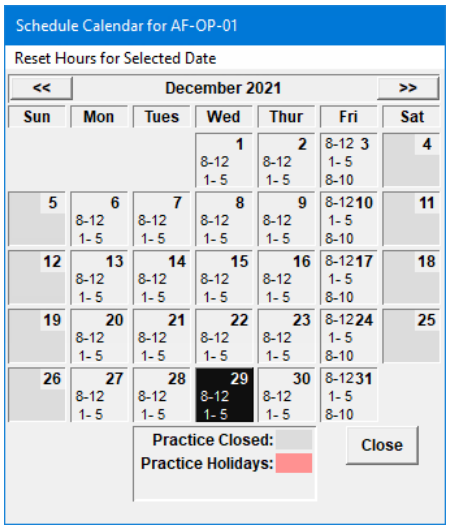
1. While viewing the operatories for a clinic in Appointment Book (the view does not have to include all operatories), from the **Setup** menu, click **Operatory Setup**.

   The **Operatory Setup** dialog box appears.



2. Select the desired operatory.
3. Click **Schedule**.

   The **Schedule Calendar for** dialog box appears for the selected operatory.



4. Click the double left or right arrows to navigate to the correct month, and then double-click the day to change the hours for the selected operatory on that date.

5. If you want to return the selected day to the operatory's default availability, click **Reset Hours for Selected Date** on the menu bar.
6. Click **Close** to return to the **Operatory Setup** dialog box.
7. Click **Close**.

Switching Between Views

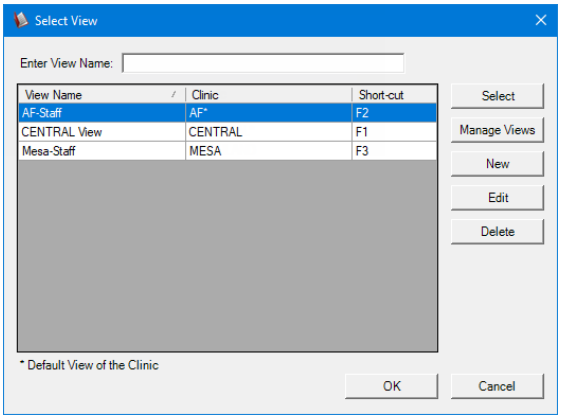
You can quickly switch between views by pressing the shortcut key (F1, F2, F3, and so forth) that corresponds to the shortcut key that is assigned to the desired view. However, if you don't know the view's shortcut key, the view doesn't have a shortcut key, or you don't want to use the view's shortcut key, you can select the view that you want to switch to from a list.

For information about adding and editing views, see "Setting Up Views" in Chapter 1: Introduction and Initial Setup.

Alternatively, to switch to another view

1. In Appointment Book, click **View** on the menu bar.

   The **Select View** dialog box appears.



2. Select the view you want to use.
3. Click **Select**.

Finding Open Appointment Times

Dentrix Enterprise provides you with multiple ways to search for an available appointment time as explained in the following topics:

- Manually Finding an Appointment Time
- Using the Find Appointment Tool

Manually Finding an Appointment Time

Dentrix Enterprise provides the following features to help you search for an available appointment slot manually:

- **Day view** – For information about this feature, see "Using the Day View" in this chapter.
- **Week view** – For information about this feature, see "Using the Week View" in this chapter.
- **Month view** – For information about this feature, see "Using the Month View" in this chapter.
- **Month calendar** – For information about this feature, see "Using the Month Calendar" in this chapter.
- **Flip tabs** – For information about this feature, see "Using the Flip Tabs" in this chapter.

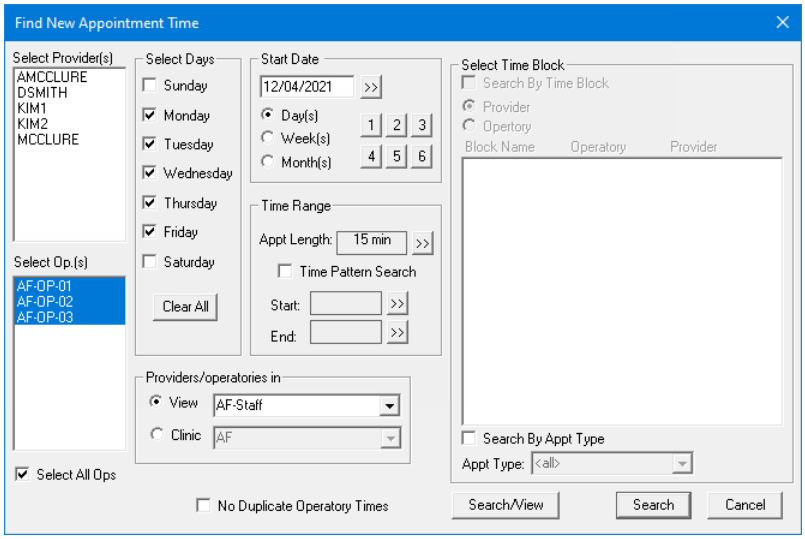
Using the Find Appointment Tool

When a patient with very specific scheduling needs calls to make an appointment, combing through your schedule and looking for any available time slot that both meets the needs of your office and the patient can be complicated and a little stressful. To help you find available openings in Appointment Book, Dentrix Enterprise provides an effective tool that allows you to quickly plug in as many or as few search parameters as you desire and then presents possible openings that meet those criteria.

To search for an available appointment time

1. In Appointment Book, click the **Find New Appointment Time**. button  .

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



2. Set up the following options:

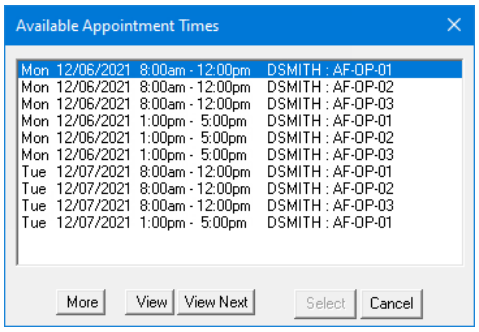
   - **Select Provider(s)** – Select the providers whose availability you want to search for. By default, the providers assigned to the current view being used in Appointment Book appear in the list.
   - **Select Op(s)** – Leave **Select All Ops** selected to search for open times in all operatories, or 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 Appointment Book appear in the list.
   - **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.

3. Click **Search/View**.

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



4. Select the date and time that you want to preview in 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.

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

For comprehensive details about all the search options available, see the "Using the Find Appointment Tool" topic in the Dentrix Enterprise Help.

Scheduling Appointments

Keeping the schedule organized can create harmony for the whole team just as a messy and disorganized schedule can create a ripple effect of unnecessary stress and chaos throughout the day. Since the most common operation performed in Appointment Book is simply scheduling an appointment, it's important that they are scheduled correctly and include all pertinent information so that you not only serve your existing patients, but also make sure the office reaches any daily production goals.

Dentrix Enterprise provides a flexible framework for scheduling various types of appointments:

- Scheduling Appointments for New Patients
- Scheduling Appointments for Existing Patients
- Scheduling Continuing Care Appointments

Scheduling Appointments for New Patients

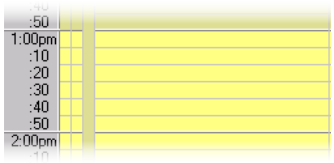
Scheduling an appointment is often a new patient's first experience with your office. Since this is a potential new customer, you need to make a good impression, so you will want to ask for only enough information to schedule the initial appointment rather than asking for the patient's entire health history over the phone (according to your organizations procedure). Also, a benefit of scheduling a new-patient appointment is that doing so does not create a patient record in your database, so if the patient cancels or doesn't show up, you don't clutter up your patient database with a patient who you might never hear from again.

Notes:

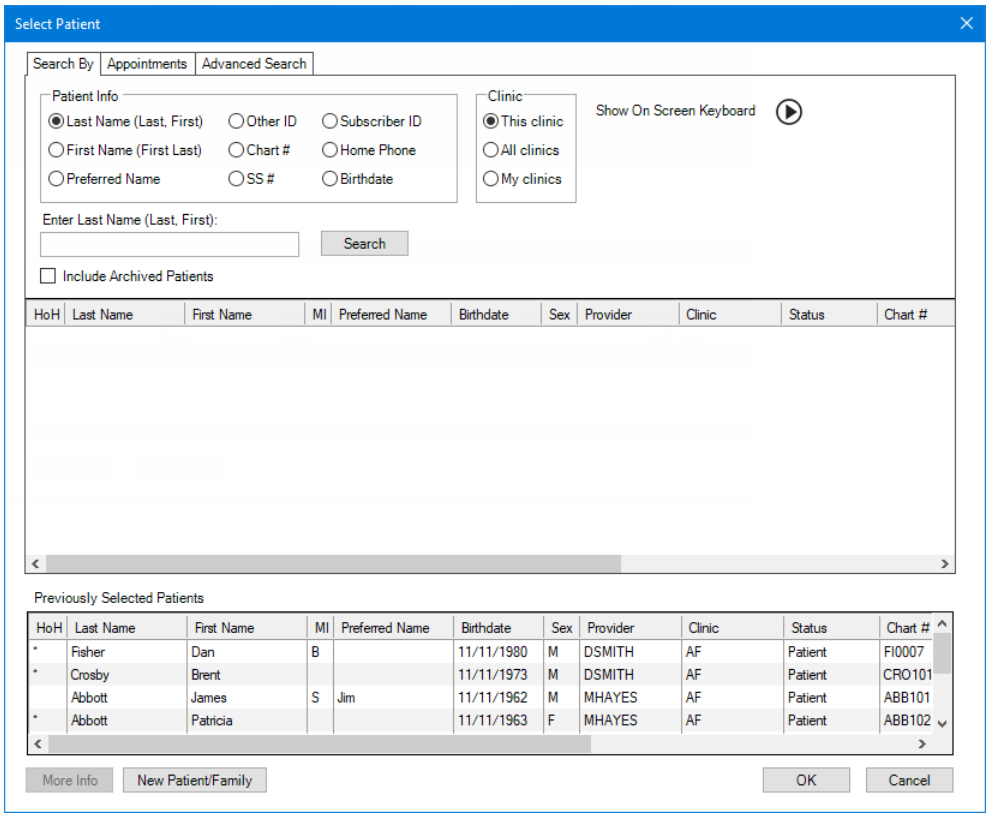
- When you create an appointment for a new patient, the patient's contact information is stored only in Appointment Book. Dentrix doesn't automatically create a patient record in the Family File. Instead, you must create a patient record in the Family File record when the patient arrives for the appointment, but Dentrix Enterprise uses the information entered for the appointment to create that patient record to make it so that you don't have to re-enter anything.
- If the new patient fails to show up for his or her first visit, you can delete the appointment from Appointment Book.
- Be aware that your organization's standards and policies may require you to collect or not collect certain information when scheduling a new-patient appointment.

To schedule a new-patient appointment

1. In Appointment Book, locate an available time on the schedule as explained in "Finding Open Appointment Times" in this chapter, and then double-click in the desired operatory at the desired time.

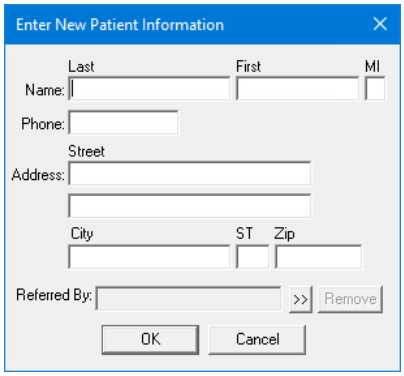


The **Select Patient** dialog box appears.



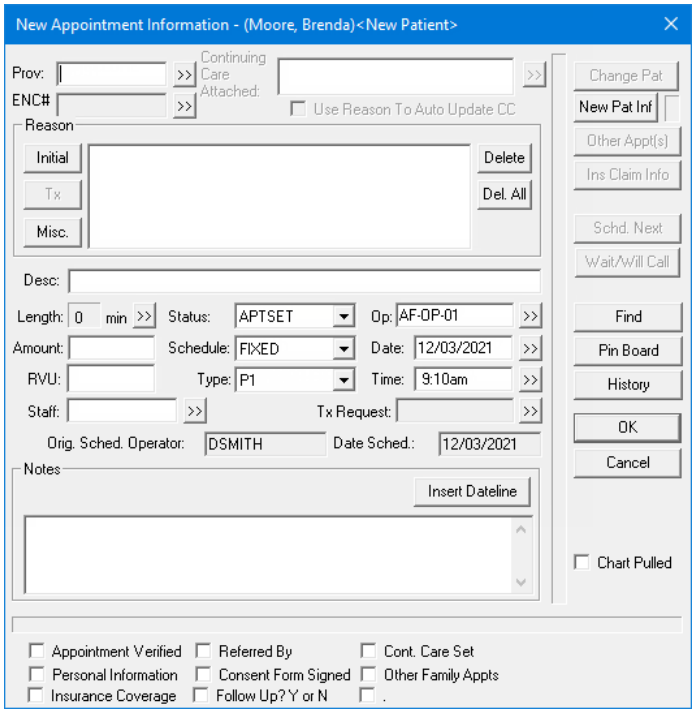
2. Search for the patient to make sure that he or she does not already have a Family File record. Then, if the patient does not exist in your database, click **New Patient/Family**.

   The **Enter New Patient Information** dialog box appears.



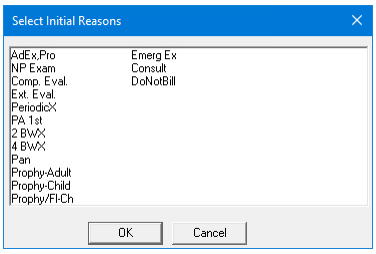
3. Enter the following information:
   - **Name** – Enter the patient's last name, first name, and middle initial.
   - **Phone** – Enter the patient's home phone number.
   - **Address** – Enter the patient's address.
   - **Referred By** – If the patient was referred to your office, click the search button >> to select the referral source.
4. Click **OK**.

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

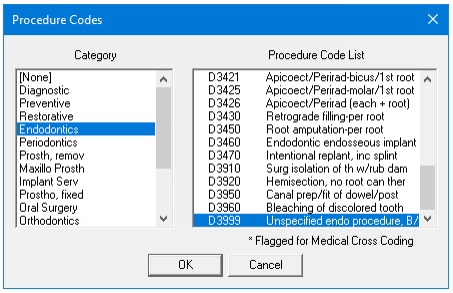


5. Select the reasons for the appointment:

   - **Initial** – If the patient is being seen for work that is part of an initial visit, such as an exam and cleaning, click **Initial**. The **Select Initial Reasons** dialog box appears. Select the desired reasons, and then click **OK**.



   - **Misc** – If the patient is being seen for something else, click **Misc**. The **Procedure Codes** dialog box appears. Select the desired procedure code, and then click **OK**.



6. Set up any other options as needed as explained in "Scheduling Continuing Care Appointments" in this chapter.

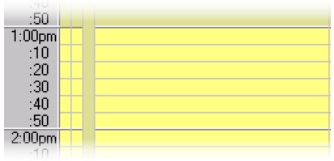
7. Click **OK**.

Scheduling Appointments for Existing Patients

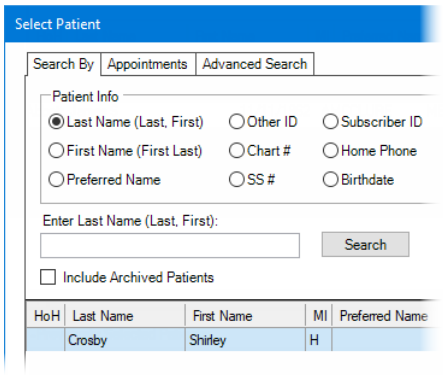
You can schedule appointments for your patients of record. You can schedule an appointment for any procedure codes and for treatment-planned procedures.

To schedule an appointment

1. In Appointment Book, locate an available time on the schedule as explained in "Finding Open Appointment Times" in this chapter, and then double-click in the desired operatory at the desired time.

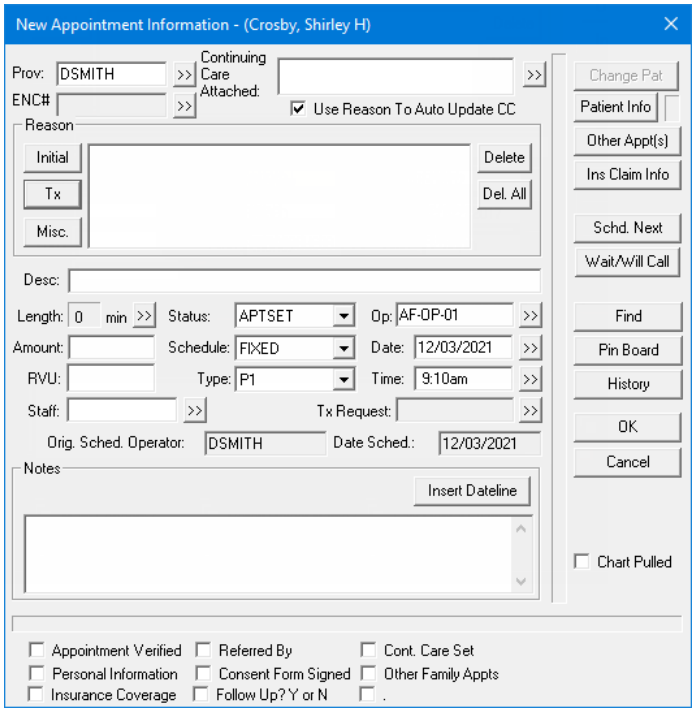


The **Select Patient** dialog box appears.

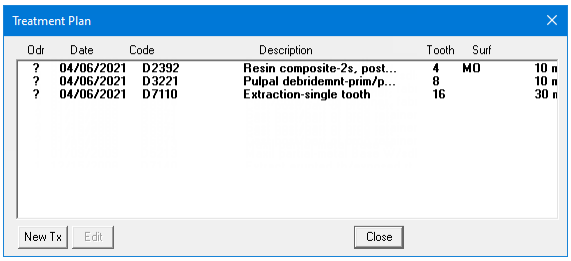


2. Search for the desired patient, and then double-click the patient name in the list of matches.

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

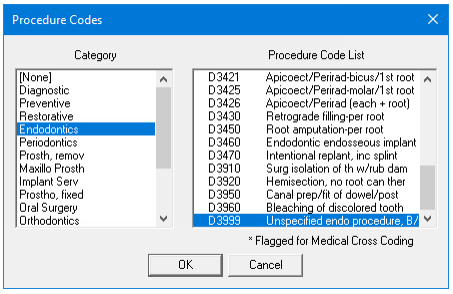


3. Select the reasons for the appointment:
   - **Tx** – If the patient is going to be seen for treatment-planned work, click **Tx**. The **Treatment Plan** dialog box appears. Select the desired procedures, and then click **Close**.



   Tip: To add to the treatment plans listed in the **Treatment Plan** dialog box, click **New Tx**.

   - **Misc** – If the patient is being seen for treatment that has not been treatment-planned, click **Misc**. The **Procedure Codes** dialog box appears, select the desired procedure code, and then click **OK**.



4. Set up the following options as needed:
   - **Provider** – By default, Dentrix Enterprise assigns the patient's primary provider, but you can select another provider for the appointment.
   - **Appointment Desc** – Dentrix Enterprise updates the description automatically as you add an appointment reason, but you can change it as needed.
   - **Length** – Dentrix Enterprise updates the length automatically as you add an appointment reason. If more or less time is needed to complete the appointment, you can change the length. You can also set up the time pattern for each unit of the length (chair time , assistant's time /, or provider's time X) to help you maximize your productivity and the use of all operatories.
   - **Amount** – Dentrix Enterprise updates the amount as you add an appointment reason, but you can change it as needed.
   - **Staff** – If applicable, click the search button >> to select the staff member who will assist with this appointment.
   - **Schedule** – You can categorize appointments into three groups. Select one of the following options:
     - **FIXED** – The patient has an inflexible schedule and can only be seen at the scheduled time.
     - **OPEN** – The patient is willing to change the date and time of the appointment if necessary.
     - **ASAP** – The patient want to be seen earlier if an appointment time becomes available.
   - **Type** – If you are using Perfect Day Scheduling, select an appointment type. For an explanation of Perfect Day Scheduling and appointment types, see "Using Perfect Day Scheduling" in this chapter.
   - **Op, Date, Time** – Dentrix Enterprise automatically inserts the operatory, date, and time for the appointment that corresponds to the time slot where you double-clicked to begin scheduling this appointment. You can change the **Op**, **Date**, and/or **Time** as needed.
   - **Note** – If clarification is needed or to add other details about the appointment, enter a note.

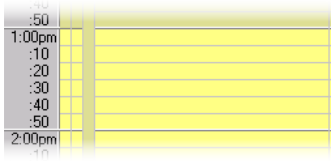
- **Chart Pulled, Check List** – If you have pulled the patient's paper chart, select **Chart Pulled**. Also, you can select any of the check boxes (the check list items as set up in the Practice Definitions) at the bottom of the dialog box as needed.

5. Click **OK**.

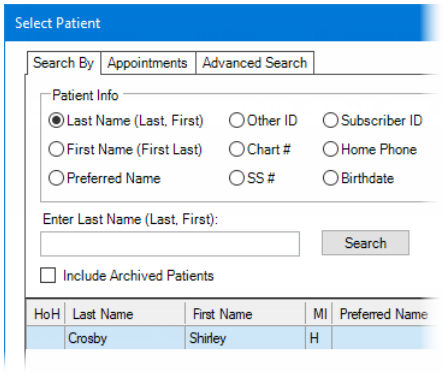
Scheduling Continuing Care Appointments

To schedule a continuing care appointment

1. In Appointment Book, locate an available time on the schedule as explained in "Finding Open Appointment Times" in this chapter, and then double-click in the desired operatory at the appropriate date and time.

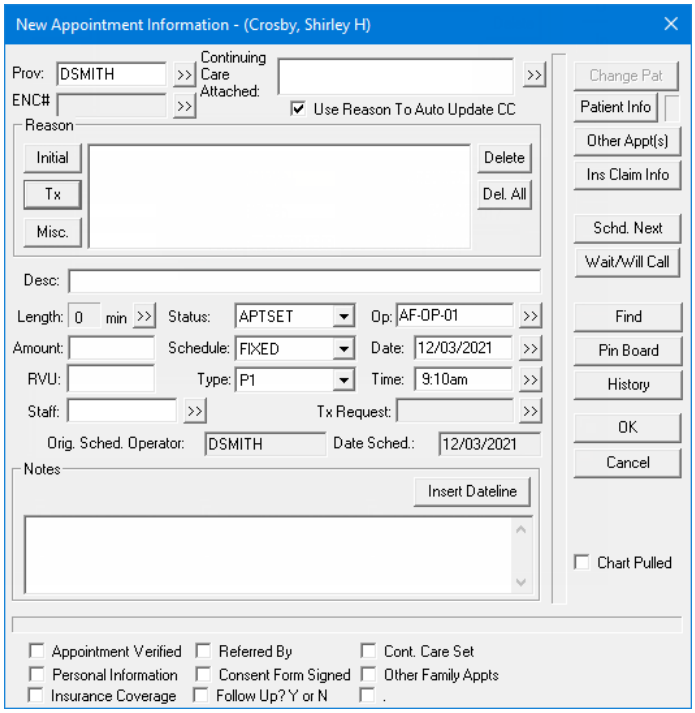


The **Select Patient** dialog box appears.

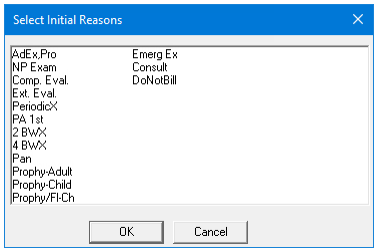


2. Search for the desired patient, and then double-click the patient name in the list of matches.

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



3. The initial reasons are the most common procedures that your office performs, typically for initial and recurring visits, such as exams and cleanings. To select the continuing care appointment reasons, click **Initial**. The **Select Initial Reasons** dialog box appears. Select one or more reasons, and then click **OK**.



Note: If any of the selected procedures corresponds to a continuing care type that is not attached to the patient's record, and the **Use Reason to Auto Update CC** check box is selected, a message appears and asks if you want to attach the missing continuing care to the patient's record using the default settings. Click **Yes** to attach the continuing care to the patient's Family File.

4. Set up the following options as needed:
   - **Provider** – By default, Dentrix Enterprise assigns the patient's primary provider, but you can select another provider for the appointment.
   - **Appointment Desc** – Dentrix Enterprise updates the description automatically as you add an appointment reason, but you can change it as needed.
   - **Length** – Dentrix Enterprise updates the length automatically as you add an appointment reason. If more or less time is needed to complete the appointment, you can change the length. You can also set up the time pattern for each unit of the length (chair time ┌, assistant's time /, or provider's time X) to help you maximize your productivity and the use of all operatories.
   - **Amount** – Dentrix Enterprise updates the amount as you add an appointment reason, but you can change it as needed.
   - **Staff** – If applicable, click the search button ›› to select the staff member who will assist with this appointment.

- **Schedule** – You can categorize appointments into three groups. Select one of the following options:
  - **FIXED** – The patient has an inflexible schedule and can only be seen at the scheduled time.
  - **OPEN** – The patient is willing to change the date and time of the appointment if necessary.
  - **ASAP** – The patient want to be seen earlier if an appointment time becomes available.
- **Type** – If you are using Perfect Day Scheduling, select an appointment type. For an explanation of Perfect Day Scheduling and appointment types, see "Using Perfect Day Scheduling" in this chapter.
- **Op, Date, Time** – Dentrix Enterprise automatically inserts the operatory, date, and time for the appointment that corresponds to the time slot where you double-clicked to begin scheduling this appointment. You can change the **Op**, **Date**, and/or **Time** as needed.
- **Note** – If clarification is needed or to add other details about the appointment, enter a note.
- **Chart Pulled, Check List** – If you have pulled the patient's paper chart, select **Chart Pulled**. Also, you can select any of the check boxes (the check list items as set up in the Practice Definitions) at the bottom of the dialog box as needed.

5. Click **OK**.

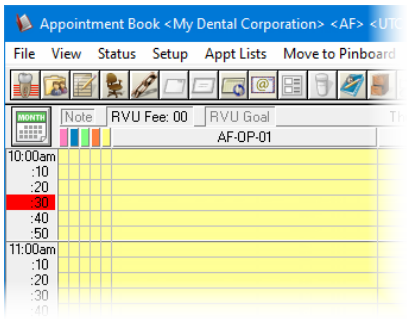
For a comprehensive description of all the options available for scheduling appointments, see the "Scheduling appointments" topics in the Dentrix Enterprise Help.

Scheduling Events

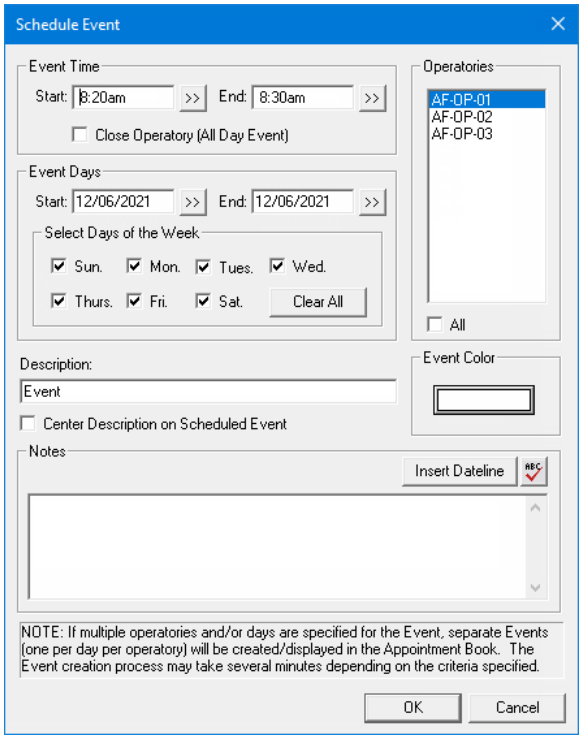
The Dentrix Enterprise Appointment Book is not just for managing patient appointments. It also allows you to schedule events, such as staff meetings, vacations, and activity reminders. You can use an event to block out time or close one or all operatories in Appointment Book, so you have a visual reminder 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 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, Operatores** – 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.

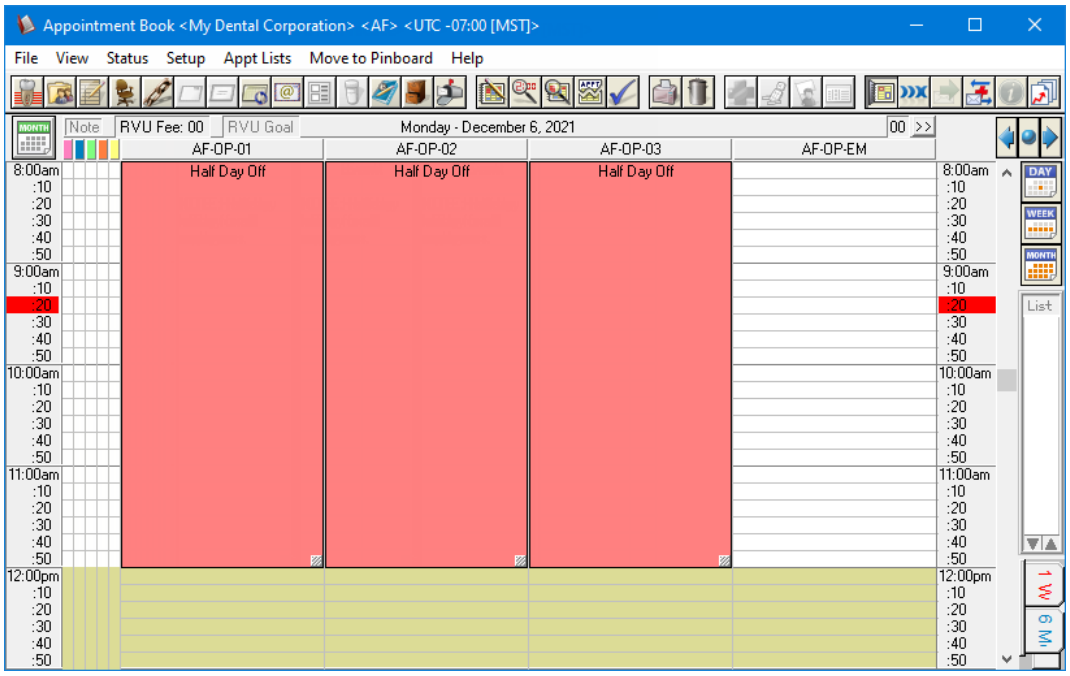
   - **Description** – Enter a description for the event or series. To center the description horizontally at the top of the event block in Appointment Book, select **Center Description on Scheduled Event**. With this check box cleared, the description is left aligned.
   - **Event Color** – Click the button 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** – Enter 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.

Managing Appointment Book Lists

Failed or canceled appointments can cost a dental office thousands of dollars a year in lost production time. Dentrix Enterprise helps you avoid that missed revenue by providing you with several types of appointment lists that can be used to fill open blocks of time in your schedule. This section covers the following topics about how to use these lists:

- Using the Appointment List
- Using the ASAP List
- Using the Open List
- Using the Unscheduled List
- Using the Pinboard List

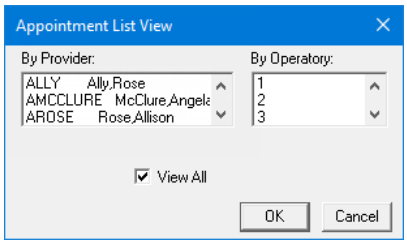
Using the Appointment List

The Appointment List displays all appointments scheduled in Appointment Book for a selected date. As a useful tool to confirm appointments, the Appointment List displays the time, status, name of patient, provider, operatory, reason, length, and patient phone number for the appointment.

To use the Appointment List

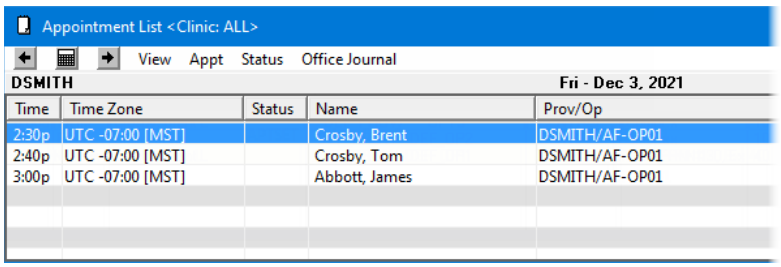
1. In Appointment Book, from the **Appt Lists** menu, point to **Appt List**, and then click either **Current Clinic** (to view appointments for the clinic currently being viewed) or **All Clinics** (to view appointments for all clinics).

   The **Appointment List View** dialog box appears.



2. Make your provider and operatory selections to filter the appointments in the list, and then click **OK**.

   The **Appointment List** window appears.



3. Perform any of the following tasks:
   - To see more information regarding an appointment or to make changes to an appointment, double-click it to open the **Appointment Information** dialog box.
   - To move back one day at a time or forward one day at a time, click the left or right arrow button. To select a specific date, click the calendar button.
   - To move a selected appointment to the Pinboard for quick rescheduling, from the **Appt** menu, click **Move Appointment to Pinboard**.
   - To break a selected appointment and move it to the Unscheduled List, from the **Appt** menu, click **Break Appointment**.
   - To delete a selected appointment permanently, from the **Appt** menu, click **Delete** Appointment.
   - When confirming a selected appointment, from the **Status** menu, select the appropriate status type to indicate the last contact with the patient.
   - To open the Office Journal of the patient that corresponds to a selected appointment, on the menu bar, click **Office Journal**.

Using the ASAP List

Many times patients call wanting an appointment sooner than your next available time. In these situations, you can offer to call the patient if an appointment time becomes available. With Dentrix Enterprise, you can flag scheduled appointments as ASAP (As Soon As Possible).

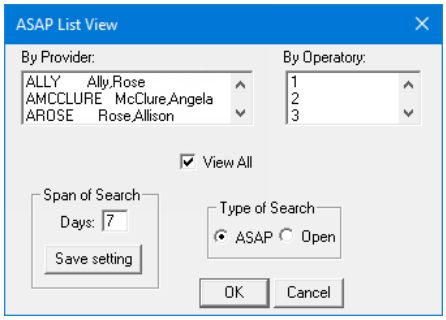
Once you have flagged an appointment as ASAP, it appears on the ASAP List. This satisfies the patient's request for a sooner appointment, while benefiting the office at the same time, by providing a list of patients who can fill holes in an otherwise full schedule.

In addition to providing you with names of patients who can fill open appointment times, the interactive nature of the ASAP List makes it simple to contact a patient and then create or move an appointment as needed.

To use the ASAP List

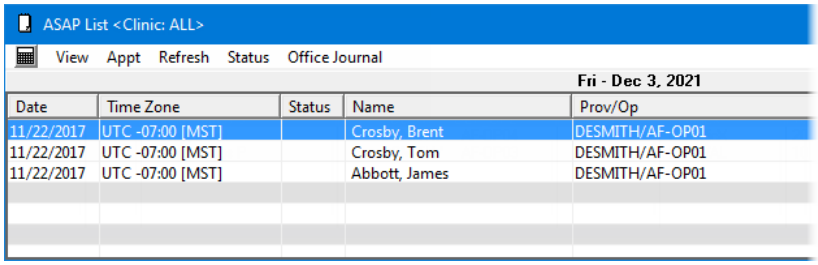
1. In Appointment Book, from the **Appt Lists** menu, point to **ASAP List**, and then click either **Current Clinic** (to view appointments for the clinic currently being viewed) or **All Clinics** (to view appointments for all clinics).

   The **ASAP List View** dialog box appears.



2. Make your provider, operatory, and day span selections to filter the appointments in the list, and then click **OK**.

   The **ASAP List** window appears.



3. Perform any of the following tasks:
   - To see more information regarding an appointment or to make changes to an appointment, double-click it to open the **Appointment Information** dialog box.
   - To change the start date for the view, click the calendar button.
   - To move a selected appointment to the Pinboard for quick rescheduling, from the **Appt** menu, click **Move Appointment to Pinboard**.
   - To delete a selected appointment permanently, from the **Appt** menu, click **Delete Appointment**.
   - If you or someone else changed an appointment in another module or on another computer, to update the ASAP List to reflect the most recent changes, on the menu bar, click **Refresh**.
   - When confirming a selected appointment, from the **Status** menu, select the appropriate status type to indicate the last contact with the patient.
   - To open the Office Journal of the patient that corresponds to a selected appointment, on the menu bar, click **Office Journal**.

Using the Open List

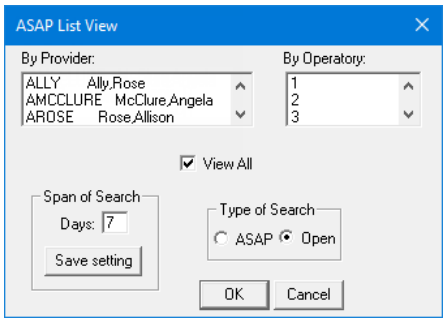
When a patient calls to cancel at the last minute, the office must either scramble to find a patient willing to come in on short notice or else lose valuable production. The Open List can help you quickly fill those available slots by providing you with a list of scheduled patients who have more flexible schedules and may be willing to come in at the last minute.

In addition to providing you with names of patients who can fill open appointment times, the interactive nature of the Open List makes it simple to contact a patient and then create or move an appointment as needed.

To use the Open List

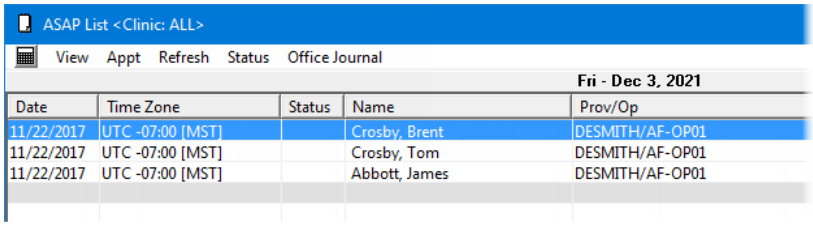
1. In Appointment Book, from the **Appt Lists** menu, point to **ASAP List**, and then click either **Current Clinic** (to view appointments for the clinic currently being viewed) or **All Clinics** (to view appointments for all clinics).

   The **ASAP List View** dialog box appears.



2. Make your provider, operatory, and day span selections to filter the appointments in the list; under **Type of Search**, select **Open**; and then click **OK**.

   The **ASAP List** window appears, displaying appointments that are flagged as Open.



3. Perform any of the following tasks:
   - To see more information regarding an appointment or to make changes to an appointment, double-click it to open the **Appointment Information** dialog box.
   - To change the start date for the view, click the calendar button.
   - To move a selected appointment to the Pinboard for quick rescheduling, from the **Appt** menu, click **Move Appointment to Pinboard**.
   - To delete a selected appointment permanently, from the **Appt** menu, click **Delete Appointment**.
   - If you or someone else changed an appointment in another module or on another computer, to update the Open List to reflect the most recent changes, on the menu bar, click **Refresh**.
   - When confirming a selected appointment, from the **Status** menu, select the appropriate status type to indicate the last contact with the patient.
   - To open the Office Journal of the patient that corresponds to a selected appointment, on the menu bar, click **Office Journal**.

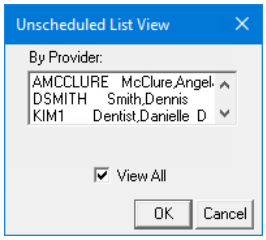
Using the Unscheduled List

The Unscheduled List provides you with an easy way to view broken or wait/will call appointments.

To use the Unscheduled List

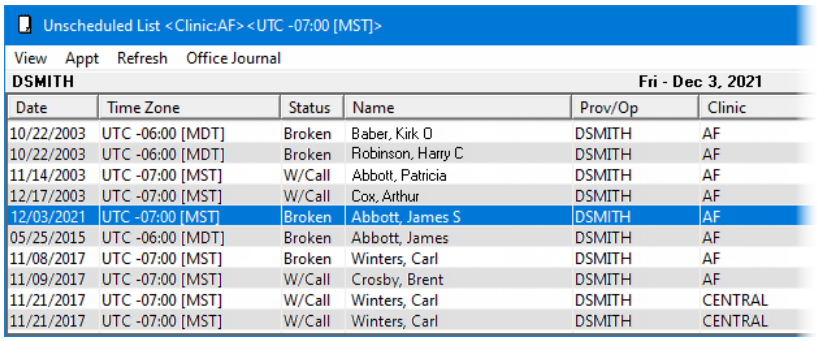
1. In Appointment Book, from the **Appt Lists** menu, point to **Unscheduled List**, and then click either **Current Clinic** (to view appointments for the clinic currently being viewed) or **All Clinics** (to view appointments for all clinics).

   The **Unscheduled List View** dialog box appears.



2. Make your provider selections to filter the appointments in the list, and then click **OK**.

   The **Unscheduled List** window appears.



Date	Time Zone	Status	Name	Prov/Op	Clinic
10/22/2003	UTC -06:00 [MDT]	Broken	Baber, Kirk O	DSMITH	AF
10/22/2003	UTC -06:00 [MDT]	Broken	Robinson, Harry C	DSMITH	AF
11/14/2003	UTC -07:00 [MST]	W/Call	Abbott, Patricia	DSMITH	AF
12/17/2003	UTC -07:00 [MST]	W/Call	Cox, Arthur	DSMITH	AF
12/03/2021	UTC -07:00 [MST]	Broken	Abbott, James S	DSMITH	AF
05/25/2015	UTC -06:00 [MDT]	Broken	Abbott, James	DSMITH	AF
11/08/2017	UTC -07:00 [MST]	Broken	Winters, Carl	DSMITH	AF
11/09/2017	UTC -07:00 [MST]	W/Call	Crosby, Brent	DSMITH	AF
11/21/2017	UTC -07:00 [MST]	W/Call	Winters, Carl	DSMITH	CENTRAL
11/21/2017	UTC -07:00 [MST]	W/Call	Winters, Carl	DSMITH	CENTRAL

3. Perform any of the following tasks

   - To see more information regarding an appointment or to make changes to an appointment, double-click it to open the **Appointment Information** dialog box.
   - To move a selected appointment to the Pinboard for quick rescheduling, from the **Appt** menu, click **Move Appointment to Pinboard**.
   - To delete a selected appointment permanently, from the **Appt** menu, click **Delete Appointment**.
   - If you or someone else changed an appointment in another module or on another computer, to update the Unscheduled List to reflect the most recent changes, on the menu bar, click **Refresh**.
   - To open the Office Journal of the patient that corresponds to a selected appointment, on the menu bar, click **Office Journal**.

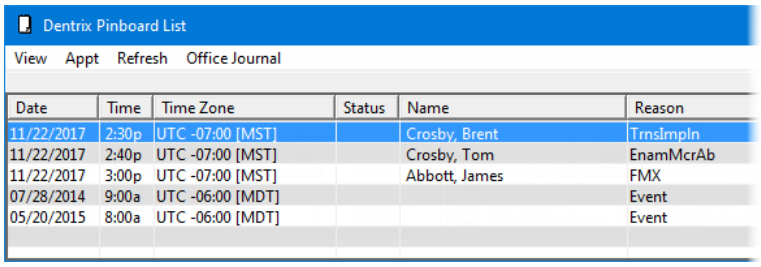
Using the Pinboard List

The Pinboard List provides you with an easy way to view appointments and events that are on the Pinboard of users in all clinics.

To use the Pinboard List

1. In Appointment Book, from the **Appt Lists** menu, click **Pinboard List**.

   The **Pinboard List** window appears.



   Notes:

   - An appointment with a date and time was put on the Pinboard by clicking one of the **Move to Pinboard** options from the shortcut menu that appears when you right-click an appointment, by clicking one of the **Move to Pinboard** menu options with an appointment selected, or by clicking the **Pin Board** button that is available from an appointment's **Appointment Information** dialog box appears only on the Pinboard or in the **Pinboard List** window.
   - An appointment without a date and time that was put on the Pinboard by dragging it there, still appears on the schedule.
   - If you close Appointment Book or click **Refresh** from the **File** menu, any appointment or event that was dragged to the Pinboard remains on the Pinboard and is still scheduled at its original date, time, and operatory.

2. Perform any of the following tasks:
   - To see more information regarding an appointment or to make changes to an appointment, double-click it to open the **Appointment Information** dialog box.
   - To delete a selected appointment permanently, from the **Appt** menu, click **Delete Appointment**.
   - If you or someone else changed an appointment in another module or on another computer, to update the Pinboard List to reflect the most recent changes, on the menu bar, click **Refresh**.
   - To open the Office Journal of the patient that corresponds to a selected appointment, on the menu bar, click **Office Journal**.

Using the 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, and you can schedule appointments directly from the Scheduling Assistant. This section covers the following topics about the Scheduling Assistant:

- Viewing Patients in the Scheduling Assistant
- Scheduling Appointments from the Scheduling Assistant

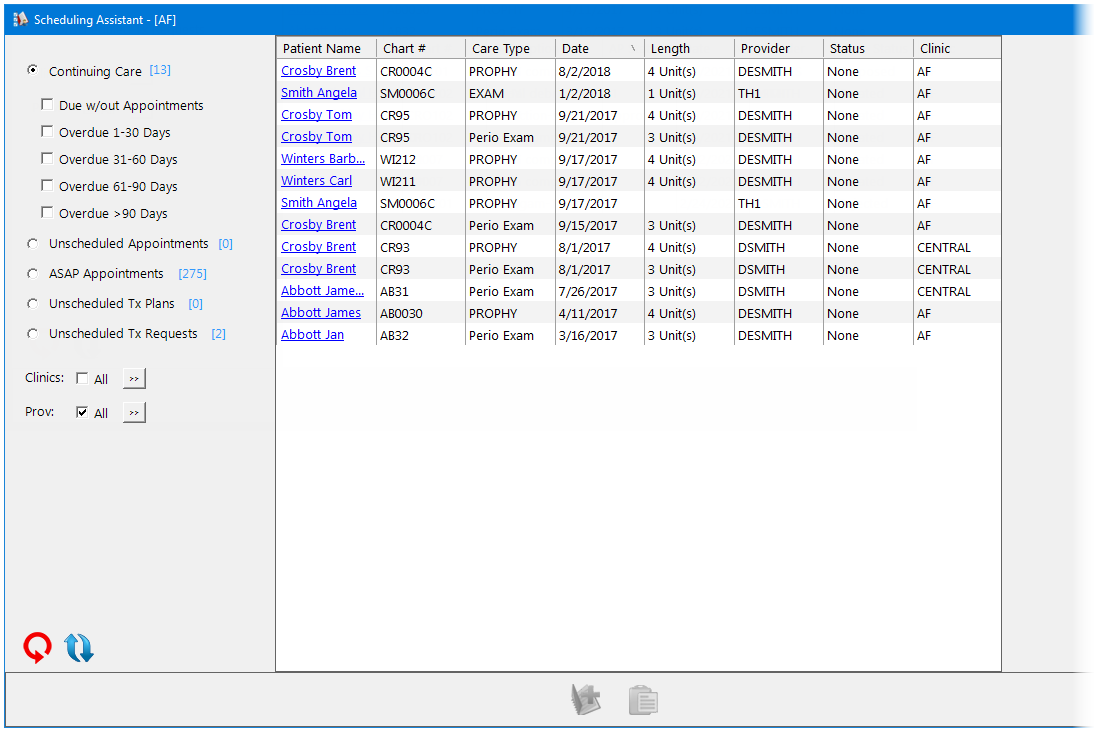
Viewing Patients in the Scheduling Assistant

You can open the Scheduling Assistant from the Office Manager module, and filter the list of patients in that window to suit your preferences.

To view patients in the Scheduling Assistant

1. In Office Manager, from the **File** menu, click **Scheduling Assistant**.

   The Scheduling Assistant opens.



2. 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.

       Note: A continuing care type is considered due or overdue according to the specified **Due w/out Appointments Date Range** of the **Continuing Care** filter.
     - **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.
     - **ASAP Appointments** – The list displays patients who have appointments that are marked as ASAP. The number in square brackets is a count of patients that have appointments on the ASAP List.
     - **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.
     - **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.
   - **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.
3. Click the **Refresh/Apply filter settings** button  .

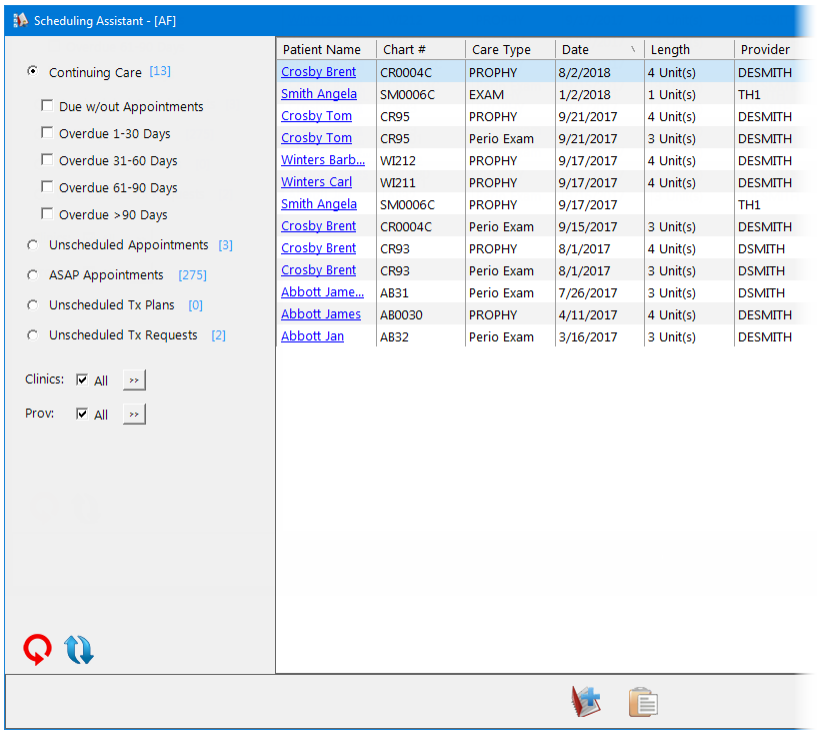
For comprehensive information about customizing the filter settings for the lists in the Scheduling Assistant, see the "Customizing the Scheduling Assistant Filters" topic in the Dentrix Enterprise Help.

Scheduling Appointments from the Scheduling Assistant

You can schedule an appointment from the Scheduling Assistant.

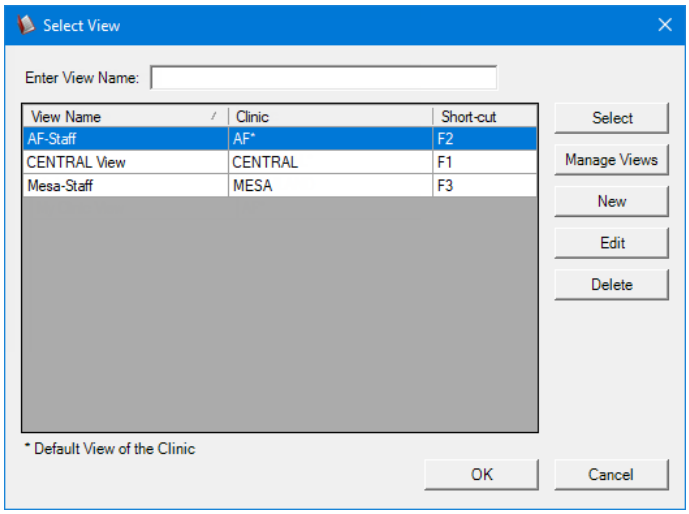
To schedule an appointment

1. In the Scheduling Assistant, select a record.



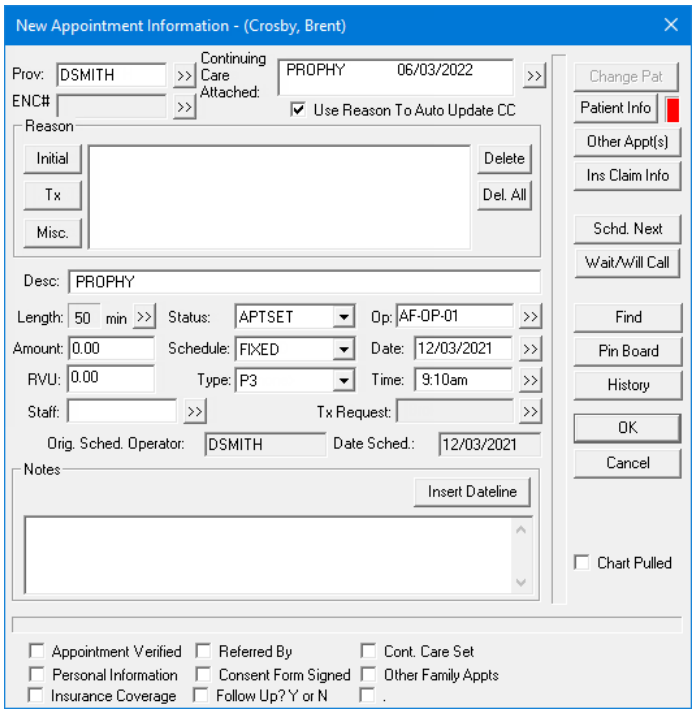
2. Click the **Create Appointment** button .

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



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

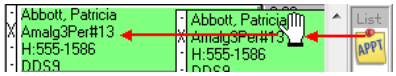
The **New Appointment Information** dialog box appears.



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 an ASAP 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. On the confirmation message that appears, click **Yes**.



Managing Appointments

With Dentrix Enterprise, you can not only schedule appointments, but you can quickly perform other appointment-related tasks. This section will explain the following tasks:

- Locating Existing Appointments
- Editing Appointments
- Moving Appointments
- Breaking or Canceling Appointments
- Rescheduling Broken or Canceled Appointments
- Deleting Appointments
- Changing a Patient's Default Dental Insurance Claim Settings

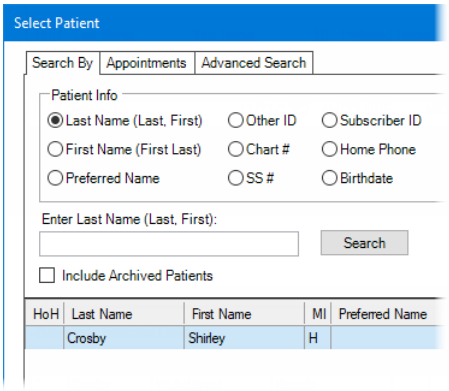
Locating Existing Appointments

You have several options for finding existing appointments:

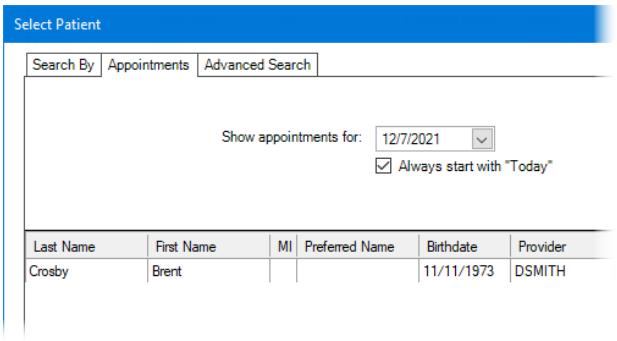
- **Using the Locate Existing Appointment option**

  1. In Appointment Book, from the **File** menu, click **Locate Existing Appointment**.

     The **Select Patient** dialog box appears.

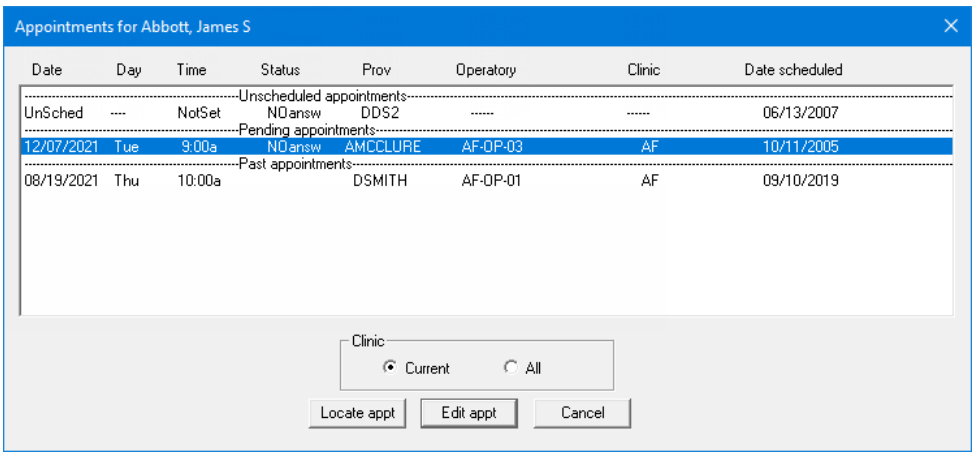


Note: On the **Appointments** tab, you can locate a patient's appointment for a specified date. Then, to go to that appointment in Appointment Book, double-click it.



  2. Search for the desired patient. (If you are looking for a new patient, in the results list, an "NP-" precedes the last name of that patient.) Then, double-click the patient name in the list of matches.

     The **Appointments for** dialog box appears.



Note: By default, the appointments for this patient in the **Current** clinic appear in the list. To view appointments for this patient in any clinic, under **Clinic**, select **All**.

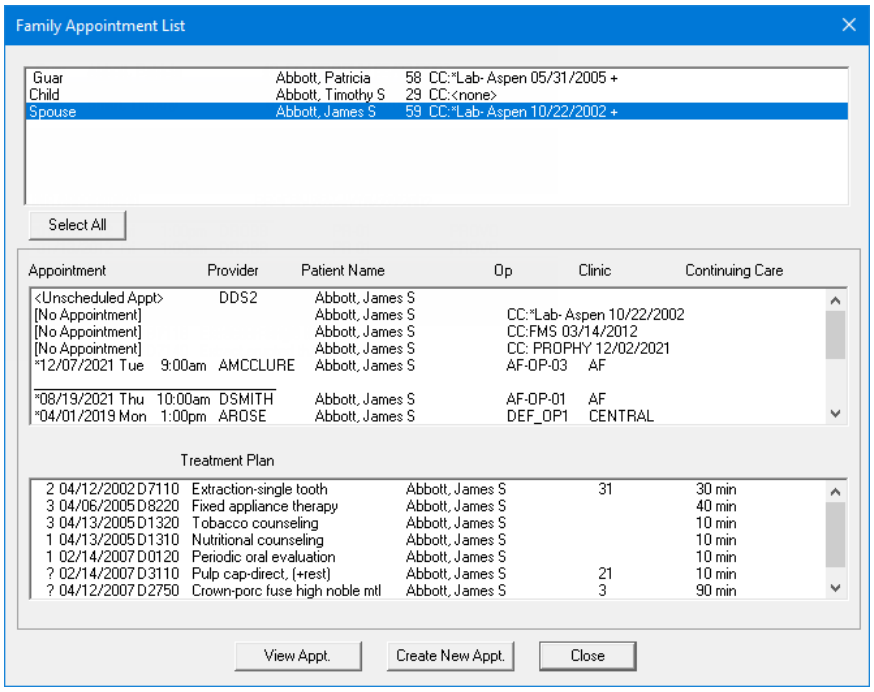
3. Select the appointment that you want to view or edit.
4. Click either **Locate appt** (to go to the selected appointment in Appointment Book) or **Edit appt** (to open the **Appointment Information** dialog box for the selected appointment).

- **By right-clicking an appointment**

1. To find other appointments a patient has, with one of that patient's appointments selected in Appointment Book, right-click it, and then click **Other Appointments**.



The **Family Appointment List** dialog box appears.



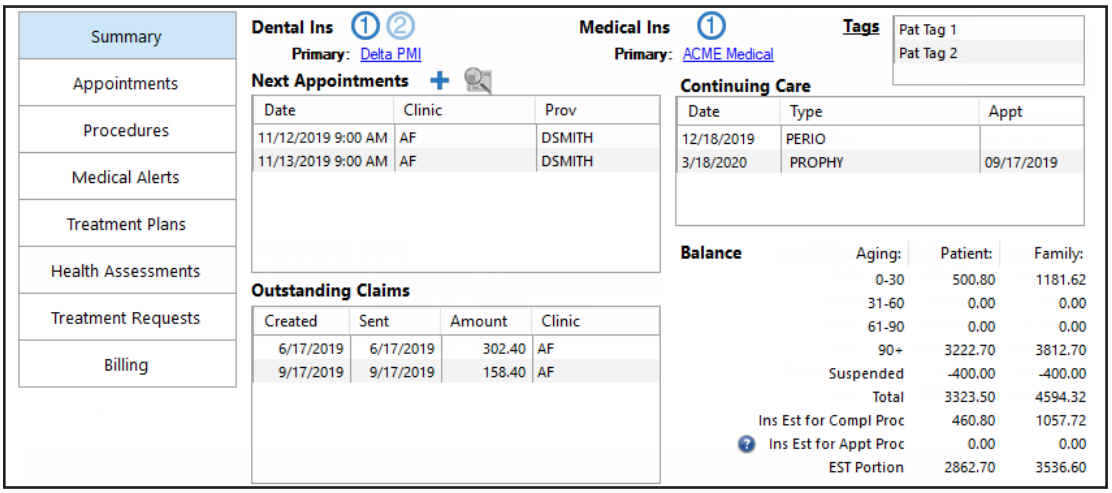
Notes:

- This dialog box also displays appointments for other family members of the selected patient. To switch between family members, select a different family member from the top list box. To view appointments for all family members at the same time, click **Select All**.
- To create a new appointment, select a family member, click **Create New Appt**.

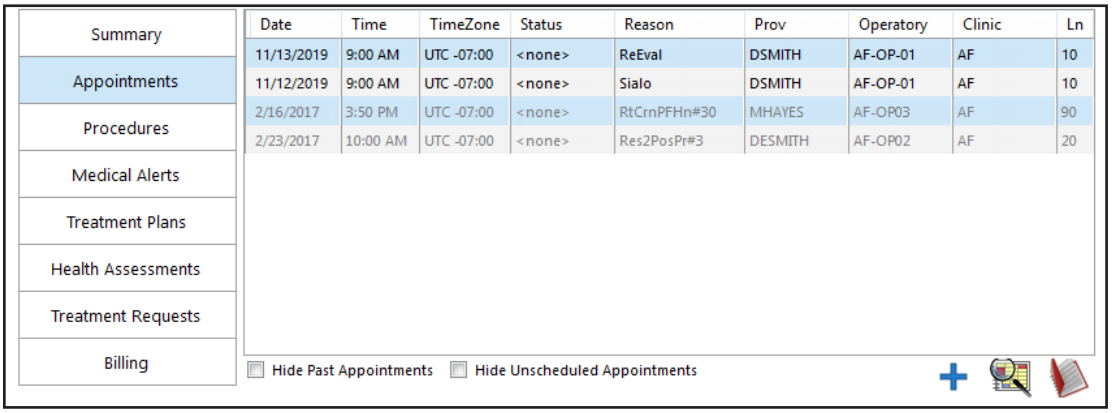
2. Select the appointment that you want to view.
3. To go to the selected appointment in Appointment Book, click **View Appt**.

- **From the More Information window**

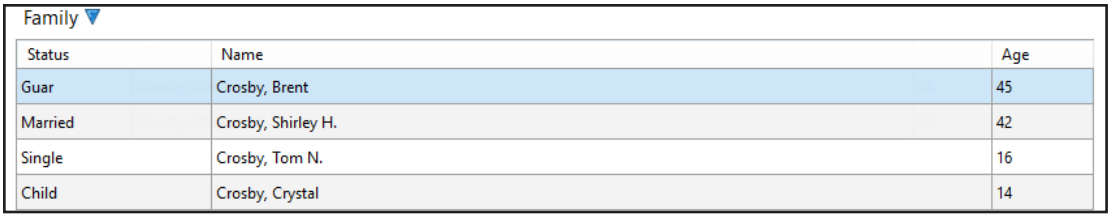
1. Open a patient's **More Information** window as explained in "Viewing More Patient Information" in Chapter 11: Other Features.
2. The **Summary** tabs shows the patient's **Next Appointments**. To view an appointment, select it, and then click the **Locate Appointment** button.



3. You can also view this patient's appointments on the **Appointments** tab. To view an appointment, select it, and then click the **Locate Appointment** button.



4. You can also view appointments for other family members. Double-click any family member who is listed to view that patient's information in the **More Information** window.

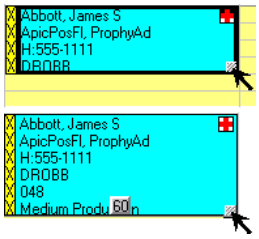


Editing Appointments

You change any information pertaining to an appointment (provider, reasons, time, notes, and so on) as needed.

To quickly change an appointment length

To quickly change the length of the appointment, click the gray square in the lower-right corner of the appointment so that the cursor turns into double-headed arrow, and then drag the bottom edge of the appointment up or down. While you are dragging, a small box appears and shows the length, in minutes, of the appointment.

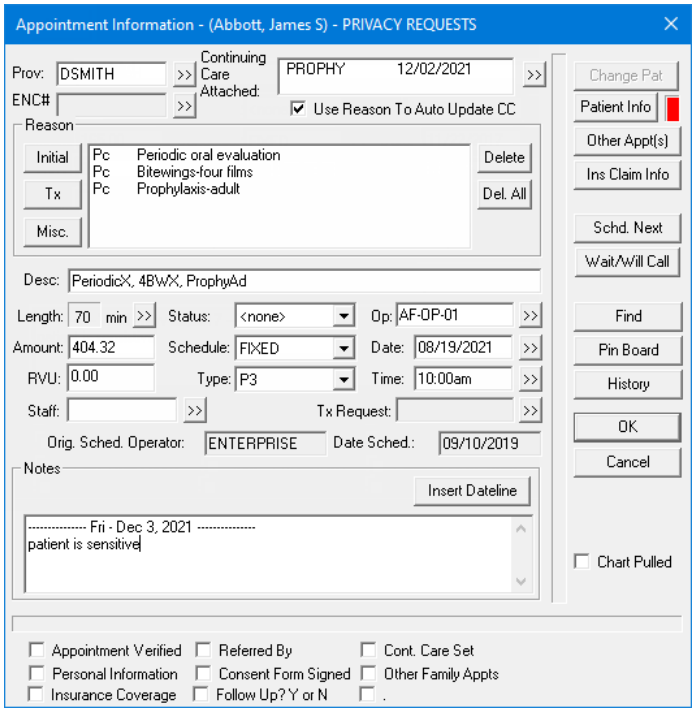


To edit an appointment

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



The **Appointment Information** dialog box appears.

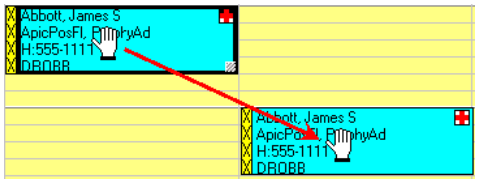


2. Make any necessary changes to the options explained in "Scheduling Appointments for Existing Patients" in this chapter.
3. Click **OK**.

Moving Appointments

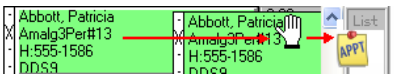
Whether a patient needs to reschedule or the office needs to lighten the schedule, from time to time you will need to move an appointment to a new date or time:

- **On the same date** – In Appointment Book, click and drag the appointment to a new time and/or operatory. On the confirmation message that appears, click **OK**.



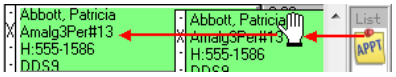
- **To a different date**

  1. In Appointment Book, click and drag the appointment to the pin board.



  Tip: To return an appointment on the pin board to its original date and time, from the **File** menu, click **Refresh**.

  2. Once you find a new date and time for the appointment, click and drag the appointment to the desired spot on the schedule.



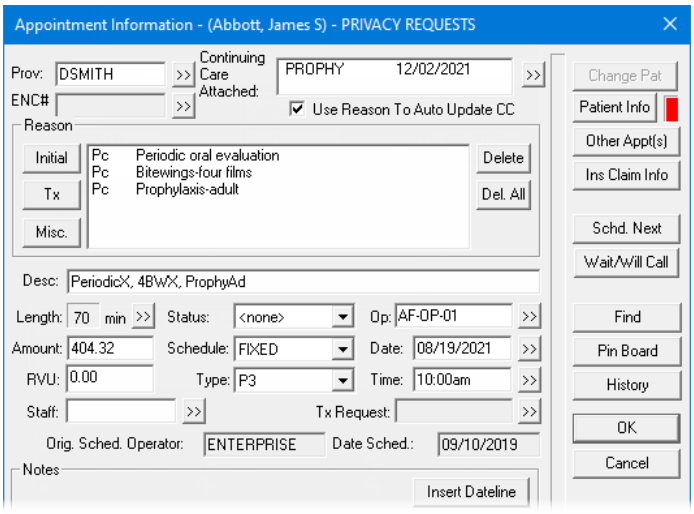
  3. On the confirmation message that appears, click **OK**.

- **By double-clicking an appointment**

  1. If you know the exact date and time to which you want to move an appointment, in Appointment Book, double-click the appointment you want to move.



  The **Appointment Information** dialog box appears.



2. Enter the new **Date** and **Time**, and if necessary, select the desired **Op**.
3. Click **OK**.

Tip: To move multiple appointments to the pin board, from the **Move to Pinboard** menu, click one of the following options:

- **All Appts for Displayed Date** – To move all the appointments scheduled on the date being displayed.
- **Family Appts for Displayed Date** – To move all the appointments for all patients in the same family with appointments on the date being displayed.
- **Provider's Appts for Displayed Date** – To move all the appointments with the same provider as the selected appointment.
- **Operatory Appts for Displayed Date** – To move all the appointments in the same operatory as the selected appointment.

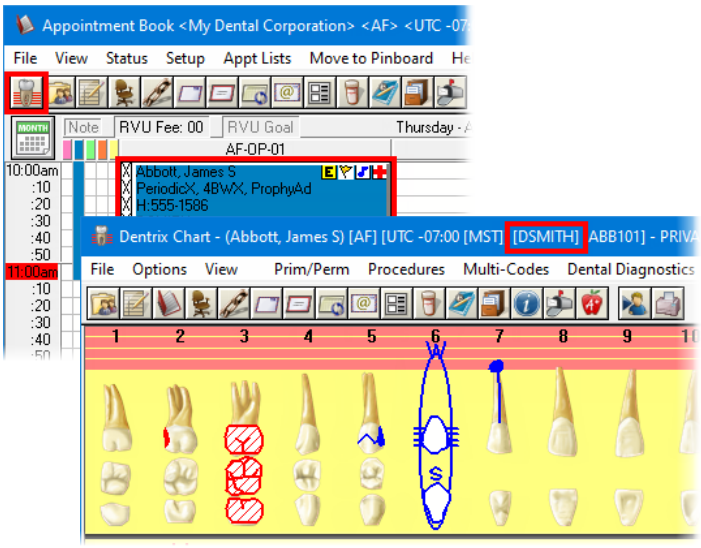
Breaking or Canceling Appointments

When a patient calls and cancels an 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. If the patient fails to call back and confirm a date and time, the appointment remains on the Unscheduled List where you can access it to fill last-minute cancellations or to increase production during slow months.

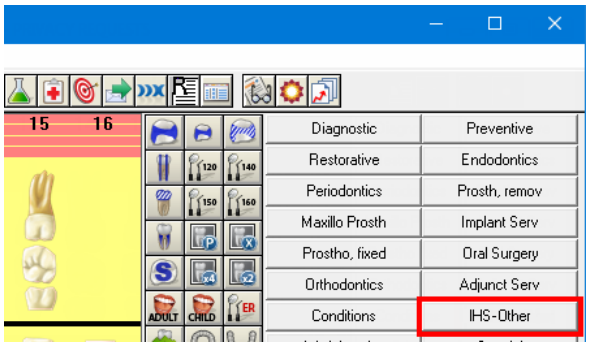
Also, when you try to schedule an appointment for a patient with a broken appointment, Dentrix Enterprise displays a message that states that the patient has a broken appointment and prompts you to reschedule it.

To break or cancel an appointment

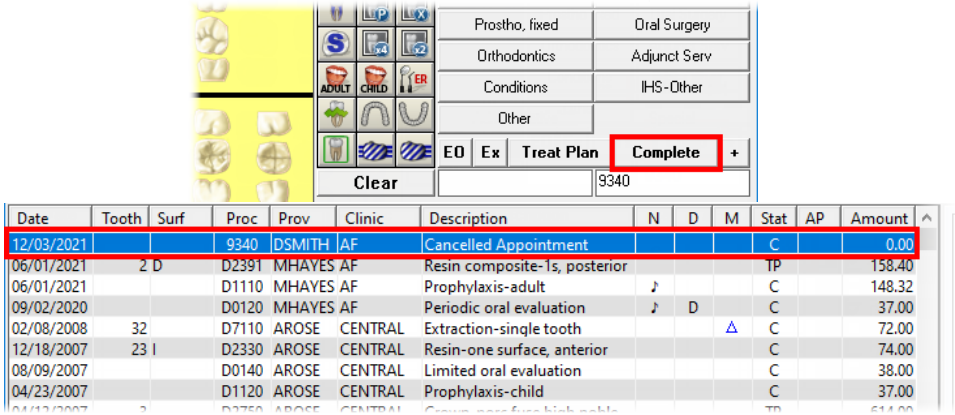
1. Code/complete the canceled or broken appointment.
2. In Appointment Book, select the appointment, and then click the **Patient Chart** button on the toolbar to open the Patient Chart module.



3. Verify that the provider with whom the patient was scheduled is displayed on the title bar of the **Patient Chart** window. If the correct provider is shown, skip step 4.
4. If you need to change the provider being displayed in the Patient Chart, from the **File** menu, click **Change Provider** to open the **Select Provider** dialog box. Select the correct provider, and then click **OK**.
5. Click the **IHS - Other** procedure code category button to open the **Select Procedure Code** dialog box. Select the broken or canceled appointment code, and then click **OK**.

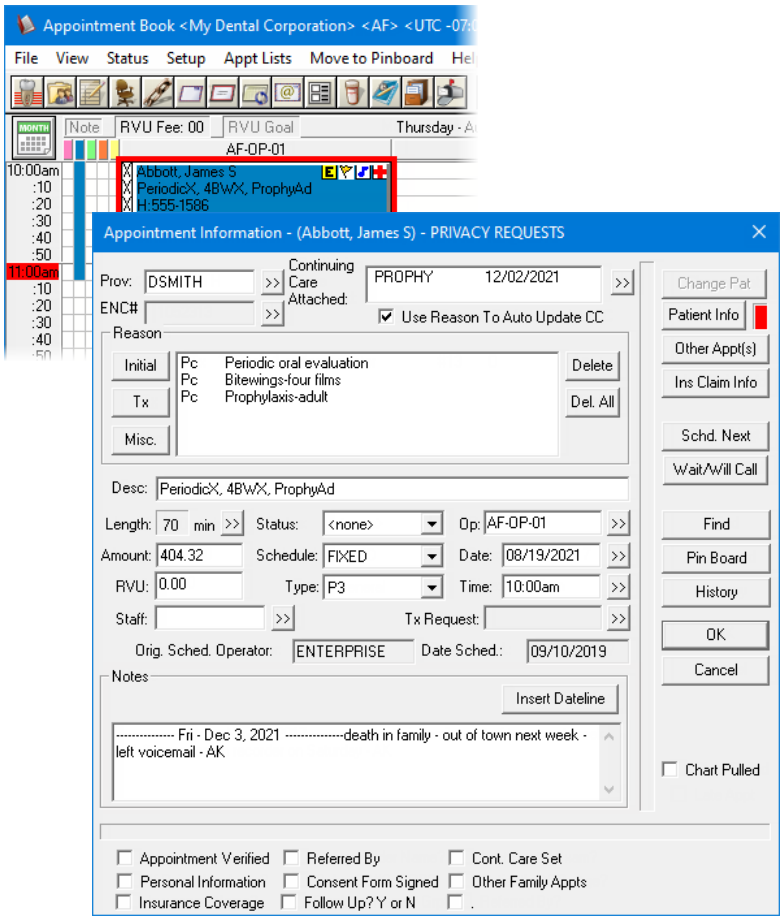


6. Click **Comp** to complete the code. The code and description are displayed in the progress notes, and the code will be sent to RPMS like any other completed code.



7. Update the appointment note:

8. Double-click a patient's appointment to open the **Appointment Information** dialog box.



9. Under **Notes**, click **Insert Dateline**, and then enter the reason for the broken or canceled appointment. Be sure to add your initials at the end of the note.

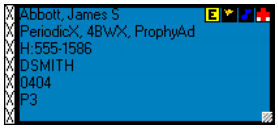
10. Also, as part of the note, enter the number of times this appointment has been missed and the next date the patient is allowed to be seen.

11. Click **OK** to save the note. The information in the note will stay with this appointment, for your reference, when you reschedule the patient.

12. Move the appointment to the Unscheduled List:

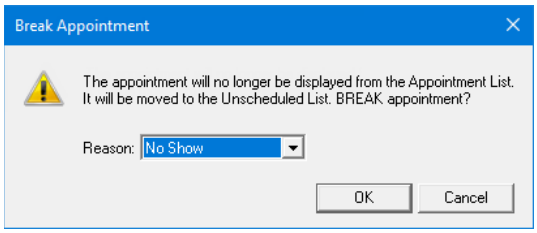
- **Break the appointment** – For no shows, last-minute cancelations with short notice, and patients arriving too late to be seen, use this method to move the appointment to the Unscheduled List.

  a. In Appointment Book, select the appointment.

  b. Click the **Break Appointment** button  .

  The **Break Appointment** dialog box appears.

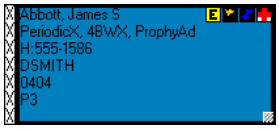
  

  c. Select a **Reason**.

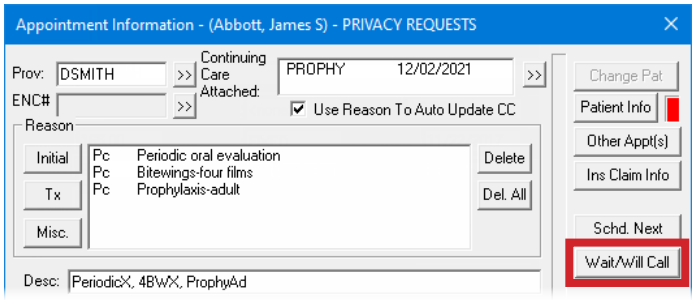
  d. Click **OK**.

- **Flag the appointment as "Wait/Will Call"** – When a cancellation is made with advanced notice or you must reschedule the appointment, use this method to move the appointment to the Unscheduled List

  a. In Appointment Book, double-click the appointment.

  The **Appointment Information** dialog box appears.

  b. Click **Wait/Will Call**.

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.

Rescheduling Broken or Canceled Appointments

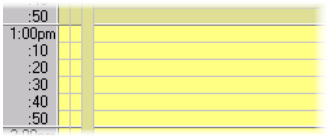
To help keep missed or canceled appointments from falling through the cracks, Dentrix Enterprise stores appointments that have been broken and appointments that have been flagged as Wait/Will Call on the Unscheduled List. You can use the Unscheduled List to fill gaps in your schedule to avoid missing out on valuable production. Also, if you contact a patient, or if a patient contacts you, to reschedule a broken or canceled appointment, you can quickly reschedule it from the Unscheduled List without having to re-enter the main details of that appointment.

Tip: If you attempt to schedule an appointment for a patient who has an appointment on the Unscheduled List, Dentrix Enterprise will ask if you want to view a list of that patient's appointments, which will include the unscheduled appointment. You can then reschedule that appointment without having to create a whole new appointment from scratch. However, if you don't take care of the unscheduled appointment, you will continue to receive messages that the patient has unscheduled appointments, and the Unscheduled List will have an appointment for treatment that may have already been scheduled or even performed. And, if the patient is contacted about rescheduling that treatment, it can make your office or the staff member doing the contacting seem somewhat unprofessional.

To reschedule a broken or canceled appointment

- When attempting to schedule an appointment (from the Family Appointment List)

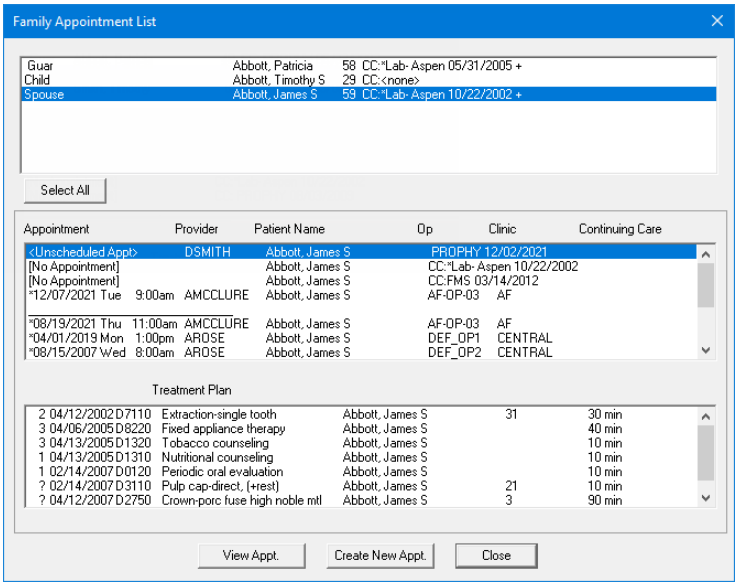
1. In Appointment Book, double-click an open time slot.



   The **Select Patient** dialog box appears.

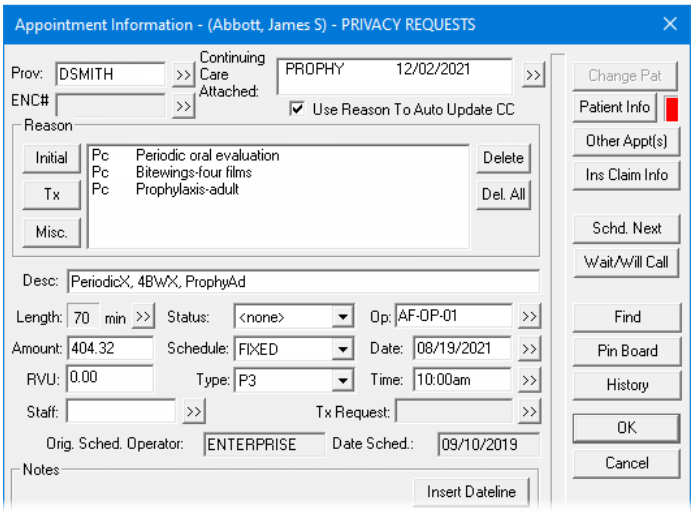
2. Search for the desired patient, and then double-click the patient name in the list of matches. If the patient has an unscheduled appointment, a message appears. To view the appointment list for the patient and other family members, click **Yes**.

   The **Family Appointment List** dialog box appears.

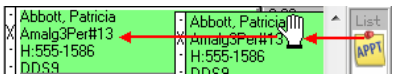


3. Select an unscheduled appointment (with "<Unscheduled Appt>" instead of a date and time) in the middle list box.
4. Click **View Appt**.

   The **Appointment Information** dialog box for the selected appointment appears.



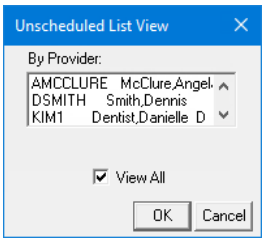
5. Click **Pin Board** to move the appointment to the Pinboard.
6. Drag the appointment to the desired date, time, and operatory on the schedule.



- From the Unscheduled List

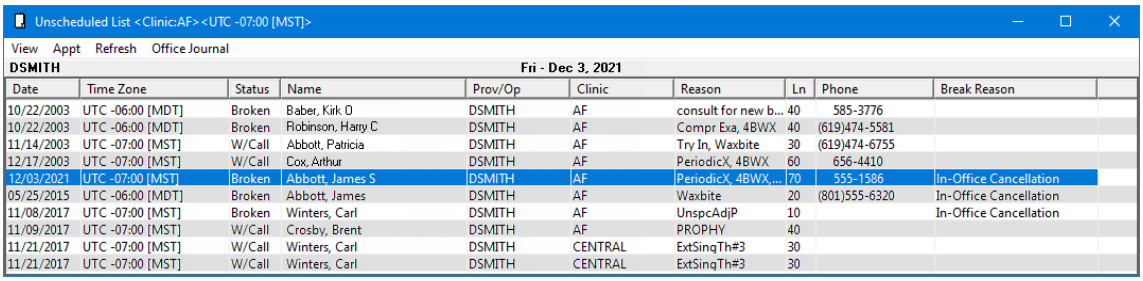
1. In Appointment Book, from the **Appt Lists** menu, point to **Unscheduled List**, and then click either **Current Clinic** (to view appointments for the clinic currently being viewed) or **All Clinics** (to view appointments for all clinics).

   The **Unscheduled List View** dialog box appears.



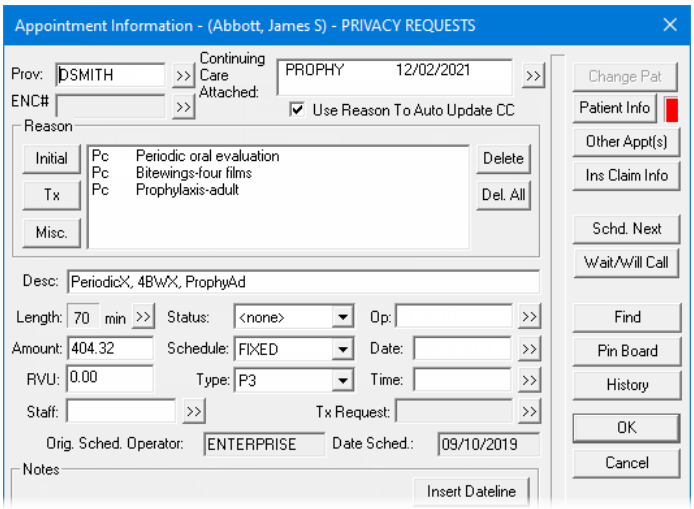
2. To filter the list by provider, select the desired providers; otherwise leave **View All** selected to not filter the list by provider. Then, click **OK**.

   The **Unscheduled List** window appears.

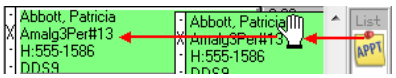


3. Double-click an appointment.

   The **Appointment Information** dialog box for that appointment appears.



4. Click **Pin Board** to move the appointment to the Pinboard.
5. Drag the appointment to the desired date, time, and operatory on the schedule.



Deleting Appointments

You can permanently delete an appointment from 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. The only time you should delete an appointment for a new patient is when that patient will not be coming to your office at all.

To delete an appointment

1. In Appointment Book, select the appointment you want to delete.
2. From the **File** menu, click **Delete Appointment**. On the confirmation message that appears, click **Yes**.

Changing a Patient's Default Dental Insurance Claim Settings

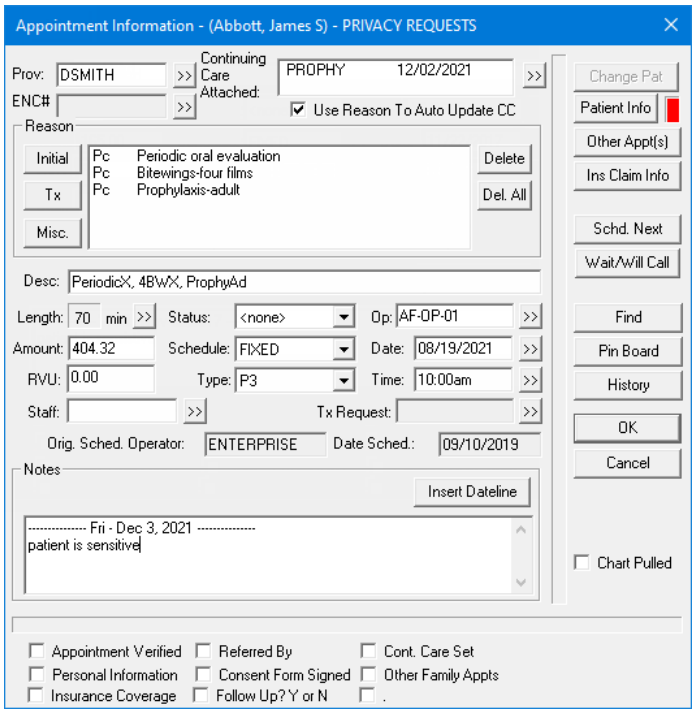
You can specify a patient's default dental insurance claim settings as needed. When a new dental insurance claim is created, Dentrix Enterprise uses the patient's default settings for that claim.

To change a patient's default dental insurance claim settings

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

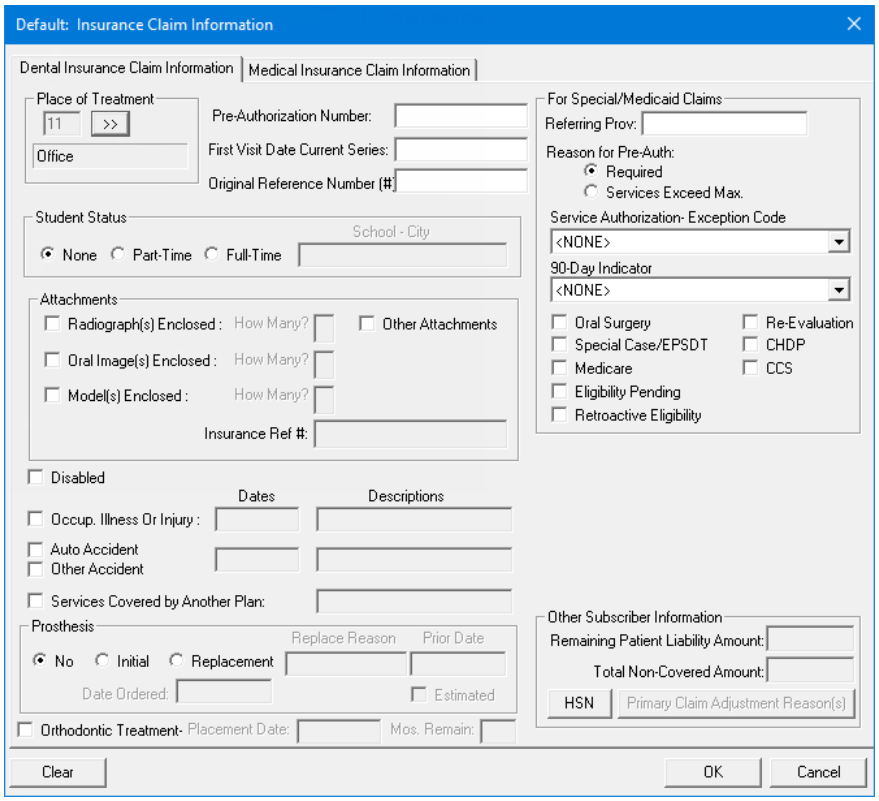


The **Appointment Information** dialog box appears.



2. Click **Ins Claim Info**.

The **Default: Insurance Claim Information** dialog box appears.

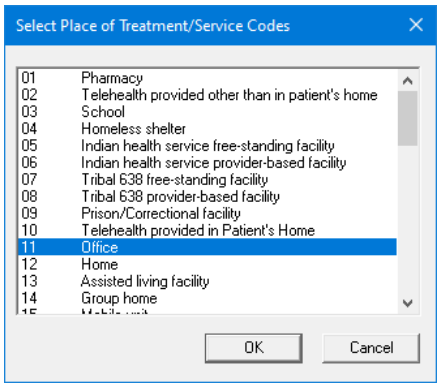


3. Change any of the following options as needed:

   - **Place of Treatment** – Where treatment is usually performed. To change the default place of treatment for this patient, do the following:

     a. Click the **Default** search button >>.

        The **Select Place of Treatment/Service Codes** dialog box appears.



     c. Select a place of treatment.

     d. Click **OK**.

     Note: You can change the default place of treatment for your organization. Also, you can override the organization-level default place of treatment per clinic.

   - **First Visit Date Current Series** – The first date of service for a series of treatments.

4. Click **OK**.

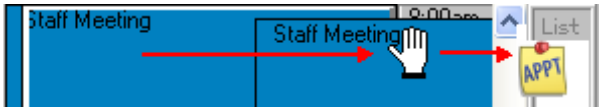
Managing Events

WithDentrix Enterprise, you can not only schedule events, but you can quickly perform other event-related tasks. This section will explain the following tasks:

- Rescheduling Events Using the Pin Board
- Editing Events
- Deleting Events

Rescheduling Events Using the Pin Board

You can drag a partial-day or all-day event to the pin board as a means to reschedule the event. A copy of the event will appear as an event icon on the pin board. To reschedule that pin board event, drag the icon to the desired date, time, and operatory.

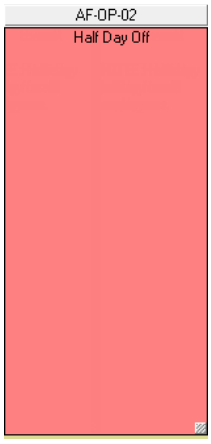


Editing Events

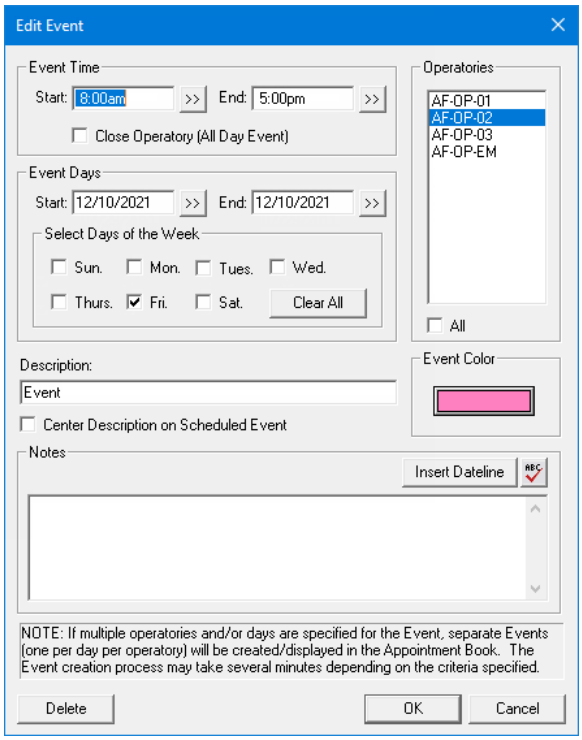
You can edit an event's details as needed. If the event is part of a series (an event that repeats at regular intervals), only the occurrence you are editing is affected.

To edit an event

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



The **Edit Event** dialog box appears.



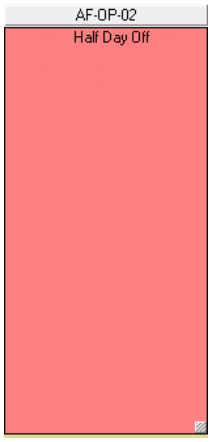
2. Edit the various event options as needed. For information on setting up event options, see "Scheduling Events" in this chapter.
3. Click **OK**.

Deleting Events

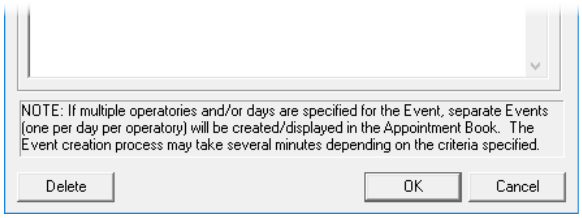
You can delete a single event or an event that is part of a series. You cannot delete a whole series of events at one time; you must delete each occurrence separately.

To delete an event

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



The **Edit Event** dialog box appears.



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

Generating Appointment Book Reports

There are two reports that can be printed directly from Appointment Book:

- Appointment Book View Report
- Route slip

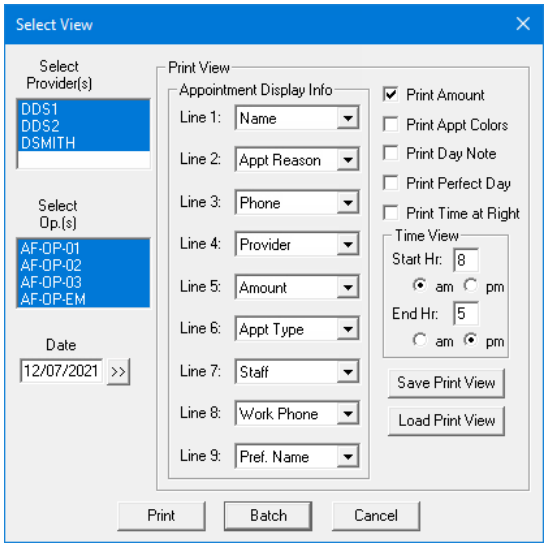
Appointment Book View Report

The Appointment Book View Report shows your daily schedule.

To print the Appointment Book View Report

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

   The **Select View** dialog box appears.



   Notes:

   - The current view in Appointment Book determines the default settings for the report.
   - If you have print settings saved on this computer, you can click **Load Print View** to apply those saved settings.
   - Saved print settings do not include provider or operatory selections.

2. 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 enter a new date in the **Date** box 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** – Enter the earliest hour of appointments that you want to print in the **Start Hr** box. Enter the latest hour of appointments that you want to print in the **End Hr** box. Click **am** or **pm** for both boxes.

3. If you want to save the current settings, except for the provider and operatory selections, for the next time you print the Appointment Book View, click **Save Print View**. You can save only one set of print options per computer.
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.

Route slip

The route slip provides up-to-date, comprehensive information for a patient. You can use the route slip as a reminder of medical alerts, patient notes, collection information, and so forth for patients being seen that day.

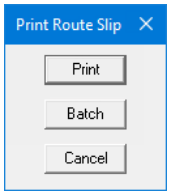
To print a single route slip for a patient

1. In Appointment Book, select an appointment.



2. From the **File** menu, click **Print Route Slip**.

   The **Print Route Slip** dialog box appears.



3. Click **Print** to send the route slip to the default printer for the Office Manager, or click **Batch** to send the route slip to the Batch Processor in the Office Manager.

Tip: To generate route slips for all scheduled patients, in the Office Manager, from the **Reports** menu, point to **Lists**, and then click **Daily Appointment List**. Set up the options, making sure the **Patient Route Slips** check box selected, and then click **OK**. For more information, see the "Daily Appointment List" topic in the Dentrix Enterprise Help.

Working with Notes in Appointment Book

You can attach important information directly to an appointment or date. This section covers the following topics on Appointment Book notes:

- Adding Appointment Notes
- Adding Appointment Book Day Notes

Adding Appointment Notes

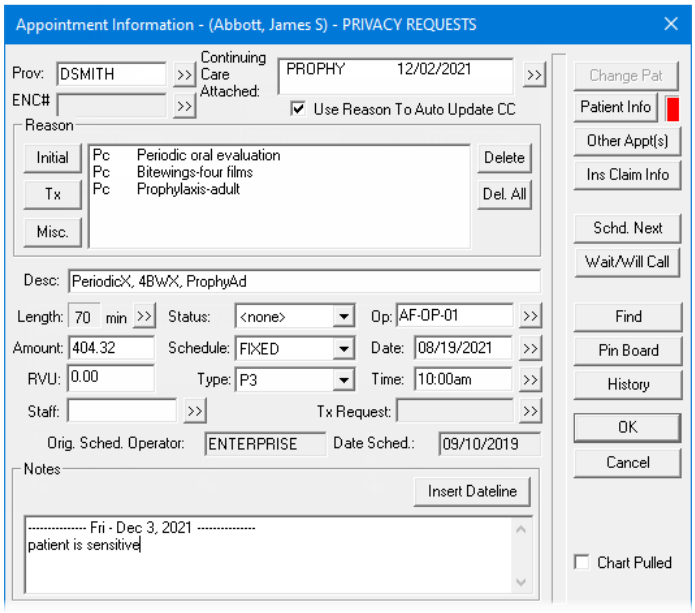
Appointment notes are attached directly to an appointment and usually reference special situations the office should be aware of before a patient is seen.

To add an appointment note

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



The **Appointment Information** dialog box appears.

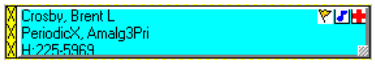


2. Enter a new note or change an existing note in the **Notes** box. Click **Insert Dateline** to date stamp the note.

   Tip: To insert a blank line or start a new line, while pressing the Ctrl key, press the Enter key.

3. Click **OK**.

   The appointment now as a blue musical note in the upper-right corner, indicating that the appointment has a note.



Adding Appointment Book Day Notes

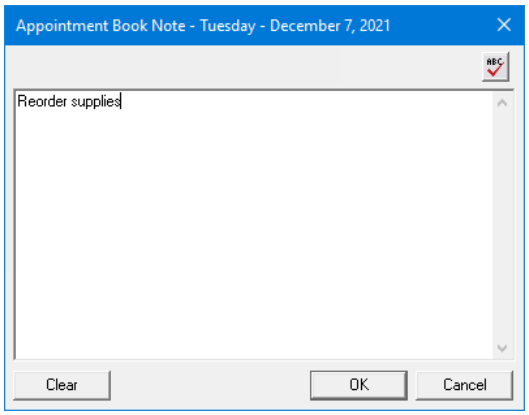
An Appointment Book day note can be created for each day of the year and is generally used as a reminder for a specific date (for example, to order supplies, to call a school about a hygiene class, or to attend a dental society meeting).

To add an Appointment Book day note

1. In Appointment Book, click the **Note** icon located in the upper-left corner of the schedule.



The **Appointment Book Note** dialog box appears.



2. Enter a note or reminder for the day.
3. Click **OK**.

The **Note** icon is now has a yellow background, indicating that the day has a note.



Using Perfect Day Scheduling

Many practice management consultants advocate a strategy of scheduling a day that consists of just the right balance of high production, medium production, and low production procedures. Dentrix Enterprise helps you achieve that perfect balance by allowing you to reserve certain times during the day by blocking those times for the scheduling of specific procedure types (for example, crowns or exams).

This section covers the following topics about setting up and using Perfect Day Scheduling:

- Customizing Appointment Types
- Customizing Procedure Codes
- Setting Up Perfect Day Scheduling Time Blocks
- Activating Perfect Day Scheduling
- Finding an Available Time Block

Customizing Appointment Types

The initial installation of Dentrix Enterprise includes four appointment types: General, High Production, Medium Production, Low Production. If necessary, you can delete or change these type and add more (up to a total of 10) in Practice Definitions. For information about setting up appointment types, see the "Practice Definitions" and "Customizing Appointment Types" topics in the Dentrix Enterprise Help.

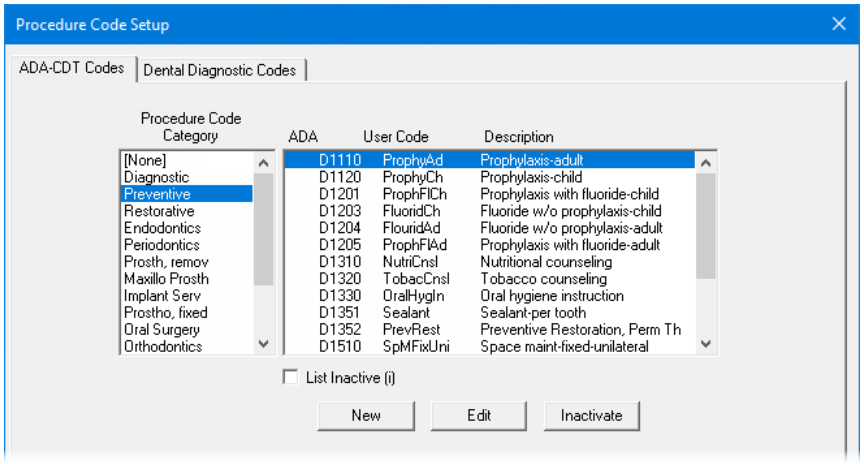
Customizing Procedure Codes

Each procedure code in Dentrix Enterprise can be assigned a default appointment type. Once a type has been properly designated for a procedure, Dentrix Enterprise automatically assigns the correct appointment type to any appointments scheduled using that procedure code. When you schedule an appointment in a Perfect Day Scheduling time block, Dentrix Enterprise verifies that the appointment's type matches the type permitted for that reserved time block.

To edit a procedure code

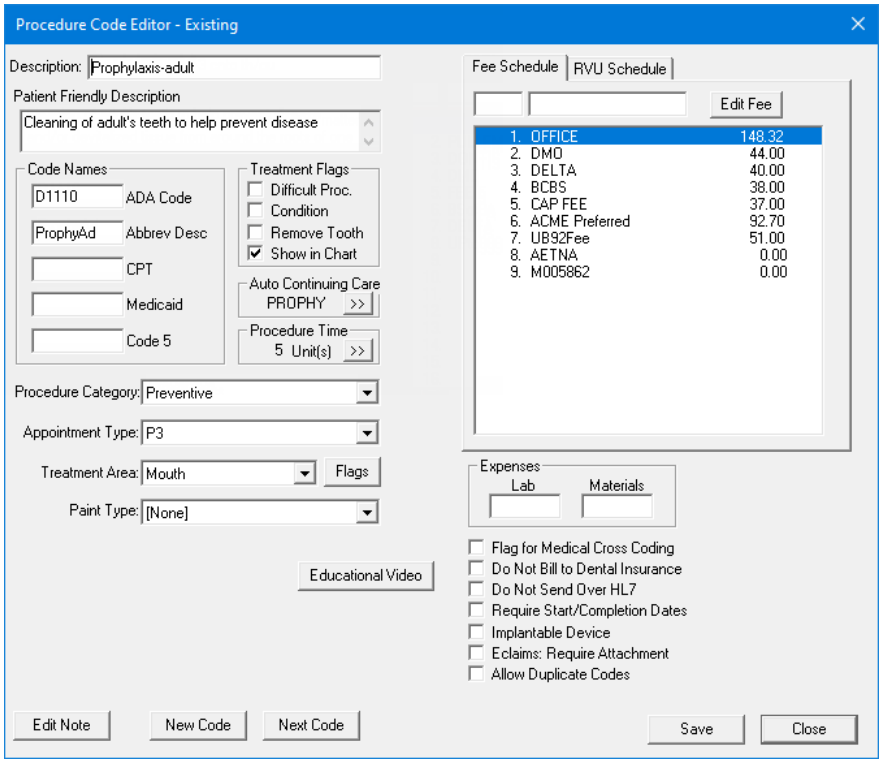
1. In Office Manager, from the **Maintenance** menu, point to **Practice Setup**, and then click **Procedure Code Setup**.

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



2. Select a **Procedure Code Category**. All procedure codes associated with that category appear in the list box to the right.
3. Select a procedure code, and then click **Edit**.

   The **Procedure Code Editor - Existing** dialog box appears.



4. Select an **Appointment Type**.
5. Click **Save**.

Setting Up Perfect Day Scheduling Time Blocks

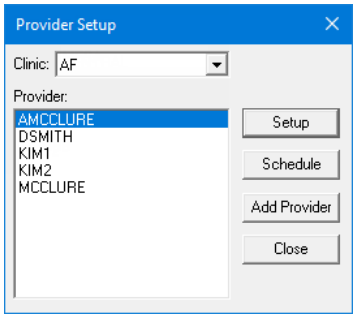
You can set up Perfect Day Scheduling time blocks for each provider. Each provider can have up to six time blocks. Also, be aware that each operatory can have up to 12 time blocks.

Note: The practical limit of time blocks between all providers in all clinics is 20; anymore than that can cause errors.

To set up a time block

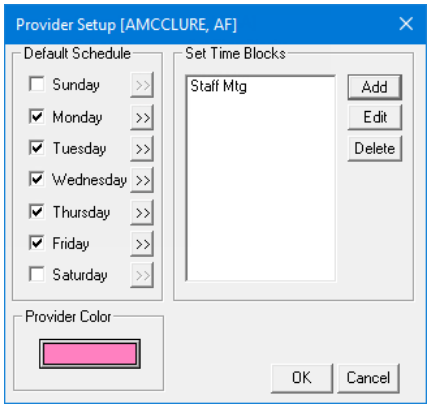
1. In Appointment Book, from the **Setup** menu, click **Provider Setup**.

   The **Provider Setup** dialog box appears.



2. Select a **Clinic**.
3. Select the provider for which you want to set a time block.
4. Click **Setup**.

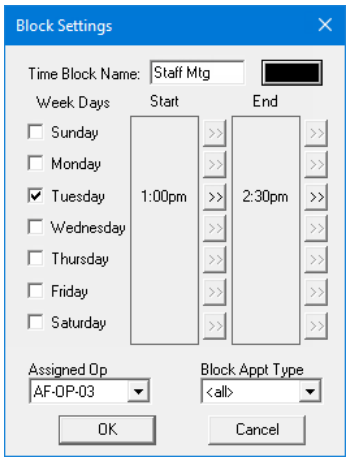
   The **Provider Setup** dialog box appears.



5. Under **Set Time Blocks,** click **Add** to add a new time block.

   Note: A provider can have up to six time blocks per clinic.

   The **Block Settings** dialog box appears.



6. Set up the following options:
   - **Time Block Name** – Enter a short description of the block's purpose (for example, "Crowns" or "Exams").

     Note: The name must be different than any other time blocks for this provider in the selected clinic only.

   - **Color** – Click the color button to the right of the **Time Block Name** box to choose a color to represent the time block.
   - **Week Days** – Select the days of the week for which you want to set the time block. Then, for each selected day, click the **Start** and **End** search buttons ›› to set the time range.

     Note: A given time block can occur only once per day.

   - **Assigned Op** – Select the operatory where the types of procedures for this time block are performed.
   - **Block Appt Type** – Select the appointment type you want to assign to this time block.
7. Click **OK** to return to the **Provider Setup** dialog box.
8. Click **OK**.

Activating Perfect Day Scheduling

To display the Perfect Day Scheduling time blocks in Appointment Book, you must activate Perfect Day Scheduling. If Perfect Day has not been activated, the defined time blocks do not appear in Appointment Book, and no warning will appear if anyone tries to schedule appointments during reserved time blocks.

To activate Perfect Day Scheduling

From the **File** menu, click **Perfect Day Scheduling**. If the **Perfect Day Scheduling** menu option has a check mark next to it, the feature is already activated.

Once Perfect Day Scheduling has been activated, Dentrix Enterprise will display the defined provider time blocks in Appointment Book. When you schedule an appointment in a defined time block, Dentrix Enterprise will check both the provider and the appointment type to verify that the provider and appointment type match what is allowed for that time block. If either the provider or the appointment type do not match, a warning message appears and asks if you want to override the time block setting and schedule the appointment.

To move a time block

Individual time blocks can be moved within their respective operatory by dragging the time block to the desired time.

To resize a time block

You can increase or decrease the size of the time block by clicking the bottom border of the time block and dragging up or down.

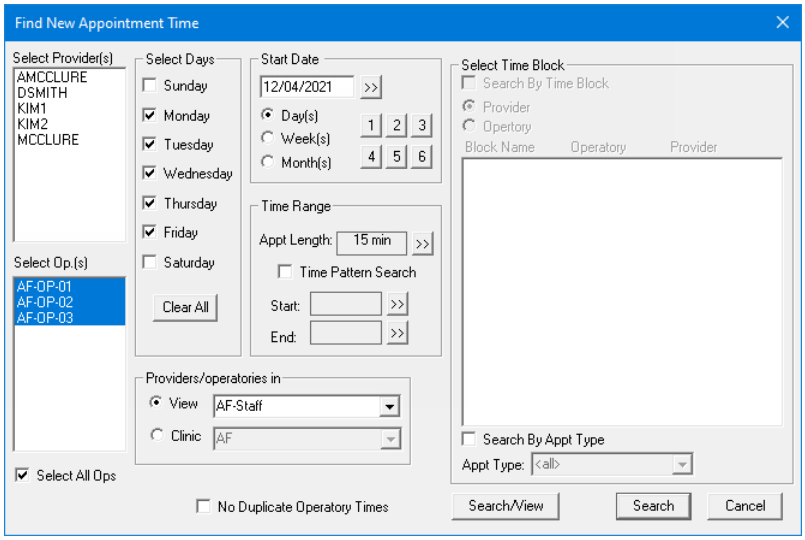
Finding an Available Time Block

You can locate the first available blocked time for the type of appointment you are scheduling.

To find the first available time block

1. In Appointment Book, click the **Find New Appointment Time** button  .

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



2. Set up your search criteria as explained in "Using the Find Appointment Tool" in this chapter. If you have Perfect Day Scheduling time blocks set up, select **Search By Time Block**, and then select the desired time block; or, select **Search By Appt Type,** and then select the desired **Appt Type**.
3. Click **Search/View** to see the available times for scheduling the appointment.

For information on previewing and scheduling appointments using the Find Appointment Tool, see "Using the Find Appointment Tool" in this chapter.

Chapter 4: Chart

The Dentrix Enterprise Chart can be used for entering and maintaining clinical records for your patients. Its complete chair-side integration makes it the perfect tool to simplify record keeping while giving you opportunity to take advantage of the newest technical innovations in dentistry. The Chart module consists of the following:

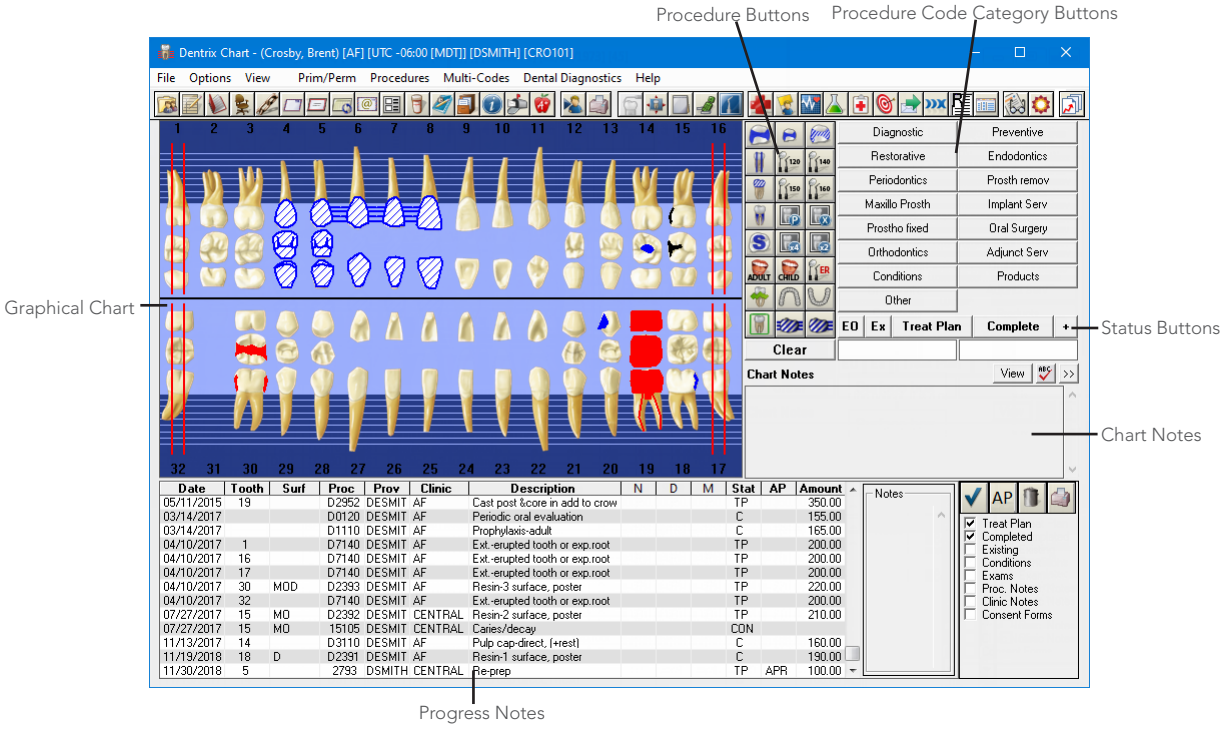
- **Chart** – Chart provides a quick and easy way to enter existing, recommended, and completed treatment or conditions. Dentrix Enterprise uses standard, easy-to-recognize textbook charting symbols. Treatment is color coded so that with a single glance at the patient's graphic chart, you can tell whether a procedure is a condition, existing, treatment-planned, or completed.
- **Clinical notes** – You can use clinical notes to document and track patient care. These notes can be attached to a patient as a clinical record. Dentrix Enterprise provides several template options (including customizable templates) to help make entering notes a simple process.
- **Treatment Planner** – You can use Treatment Planner to help explain and demonstrate proposed treatment to patients. Treatment Planner can be opened from Chart and Ledger. For more information about Treatment Planner, see Chapter 6: Treatment Planner.
- **Perio Chart** – Using customizable script settings, you can enter periodontal treatment information quickly and completely in Perio Chart. Information can be displayed graphically in Perio Chart, making it possible for patients to visually understand perio data. Perio Chart also provides a variety of letters for you to generate correspondence quickly for patients, referring dentists, and insurance consultants. For more information about the Perio Chart, see Chapter 5: Perio Chart.

This chapter covers the following topics:

- The Chart Window
- Setting Up Procedure Buttons
- Clearing the Patient in Chart
- Changing the Provider for a Charting Session
- Entering Treatment
- Editing Treatment
- Deleting Treatment
- Invalidating Procedures in History
- Changing the Displayed Dentition
- Setting the Default Dentition
- Entering Chart Notes
- Working with Clinical Notes
- Completing Oral Health Status Surveys
- OHSS – Electronic Screening Form and Report
- Printing from Chart

The Chart Window

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



This section covers the following topics to help you understand how to use Chart window:

- The Chart Toolbar
- The Graphical Chart
- The Procedure Buttons
- The Procedure Code Category Buttons
- The Status Buttons
- The Chart Notes
- The Progress Notes Panel

The Chart Toolbar

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



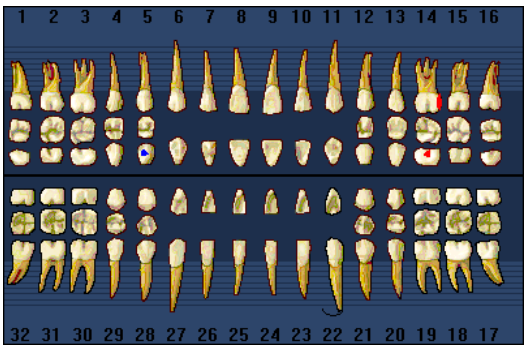
The function of the buttons specific to Chart are explained in the following table.

	Click the **MiPACS** button to open the **MiPACS Dental Enterprise Viewer** window for the selected patient.
	Click the **Select Patient** button to select a patient whose record you want to view in Chart.
	Click the **Print Dental Chart** button to print the patient chart for the selected patient.
	Click the **Work Chart** button to display the work chart view.
	Click the **Full Screen Chart** button to display the full screen chart view.
	Click the **Progress Notes** button to expand the **Progress Notes** panel to fill the **Chart** window.
	Click the **Treatment Planner** button to open Treatment Planner.
	Click the **Perio Chart** button to open Perio Chart.
	Click the **Clinical Notes** button to display any clinical notes for the selected patient.

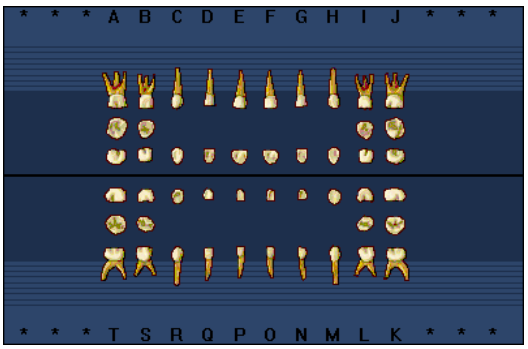
For a comprehensive explanation of all the buttons on the toolbar, see the “Using the Chart toolbar” topic in the Dentrix Enterprise Help.

The Graphical Chart

The graphical chart visually depicts the condition of the patient's mouth. Treatment is shown on the chart using textbook charting symbols. In addition, treatment is color-coded to indicate the status of the treatment. For example, completed work can be displayed in blue while recommended treatment can be displayed in red.



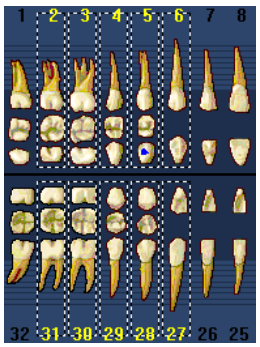
Permanent



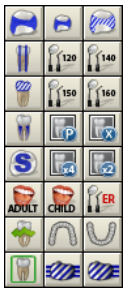
Primary

In the graphical chart, you can select the teeth you want to post treatment to by clicking the appropriate teeth. Selected teeth have a dotted box around each one.

Tip: To deselect teeth, click each tooth you want to deselect to remove the dotted box, or click **Clear** below the procedure buttons.



The Procedure Buttons



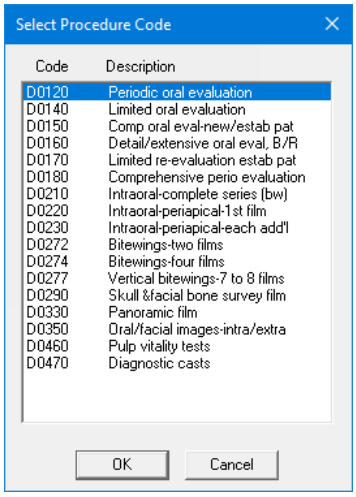
You can select the treatment to post with the procedure buttons. The 24 procedure buttons collectively represent the most common procedures performed in an operatory. Each user-definable button can represent a single ADA Procedure Code, Dental Diagnostic Code, multi-code, or condition.

The Procedure Code Category Buttons



You can select treatment to post from the procedure code category buttons.

Each of the procedure code category buttons opens a **Select Procedure Code** dialog box that displays a list of specific procedure codes for that category. For example, exam and X-ray codes are accessed from the **Diagnostic** category since those are diagnostic procedures.



The Status Buttons

The status buttons and boxes are used to specify the type of treatment being posted. Once posted, a treatment appears in the Progress Notes panel and is painted on the graphical chart (if a charting symbol is used in conjunction with the posted procedure) in the color assigned to that status.



The status buttons consist of the following options:

- **Existing Other** – The **EO** button is used when entering existing work performed by a provider outside of your practice. (Used almost exclusively when charting existing work for new patients).
- **Existing** – The **Ex** button is used when entering existing work performed by a provider within your practice. (Used almost exclusively when charting past work done by your office).
- **Treatment Plan** – The **Treat Plan** button is used to enter recommended treatment for a patient.
- **Completed** – The **Complete** button is used when entering completed work and conditions for a patient.
- **Auto-State** – This button is used to quickly assign several procedures the same status. After clicking the Auto-State button, the next button selected will remain selected until another procedure status buttons is selected. While the auto-state is turned off, the button has a plus sign (**+**). While the auto-state is turned on, the button remains depressed and has a minus sign (**-**).

  Important: If you do not turn off the auto-state when you finish charting for a patient, whatever status was selected will remain selected for the next patient's charting.

- **Surfaces** – This box shows the surfaces, if applicable, for the procedure being posted. You can enter a surface(s) in the box (multiple surfaces must be separated by commas).
- **Procedure Code** – This box shows the procedure code being posted. You can enter a procedure code in the box.

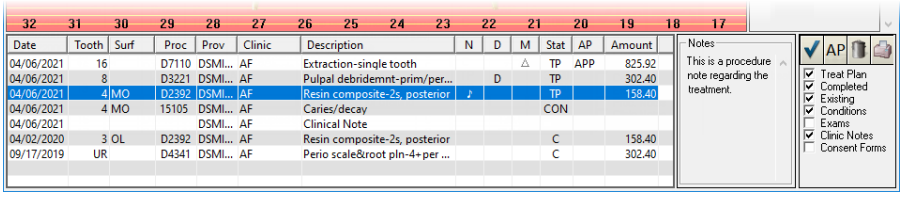
Tip: To clear the procedure code and treatment area(s) from the boxes and deselect any tooth/teeth that are selected on the graphical chart, click **Clear** below the procedure buttons.

The Chart Notes

The **Chart Notes** box can contain general notes regarding a patient's clinical chart. The notes will always be visible to anyone who opens the patient's Chart.

The Progress Notes Panel

Progress notes centralize documentation and exam information to help you quickly review a patient's history. If you are viewing the work chart view, the Progress Notes panel is located below the graphical chart. Progress notes are displayed in chronological order.

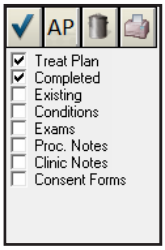


Each time a procedure, exam, condition, treatment plan, referral, or clinical note is posted in Chart, Dentrix Enterprise adds a line to the progress notes. For each item recorded in the progress notes, you will see the date the treatment was entered, treatment areas (if applicable), the procedure code, provider, a description, treatment status, treatment approval status, and the dollar amount associated with that procedure.

Notes:

- If a procedure has a note attached to it, a double arrow (>>) is visible to the right of the description.
- If a procedures has a referral attached to it, an "R" is added to the beginning of the treatment status.

You can use the controls on the Progress Notes panel to work with the items in the progress notes. The following table explains each control.

		Click the **Set Complete** button to mark the selected treatment-planned procedures as completed.
		Click the **Delete** button to remove the selected treatment-planned or existing procedures from Chart.
		Click the **Print Progress Notes** with Chart button to print the progress notes and graphical chart currently being viewed.
	Select the check boxes that correspond to what you want to have show in the progress notes: treatment-planned procedures, completed procedures, existing and existing other work, conditions, perio exams, procedures notes, clinical notes, and/or consent forms. **Note**: The next time Chart is opened, those same options will be used as the default view settings. Each computer on your office network can have different settings, and each Dentrix Enterprise user can have different settings on any given computer.	

Setting Up Procedure Buttons

Dentrix Enterprise provides you with 24 procedure buttons that can be used to quickly post procedures in Chart. This section covers the following topics about customizing the procedure buttons:

- Selecting Your Procedure Button Set
- Creating Your Own Custom Procedure Button Set

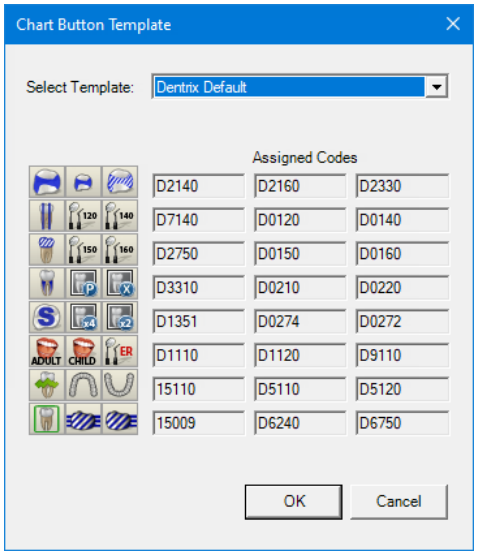
Selecting Your Procedure Button Set

Each user can choose which procedure button template to use as the default button set in Chart, unless a specific template has been set as the default for all users.

To select your procedure button set

1. In Chart, from the **File** menu, click **Setup Procedure Buttons**.

   The **Chart Button Template** dialog box appears.



2. From the **Select Template** list, select a template.
3. Click **OK**.

Creating Your Own Custom Procedure Button Set

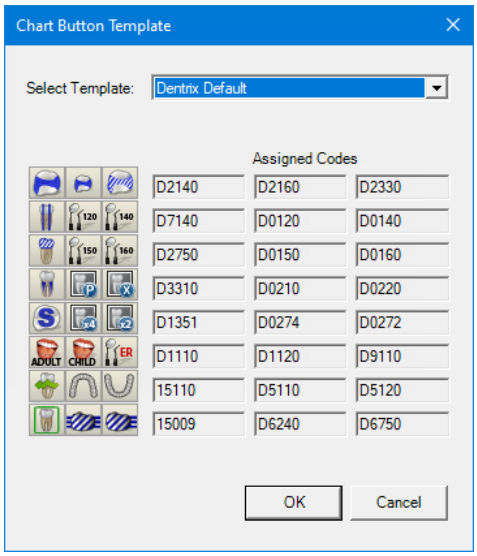
In Chart, each user can create a custom procedure button set from an existing template or the Dentrix Default template, unless a specific template has been set as the default for all users.

Note: If you edit an existing procedure button template from Chart, when you save the changes, that button set becomes your Custom template, overwriting any customizations you might have made previously to the Custom template. The original source template, which was set up from the Office Manager, is not affected.

To create your custom procedure button set

1. In Chart, from the **File** menu, click **Setup Procedure Buttons**.

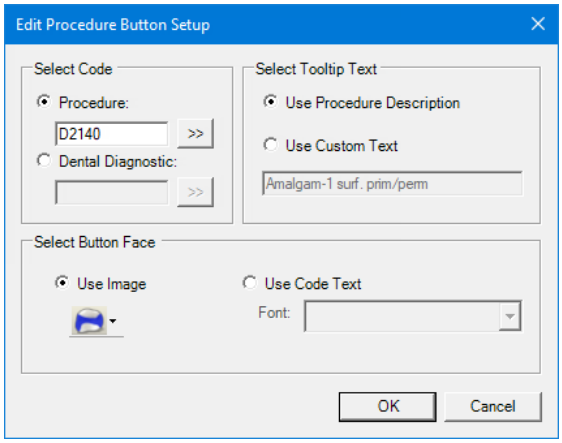
   The **Chart Button Template** dialog box appears.



2. From the **Select Template** list, select a template or **Custom**.
3. For each button that you want to customize, do the following:

   a. Click the button, such as  .

   The **Edit Procedure Button Setup** dialog box appears.



b. Under **Select Code**, select one of the following options:

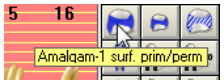
- **Procedure** – To assign a procedure code to the button. Then, either enter the desired procedure code (ADA, administrative, condition, or product code) or multi-code, or click the search button >> to select the desired code.
- **Dental Diagnostic** – To assign a dental diagnostic code to the button. Then, either enter the desired dental diagnostic code, or click the search button >> to select the desired code.

Notes:

- Dentrix Enterprise uses a smart-code feature. When you are charting a procedure code, depending on the surfaces or roots selected, the procedure will be updated when it is posted. For example, if you chart a one-surface amalgam (D2140) but select three surfaces, Dentrix Enterprise will automatically post the three-surface amalgam (D2160).
- With the smart-code feature, Dentrix Enterprise not only updates procedure codes based on surfaces and roots when posting resins and amalgams but also updates them by tooth number. For example, if you use a one-surface anterior resin procedure button when posting a three-surface resin to tooth 28, Dentrix Enterprise will update and post the procedure to reflect three surfaces and the posterior tooth.
- Because of the smart-code feature, you do not need to assign multiple variations of the same code, such as for amalgams or root canals, to your procedure buttons.

c. If you position your pointer over a procedure button, a tooltip will appear with identifying text for that button. Under **Select Tooltip Text**, select one of the following options:

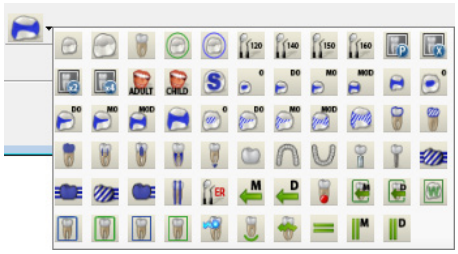
- **Use Procedure Description** – To use the procedure or diagnostic code's description in the tooltip.



- **Use Custom Text** – To use custom text in the tooltip. Then, enter the desired description in the box provided.

d. Under **Select Button Face**, select one of the following options:

- **Use Image** – To use a pre-defined graphic to identify the button. Then, from the button menu, click one of the 65 charting symbols that represent procedure codes.



- **Use Code Text** – To use the procedure or diagnostic code to identify the button. Then, select the desired **Font**.

  Tip: For best results, use a 6-point Arial font.

e. Click **OK**.

4. In the **Chart Button Template** dialog box, click **OK**.

Clearing the Patient in Chart

To protect the privacy of an individual patient, it may be wise to display a blank chart in your operatories while waiting for patients to arrive.

To display a blank chart

In Chart, from the **File** menu, click **Clear Patient**.

No patient information is displayed in Chart until another patient is selected.

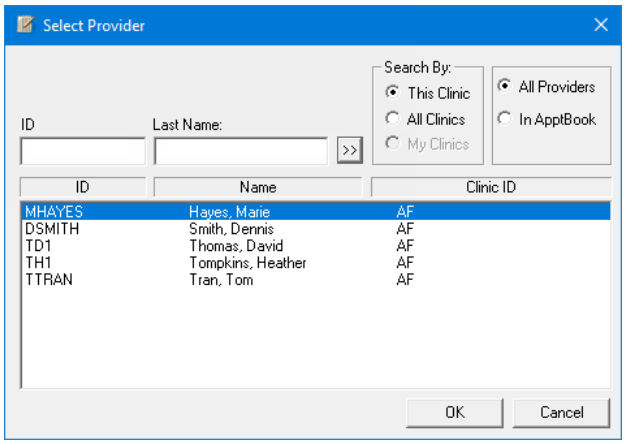
Changing the Provider for a Charting Session

By default, Dentrix Enterprise assigns all treatment posted in Chart during a patient's charting session according to the default chart provider setting in the **Practice Defaults** dialog box. However, you can select a different provider for the current charting session. All procedures posted during the current charting session will be assigned to the selected provider. The next time a patient is selected, work will automatically return to the default chart provider.

To change the provider for a charting session

1. In 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.

Entering Treatment

This section covers the following topics on how to chart treatment in Chart:

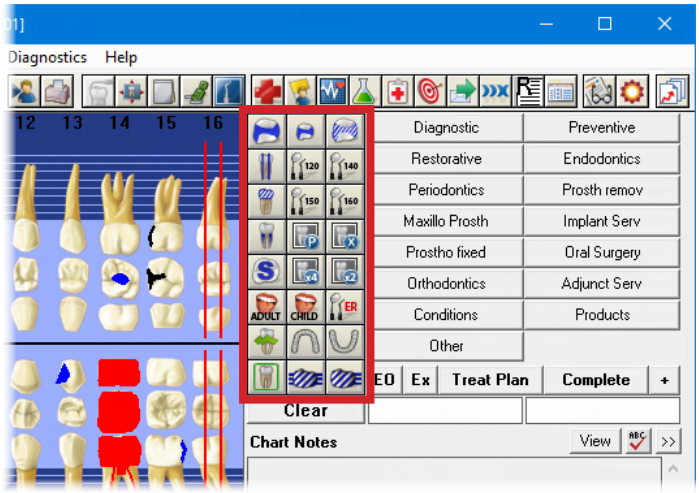
- Charting Treatment with Procedure Buttons
- Charting Treatment with Procedure Code Category Buttons
- Charting Treatment with the Auto-State Button
- Charting Supernumerary Teeth
- Charting Conditions and Existing Treatment

Charting Treatment with Procedure Buttons

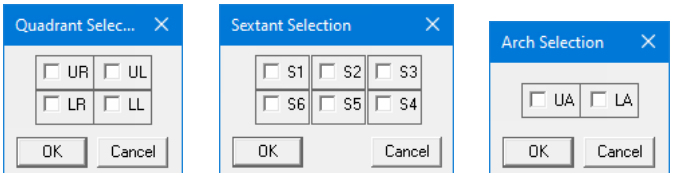
You can chart treatment, with the procedure buttons if the procedure (an ADA code, a condition, a Dental Diagnostic code, or a multi-code) for the treatment you want to enter is assigned to a procedure button. Procedure buttons are customizable and user specific, so any procedures you use frequently are readily accessible at the click of a button.

To chart treatment with a procedure button

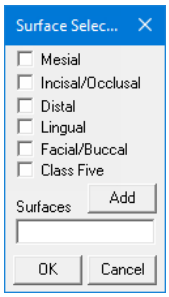
1. In Chart, with a patient selected, if the treatment you are entering requires a tooth number, select the appropriate tooth/teeth in the graphical chart.



2. Click a procedure button.
3. 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**.



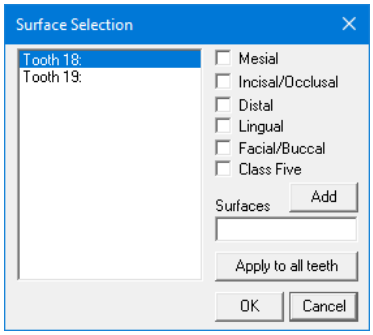
- If the selected procedure requires the selection of surfaces, the **Surface Selection** dialog box appears. Do one of the following:
  - If one tooth is selected:



    a. Select the applicable treatment areas.

    b. Click **OK**.

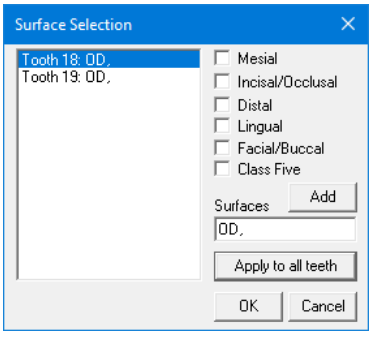
  - If multiple teeth are selected:



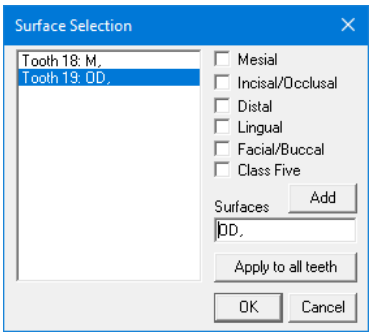
    a. With the first tooth selected in the list on the left, select the check boxes of the applicable surfaces, and then click **Add**.

    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**.

4. Click the applicable status button for the procedure being entered:

- **EO** – Use when entering existing work performed by a provider outside of your practice.
- **Ex** – Use when entering existing work performed by a provider within your practice.
- **Treat Plan** – Use when entering recommended treatment for a patient.
- **Complete** – Use when entering completed work and conditions for a patient.

The procedure is posted to the selected tooth/teeth. The procedure is added to the graphical chart (if a charting symbol is used in conjunction with the posted procedure) and the progress notes.

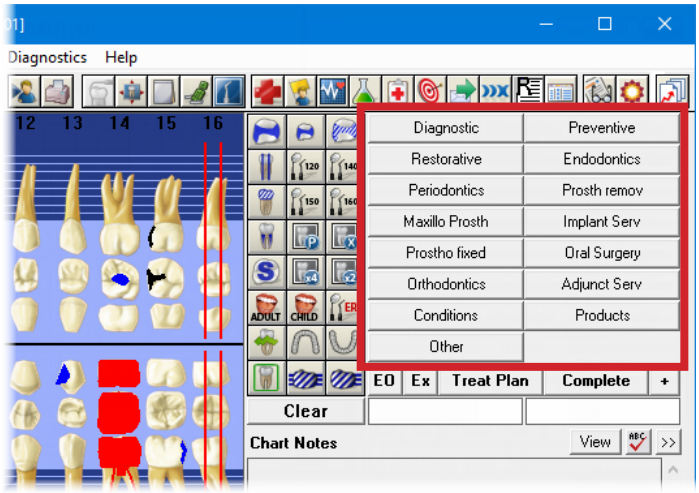
Note: All completed work posted in Chart is automatically posted to the Ledger, and the appropriate charges are listed on the patient's account. Similarly, all treatment-planned work is automatically posted to the Ledger-Treatment Plan.

Charting Treatment with Procedure Code Category Buttons

You can chart treatment with procedure code category buttons if the procedure for the treatment you want to enter is not assigned to a procedure button but is assigned to a procedure code category button.

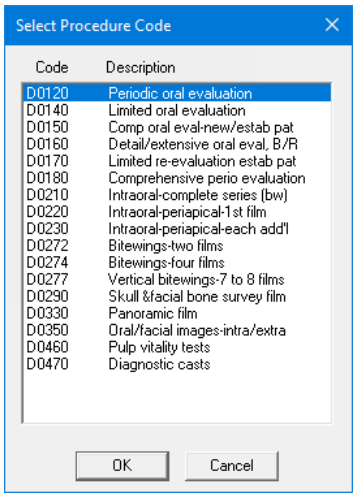
To chart treatment with a procedure code category button

1. In Chart, with a patient selected, if the treatment you are entering requires a tooth number, select the appropriate tooth/teeth in the graphical chart.



2. Click a procedure code category button.

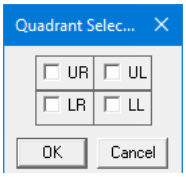
   The **Select Procedure Code** dialog box appears.

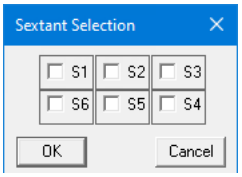


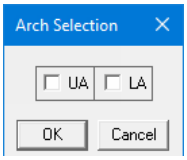
3. Select the desired procedure code, and then click **OK**.

   Note: Procedures are only available on the **Procedure Code Categories** panel if those procedures have been assigned to a procedure code category other than "None" and set up to be shown in Chart from the **Procedure Code Editor** dialog box. For details about setting up procedure codes, see "Editing Procedure Codes" in Chapter 1: Introduction and Initial Setup.

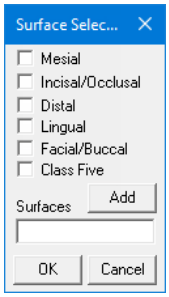
4. Do one of the following:
   - If the selected procedure requires the selection of quadrants, sextants, or arches, the **Quadrant Selection**, **Sextant Selection**, or **Arch Selection** dialog box appears. Select the applicable treatment areas, and then click **OK**.







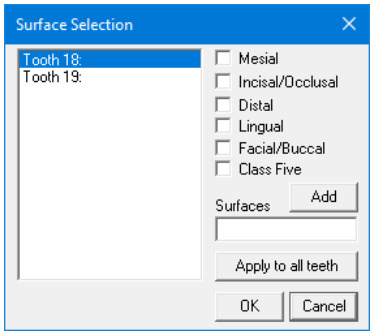
   - If the selected procedure requires the selection of surfaces, the **Surface Selection** dialog box appears. Do one of the following:
     - If one tooth is selected:



       a. Select the applicable treatment areas.

       b. Click **OK**.

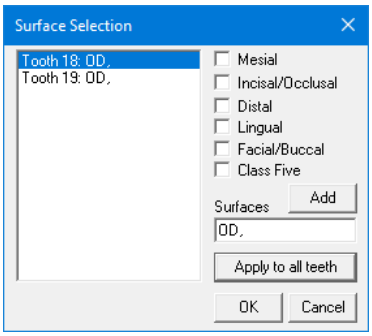
     - If multiple teeth are selected:



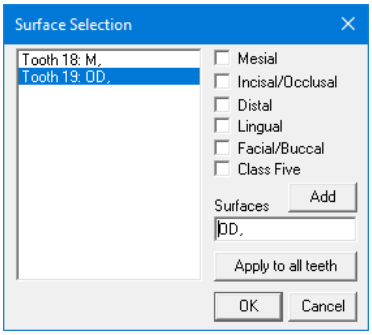
       a. With the first tooth selected in the list on the left, select the check boxes of the applicable surfaces, and then click **Add**.

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 applicable status button for the procedure being entered:

- **EO** – Use when entering existing work performed by a provider outside of your practice.
- **Ex** – Use when entering existing work performed by a provider within your practice.
- **Treat Plan** – Use when entering recommended treatment for a patient.
- **Complete** – Use when entering completed work and conditions for a patient.

The procedure is posted to the selected tooth/teeth. The procedure is added to the graphical chart (if a charting symbol is used in conjunction with the posted procedure) and the progress notes.

Note: All completed work posted in Chart is automatically posted to the Ledger, and the appropriate charges are listed on the patient's account. Similarly, all treatment-planned work is automatically posted to the Ledger-Treatment Plan.

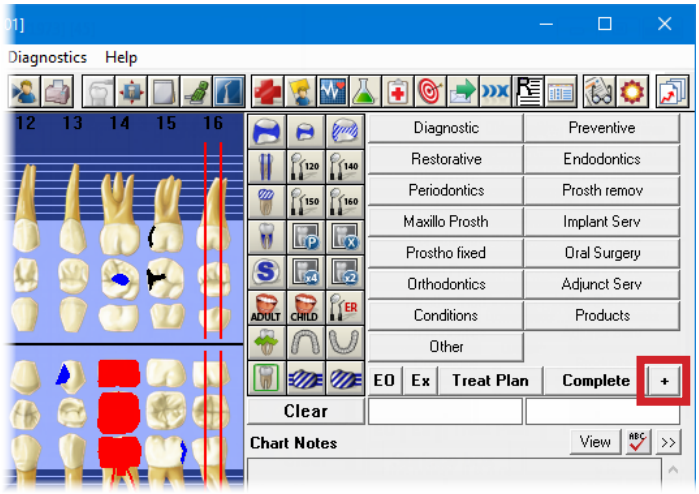
Charting Treatment with the Auto-State Button

In most offices, charting is entered in order by treatment status. For example, during a new patient exam, the treatment provider might first chart existing work and conditions. Once existing work has been charted, the provider might then enter work that needs to be completed (treatment-planned). Finally, work completed that day will be entered.

To make charting in this manner easier, Dentrix Enterprise provides the **Auto-State** button. To save you the extra step of entering the status for each procedure individually, the **Auto-State** button keeps the status button of the type of treatment you are charting selected and assigns that status to procedures entered.

To chart treatment with the Auto-State button

1. In Chart, with a patient selected, click the **Auto-State** button (**+**).



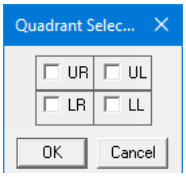
2. Leave the **Treat Plan** button selected, or click the status button that corresponds to the type of work you want to chart:
   - **EO** – Use when entering existing work performed by a provider outside of your practice.
   - **Ex** – Use when entering existing work performed by a provider within your practice.
   - **Treat Plan** – Use when entering recommended treatment for a patient.
   - **Complete** – Use when entering completed work and conditions for a patient.

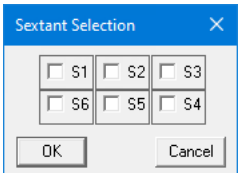


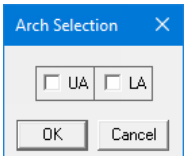
   Note: The selected status button will remain selected until another procedure status buttons is selected.

3. If the treatment you are entering requires a tooth number, select the appropriate tooth/teeth in the graphical chart.
4. Specify the desired treatment by using a procedure button (or a procedure code category button, the **Procedures** menu, or the **Multi-codes** menu).

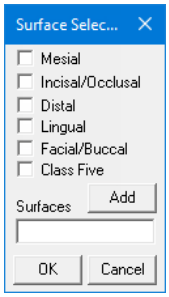
5. Do one of the following:
   - If the selected procedure requires the selection of quadrants, sextants, or arches, the **Quadrant Selection**, **Sextant Selection**, or **Arch Selection** dialog box appears. Select the applicable treatment areas, and then click **OK**.







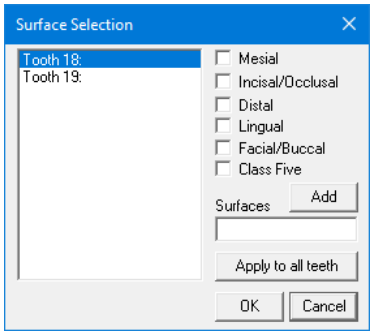
   - If the selected procedure requires the selection of surfaces, the **Surface Selection** dialog box appears. Do one of the following:
     - If one tooth is selected:



       a. Select the applicable treatment areas.

       b. Click **OK**.

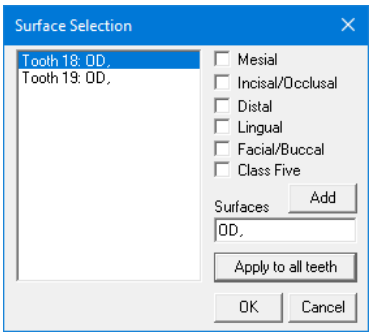
     - If multiple teeth are selected:



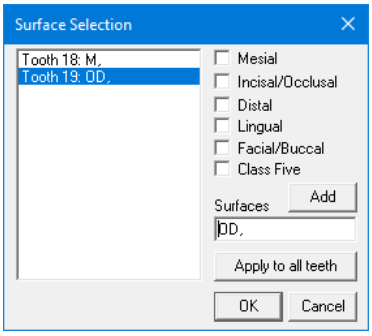
       a. With the first tooth selected in the list on the left, select the check boxes of the applicable surfaces, and then click **Add**.

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**.

6. Once you have posted all work for the selected status, click a different status button to enter work for that status, or click the **Auto-State** button (-) to turn off auto-state for the status buttons.

Charting Supernumerary Teeth

Because it is not possible to 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, based on the following ADA recommendations:

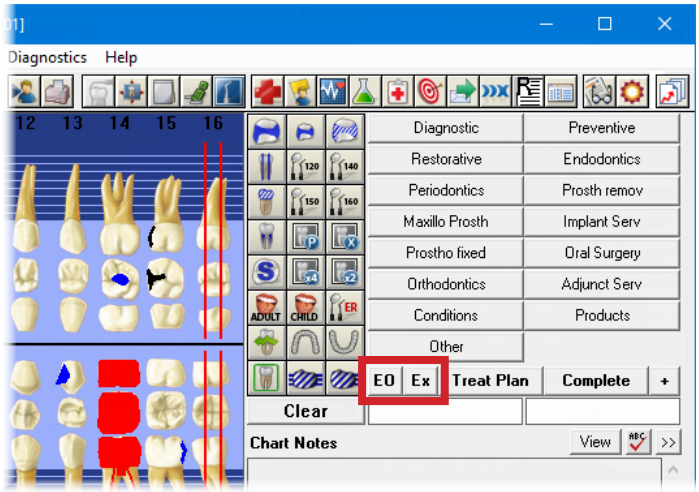
- **Permanent Teeth** – Add 50 to the tooth number nearest the supernumerary tooth (for example, 1 = 51, 2 = 52, 3 = 53, and 32 = 82).
- **Primary Teeth** – Add an "S" after the tooth letter nearest the supernumerary tooth (for example, A = AS, B = BS, C = CS, and T = TS).

Charting Conditions and Existing Treatment

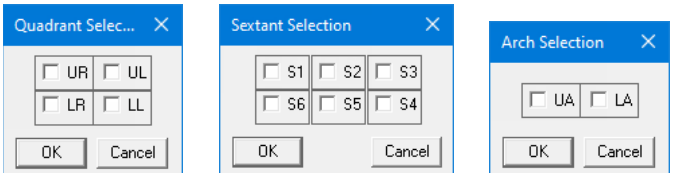
Charting a condition, such as an open contact or missing tooth, helps to provide an accurate representation of the patient's oral cavity in the graphical chart. For further accuracy, you can also chart existing treatment that was completed within or outside of your clinic network.

To chart a condition or existing treatment

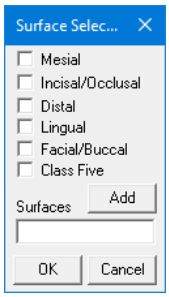
1. In Chart, with a patient selected, if the condition or existing treatment you are entering requires a tooth number, select the appropriate tooth/teeth in the graphical chart.



2. Do one of the following:
   - For existing treatment, specify it by using a procedure button (or a procedure code category button or the **Procedures** menu).
   - For a condition, click the **Conditions** procedure code category button, and then double-click a condition. (Or, click **Procedures** on the menu bar, click the **Conditions** category, and then double-click a condition.)
3. Do one of the following:
   - If the selected condition or 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**.



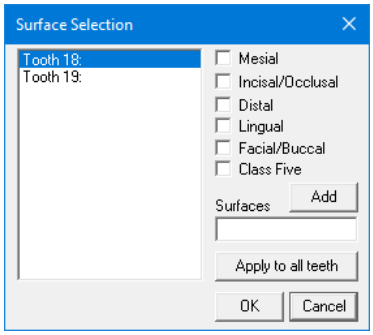
- If the selected condition or procedure requires the selection of surfaces, the **Surface Selection** dialog box appears. Do one of the following:
  - If one tooth is selected:



    a. Select the applicable treatment areas.

    b. Click **OK**.

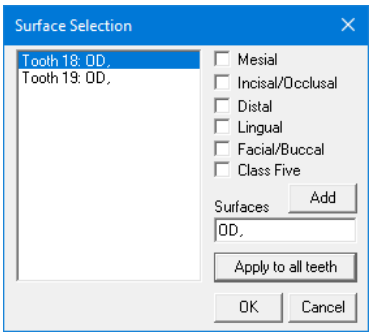
  - If multiple teeth are selected:



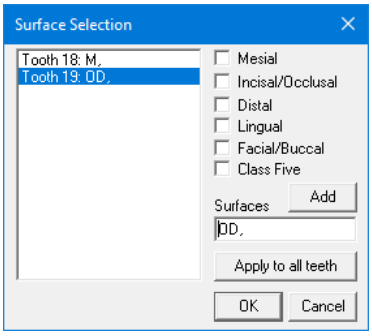
    a. With the first tooth selected in the list on the left, select the check boxes of the applicable surfaces, and then click **Add**.

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**.

4. Click the desired status button for the procedure being entered:

- **EO** – Use when entering existing work performed by a provider outside of your practice.
- **Ex** – Use when entering existing work performed by a provider within your practice.

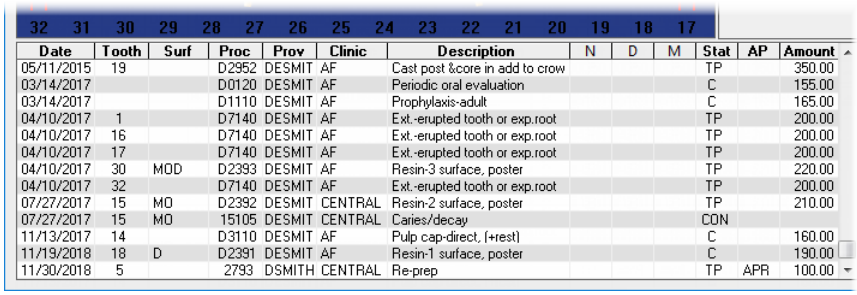
The condition or existing treatment is posted to Chart. The procedure is added to the graphical chart (if a charting symbol is used in conjunction with the posted condition or existing treatment) and to the progress notes as a condition or as an existing treatment.

Editing Treatment

After treatment has been entered into 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 an IHS-completed procedure, do not edit the procedure; delete it, and then re-enter it.

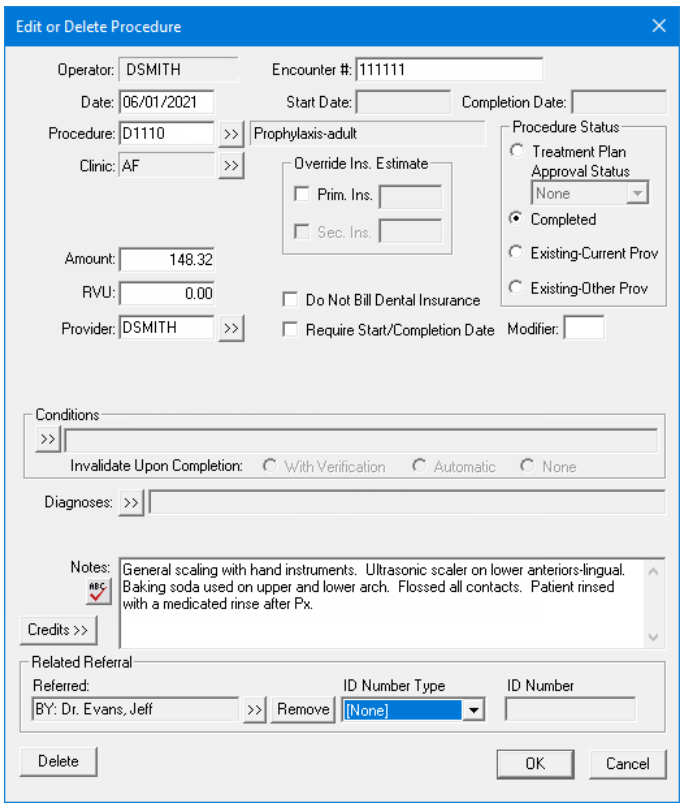
To edit treatment

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



Date	Tooth	Surf	Proc	Prov	Clinic	Description	N	D	M	Stat	AP	Amount
05/11/2015	19		D2952	DESMIT	AF	Cast post &core in add to crow				TP		350.00
03/14/2017			D0120	DESMIT	AF	Periodic oral evaluation				C		155.00
03/14/2017			D1110	DESMIT	AF	Prophylaxis-adult				C		165.00
04/10/2017	1		D7140	DESMIT	AF	Ext.-erupted tooth or exp.root				TP		200.00
04/10/2017	16		D7140	DESMIT	AF	Ext.-erupted tooth or exp.root				TP		200.00
04/10/2017	17		D7140	DESMIT	AF	Ext.-erupted tooth or exp.root				TP		200.00
04/10/2017	30	MOD	D2393	DESMIT	AF	Resin-3 surface, poster				TP		220.00
04/10/2017	32		D7140	DESMIT	AF	Ext.-erupted tooth or exp.root				TP		200.00
07/27/2017	15	MO	D2392	DESMIT	CENTRAL	Resin-2 surface, poster				TP		210.00
07/27/2017	15	MO	15105	DESMIT	CENTRAL	Caries/decay				CON		
11/13/2017	14		D3110	DESMIT	AF	Pulp cap-direct, (+rest)				C		160.00
11/19/2018	18	D	D2391	DESMIT	AF	Resin-1 surface, poster				C		190.00
11/30/2018	5		2793	DSMITH	CENTRAL	Re-prep				TP	APR	100.00

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



2. Make any necessary changes:
   - **Date** – Enter 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, enter 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** – Enter 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)

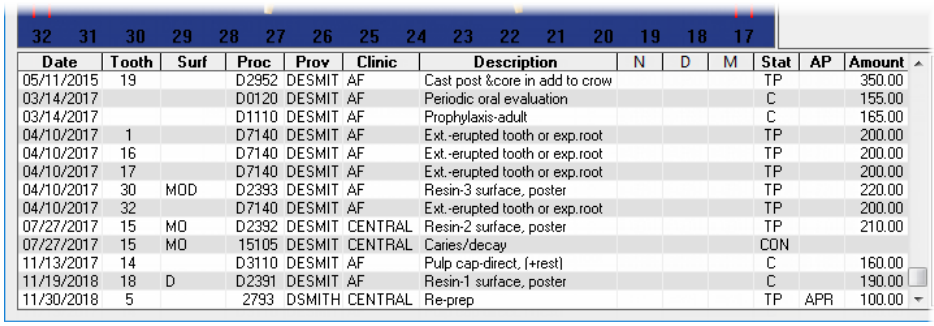
3. Click **OK**.

Deleting Treatment

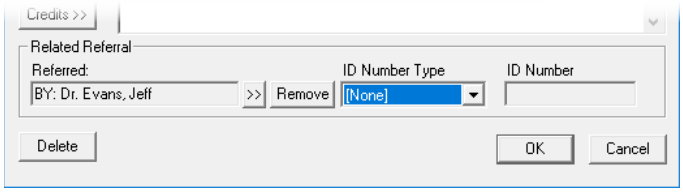
You can delete completed, treatment-planned, or existing procedures that were posted incorrectly unless the procedure is in history or attached to a claim. You can also delete conditions.

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

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



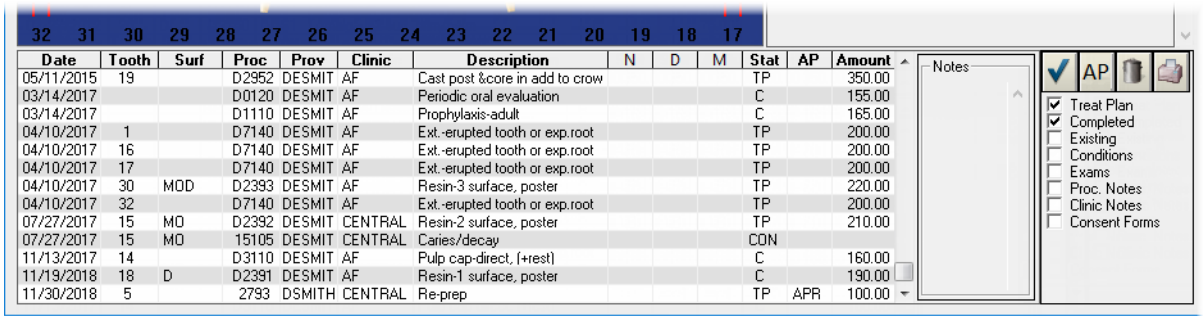
The **Edit or Delete Procedure** dialog box appears.



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

To delete treatment-planned or existing procedures

1. In 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.

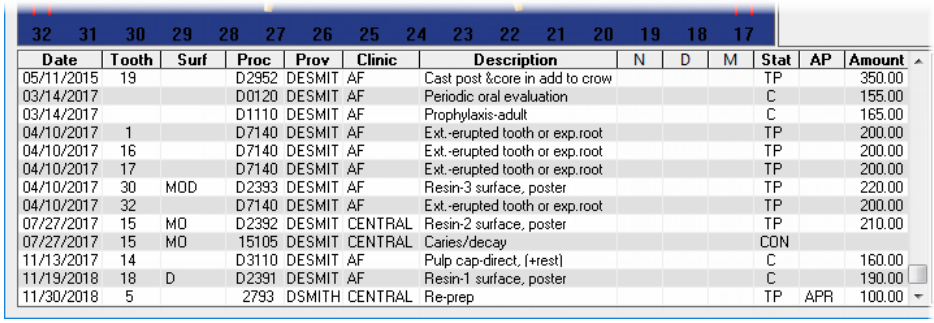
2. Click the **Delete** button  . On the confirmation message that appears, click **OK**.

Editing Conditions

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

To edit a condition

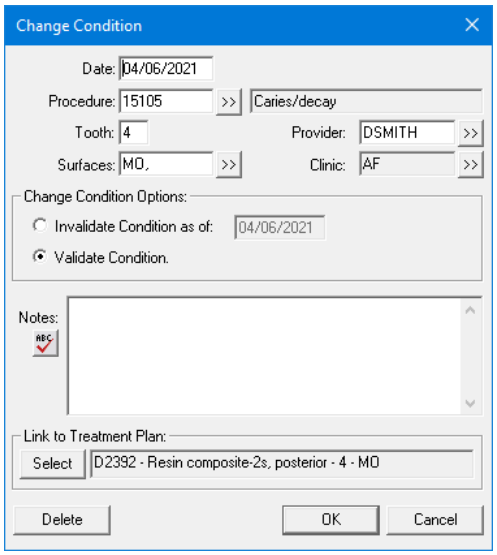
1. With a patient selected in Chart, on the **Progress Notes** panel, double-click the condition that you want to edit.



32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Date	Tooth	Surf	Proc	Prov	Clinic	Description	N	D	M	Stat	AP	Amount
05/11/2015	19		D2952	DESMIT	AF	Cast post &core in add to crow				TP		350.00
03/14/2017			D0120	DESMIT	AF	Periodic oral evaluation				C		155.00
03/14/2017			D1110	DESMIT	AF	Prophylaxis-adult				C		165.00
04/10/2017	1		D7140	DESMIT	AF	Ext.-erupted tooth or exp.root				TP		200.00
04/10/2017	16		D7140	DESMIT	AF	Ext.-erupted tooth or exp.root				TP		200.00
04/10/2017	17		D7140	DESMIT	AF	Ext.-erupted tooth or exp.root				TP		200.00
04/10/2017	30	MOD	D2393	DESMIT	AF	Resin-3 surface, poster				TP		220.00
04/10/2017	32		D7140	DESMIT	AF	Ext.-erupted tooth or exp.root				TP		200.00
07/27/2017	15	MO	D2392	DESMIT	CENTRAL	Resin-2 surface, poster				TP		210.00
07/27/2017	15	MO	15105	DESMIT	CENTRAL	Caries/decay				CON		
11/13/2017	14		D3110	DESMIT	AF	Pulp cap-direct, (+rest)				C		160.00
11/19/2018	18	D	D2391	DESMIT	AF	Resin-1 surface, poster				C		190.00
11/30/2018	5		2793	DSMITH	CENTRAL	Re-prep				TP	APR	100.00

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**.

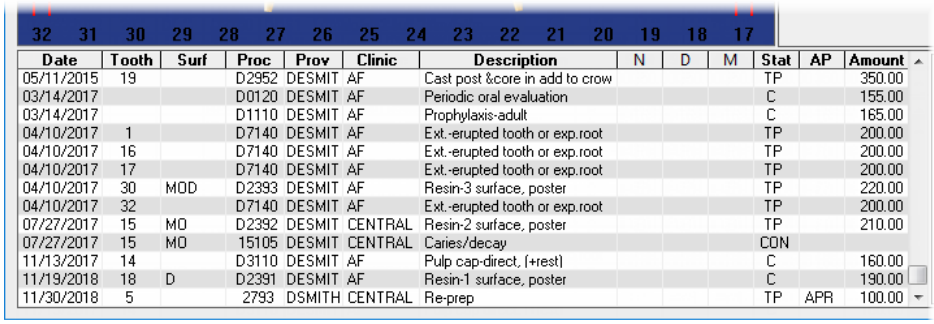
Invalidating Procedures in History

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, 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.

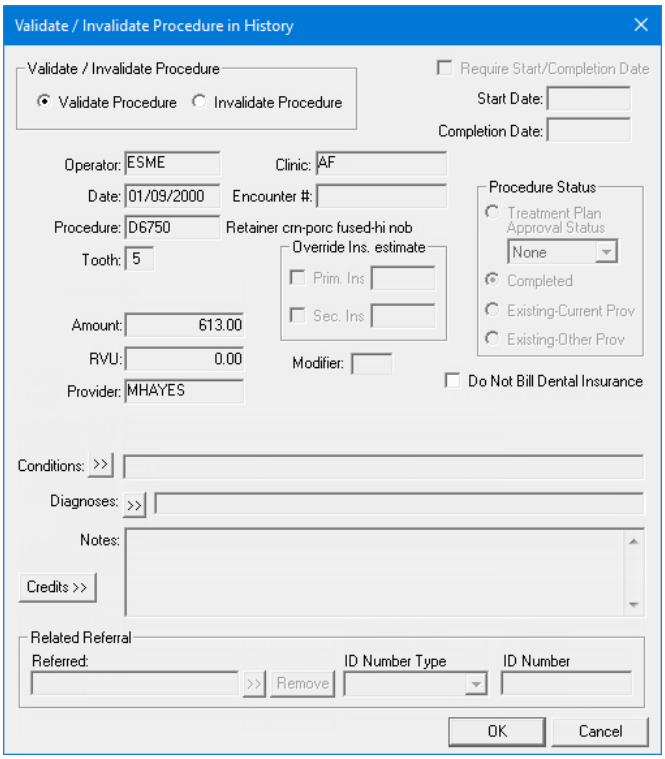
To invalidate a procedure

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



Date	Tooth	Surf	Proc	Prov	Clinic	Description	N	D	M	Stat	AP	Amount
05/11/2015	19		D2952	DESMIT	AF	Cast post &core in add to crow				TP		350.00
03/14/2017			D0120	DESMIT	AF	Periodic oral evaluation				C		155.00
03/14/2017			D1110	DESMIT	AF	Prophylaxis-adult				C		165.00
04/10/2017	1		D7140	DESMIT	AF	Ext.-erupted tooth or exp.root				TP		200.00
04/10/2017	16		D7140	DESMIT	AF	Ext.-erupted tooth or exp.root				TP		200.00
04/10/2017	17		D7140	DESMIT	AF	Ext.-erupted tooth or exp.root				TP		200.00
04/10/2017	30	MOD	D2393	DESMIT	AF	Resin-3 surface, poster				TP		220.00
04/10/2017	32		D7140	DESMIT	AF	Ext.-erupted tooth or exp.root				TP		200.00
07/27/2017	15	MO	D2392	DESMIT	CENTRAL	Resin-2 surface, poster				TP		210.00
07/27/2017	15	MO	15105	DESMIT	CENTRAL	Caries/decay				CON		
11/13/2017	14		D3110	DESMIT	AF	Pulp cap-direct, [+rest]				C		160.00
11/19/2018	18	D	D2391	DESMIT	AF	Resin-1 surface, poster				C		190.00
11/30/2018	5		2793	DSMITH	CENTRAL	Re-prep				TP	APR	100.00

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 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.

Changing the Displayed Dentition

Whether the patient you have in the chair has all primary teeth, all permanent teeth, or mixed dentition, you want your charting software to show a true representation of each patient's mouth. To achieve this accuracy in a patient's clinical record, the Dentrix Chart allows you to customize the dentition that appears on a patient-by-patient basis. You can quickly switch between primary and permanent dentition for all teeth at once or for selected teeth.

To change the dentition being displayed in the graphical chart

1. In Chart, with a patient selected, if you are changing the dentition for certain teeth, select those teeth. If you are changing the dentition for all teeth, you do not have to select any teeth.
2. From the **Prim/Perm** menu, click one of the following options:
   - **Change All** – Reverses the primary/permanent state for all teeth. For example, if all teeth have been changed to primary and the **Change All** option is clicked, all the teeth in the mouth will change to permanent.
   - **Change Selected –** Reverses the primary/permanent state for the selected teeth in the graphical chart.

Setting the Default Dentition

You can indicate whether you want Chart to open with primary or permanent dentition that is being displayed in the graphical chart for all patients by default.

To set the default dentition

In Chart, with a patient selected, from the **Prim/Perm** menu, click one of the following options (the option with the check mark is the default dentition currently being used):

- **Default to Permanent** – Changes all the teeth in the graphical chart to permanent dentition. Also, every time you open Chart, the graphical chart will display all permanent teeth, even if you select a patient that does not have any permanent teeth or that has mixed dentition.
- **Default to Primary –** Changes all the teeth in the graphical chart to primary dentition. Also, every time you open Chart, the graphical chart will display all primary teeth, even if you select a patient that does not have any primary teeth or that has mixed dentition.

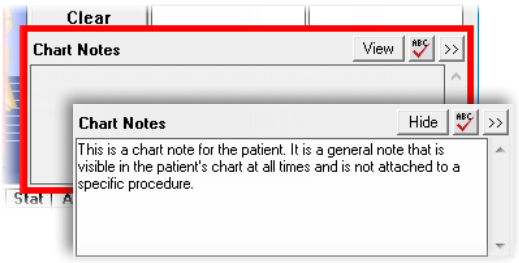
Then, on a patient-by-patient basis, you can change the dentition as explained in "Changing the Displayed Dentition" on this page.

Entering Chart Notes

You can enter a general note regarding a patient's clinical chart directly in that patient's Chart while performing work on that patient. The note will always be visible to anyone who opens that patient's Chart.

To enter a chart note

With a patient selected in Chart, next to **Chart Notes**, click **View** (if the notes are currently hidden) to allow for text entry in the box, and then enter notes for the patient.



Note: Alternatively, you can click the **More** button >>, enter notes in the **Edit Chart Notes** dialog box that appears, and then click **OK**.

Working with 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.

Tip: You can access a patient's clinical notes from not only Chart but the Ledger and Family File.

This section covers the following topics about clinical notes:

- Adding Clinical Notes
- Adding Clinical Notes Using Templates
- Editing Clinical Notes
- Adding an Addendum to a Clinical Note
- Printing Clinical Notes
- Signing Clinical Notes

Adding Clinical Notes

Clinical notes are notes for a patient's exam and/or treatment that are not specific to a procedure. You can add notes by typing them from scratch. Once a clinical note has been signed or is in history, it cannot be edited or deleted. However, an addendum can be made to a clinical note in history.

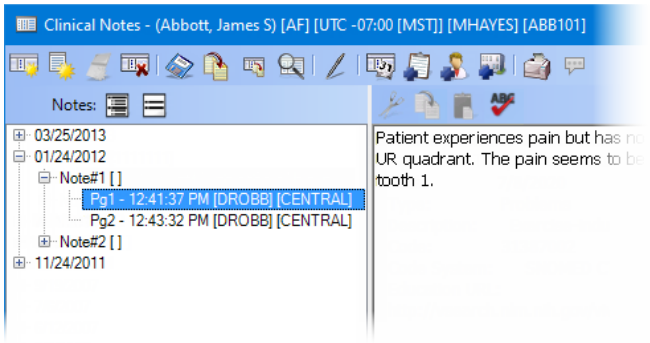
Notes:

- A clinical note was automatically started when information was entered into a patient health assessment and/or a medical history review.
- The clinical notes are arranged by date, note number, and then page. You can have as many notes as you want, with a maximum of 10 pages per note.

To add a clinical note

1. In Chart, with a patient selected, click the **Clinical Notes**. button  .

   The **Clinical Notes** window appears.



2. Do one of the following:

   - Click the **New Clinical Note** button  . The **Change Date and Time** dialog box appears. Leave the current system date and time entered, or specify a different date and/or time; and then click **OK**.
   - If you want to add a page to an existing clinical note, expand the appropriate date and note in the left pane, and then click the **New Clinical Note Page** button  . The **Change Time** dialog box appears. Leave the current system time entered, or enter a different time; and then click **OK**.

3. Enter a note you want to attach to this patient regarding an exam or treatment given.

4. To assign a different clinic than the clinic currently selected for the clinical note, click the **Change Clinic for Selected Note** button to select the appropriate clinic.

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

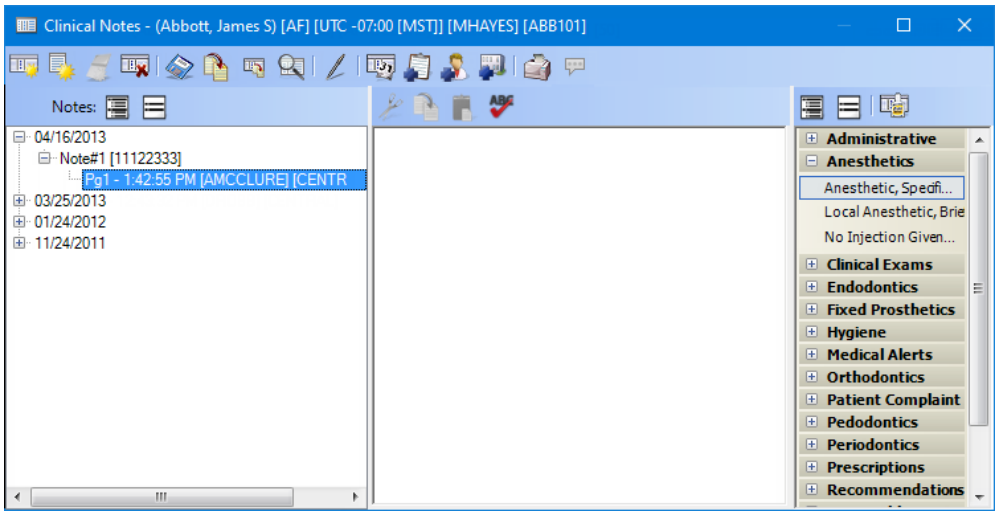
Adding Clinical Notes Using Templates

Using a clinical note template as a guide, you can quickly and accurately document a patient's visit with minimal typing or editing. Once a clinical note has been signed or is in history, it cannot be edited or deleted. However, an addendum can be made to a clinical note in history.

To add a clinical note using a template

1. In Chart, with a patient selected, click the **Clinical Notes**. button.

   The **Clinical Notes** window appears.



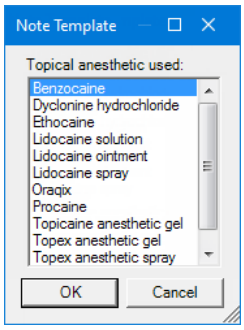
2. Do one of the following:

   - Click the **New Clinical Note** button. The **Change Date and Time** dialog box appears. Leave the current system date and time entered, or specify a different date and/or time; and then click **OK**.
   - If you want to add a page to an existing clinical note, expand the appropriate date and note in the left pane, and then click the **New Clinical Note Page** button. The **Change Date and Time** dialog box appears. Leave the current system time entered, or enter a different time; and 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.

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 box (in the middle).

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

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

For more information about clinical note templates, see the "Creating clinical note templates," "Creating clinical note prompts," and "Setting up clinical note template categories" topics in the Dentrix Enterprise Help.

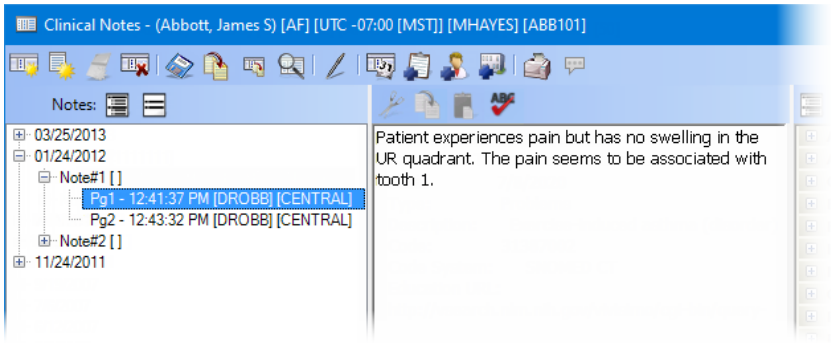
Editing Clinical Notes

You can edit a clinical note that has not been placed into history after the month-end process, that has not been signed, or that has not been locked.

To edit a clinical note

1. In Chart, with a patient selected, click the **Clinical Notes**. button .

   The **Clinical Notes** window appears.



2. Expand a date and note on the left, and then select the page you want to edit.
3. If you are adding to the note at a date other than when the clinical note was originally entered, click at the end of the text, press Enter, and then click the **Insert Date/Time** button to insert a date and time stamp.
4. Add to, change, or remove a part of the clinical note as needed.
5. To assign a different clinic than the currently selected clinic for the clinical note, click the **Change Clinic for Selected Note** button to open the **Select Clinic** dialog box and select the appropriate clinic.
6. Click the **Save Clinical Note** button .

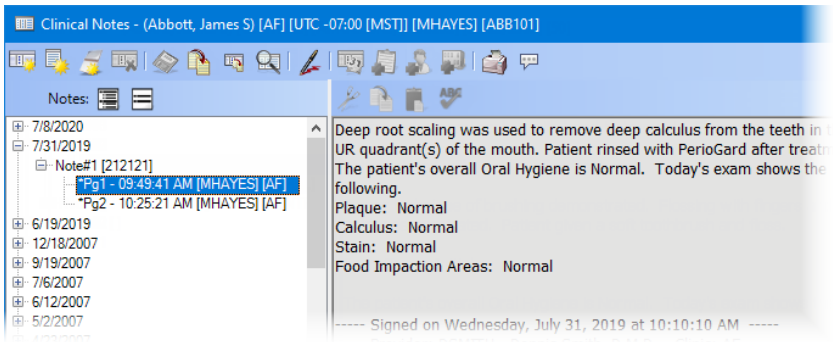
Adding an Addendum to a Clinical Note

You cannot edit a locked clinical note (a note that has been moved into history after the month-end process, has been signed or approved, or has been locked automatically). However, you can add an addendum to a clinical note that has been locked.

To add an addendum to a clinical note

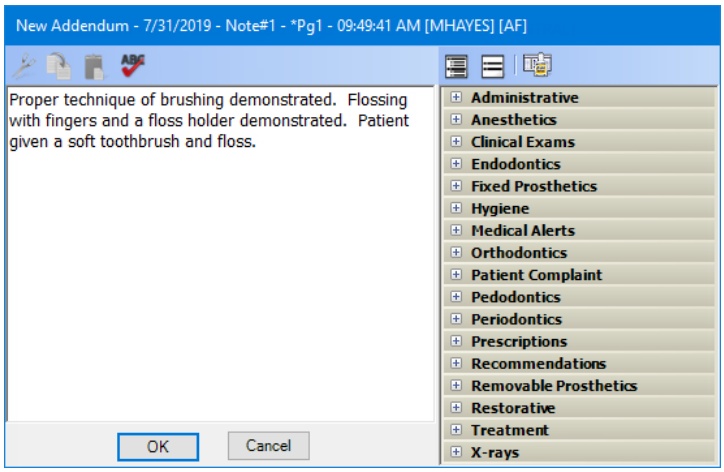
1. In Chart, with a patient selected, click the **Clinical Notes**. button  .

   The **Clinical Notes** window appears.



2. Expand a date and note on the left, and then select the page you want to add an addendum.
3. Click the **New Addendum** button  .

   The **New Addendum** dialog box appears.



4. Enter the text of the addendum.
5. Click **OK**. On the confirmation message that appears, click **Yes**.

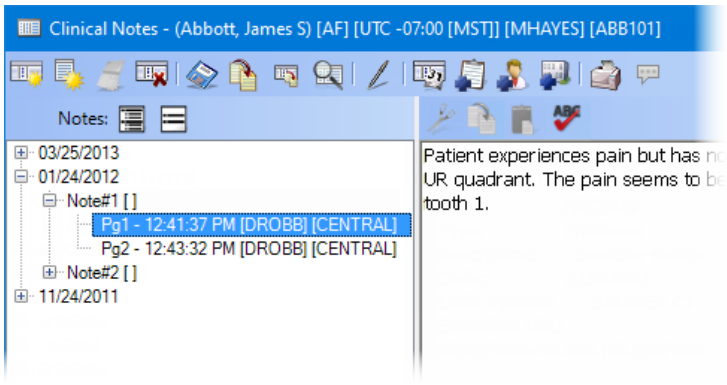
Printing Clinical Notes

From the Clinical Notes window, you can print all clinical notes within a certain date range for the current patient and/or all members of that patient's family. For instructions on how to print the Clinical Notes Report from the DXOne Reporting module, see "List Reports" in Chapter 9: DXOne Reporting.

To print clinical notes

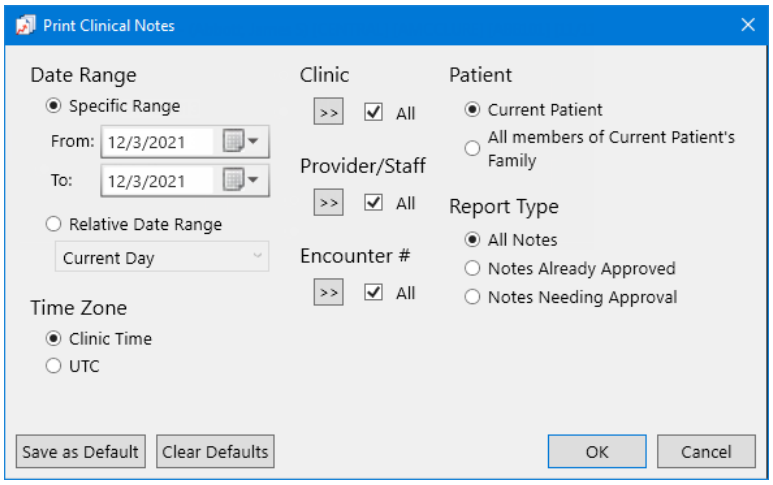
1. In Chart, with a patient selected, click the **Clinical Notes**. button .

   The **Clinical Notes** window appears.



2. Click the **Print** button .

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



3. Set up the following options:

   - **Select Date Range** – Select **Date Range**, and then enter a range in the **From** and **To** boxes. Or, select **Relative Date Range**, and then select a range. The clinical notes within that date range will appear on the report.

     Tip: 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 enter a date range each time you run the report.

   - **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 you want to include on the report, or leave **All** selected to include all providers.

- **Patient** – Select whether you want to include clinical notes for the patient currently selected or for the current patient and anyone else in that person's family.
- **Report Type** – Select whether you want to include all clinical notes, clinical notes that have already been approved or signed, or clinical notes that have not been approved or signed.

4. To save the current settings for the next time you run the report, click **Save as Default**.
5. Click **OK** to preview the report.

Signing Clinical Notes

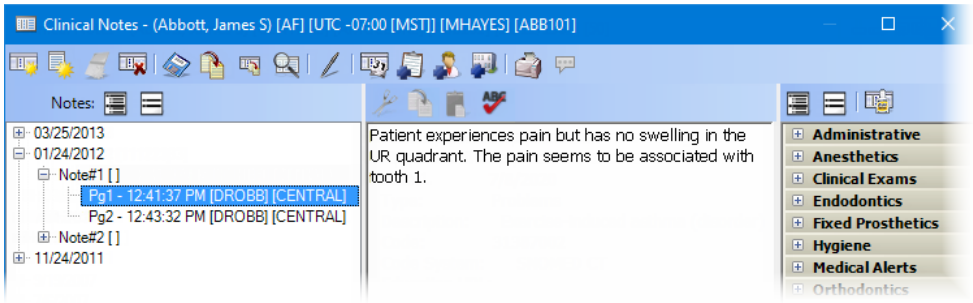
A provider can digitally sign a clinical note to indicate his or her approval of the note. Signing a clinical locks it to prevent changes from being made to the text and to prevent the note from being deleted; however, a signed or locked note can be appended to.

Tip: You can sign multiple clinical notes at once from the Office Manager.

To sign a clinical note

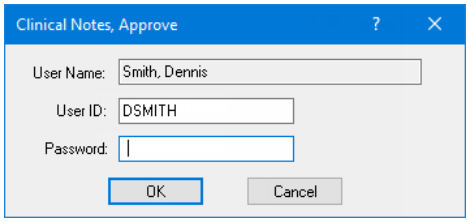
1. In Chart, with a patient selected, click the **Clinical Notes**. button  .

   The **Clinical Notes** window appears.



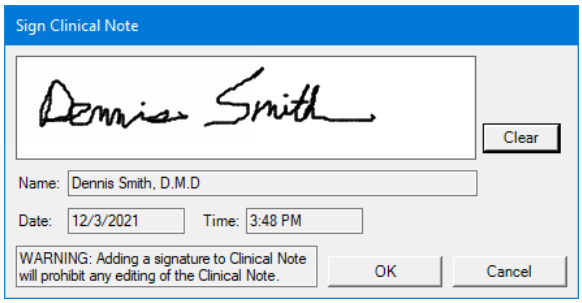
2. Expand a date and note on the left, and then select the page you want to sign.
3. Click the **Sign Clinical Note** button  .

   The **Approval Verification** dialog box appears.



4. Enter your **User ID** and **Password**, and then click **OK**.

   The **Sign Clinical Note** dialog box appears.



5. In the signature box, sign your name using a mouse, light pen, finger on a touch screen, or stylus on a writing tablet.

   Tip: If you need to clear the signature to re-sign, click **Clear**.

6. Click **OK**.

Notes:

- When a signature has been added to the clinical note, a "Signed on [date]" 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. To view a signature for the selected clinical note, click the **Signature** button.

Completing Oral Health Status Surveys

The primary goal of a continuous assessment of a patient's oral health status (OHS) is to reduce the likelihood of a patient suffering a preventable urgent or life-threatening oral health condition. Most dental "emergencies" are due to an acute flare-up of an existing condition—usually a periapical or periodontal abscess.

From the standpoint of overall healthcare system cost effectiveness, this prevention-oriented program, which provides a way to record and track oral health, leading to early diagnosis and timely intervention, should decrease the number of emergency room visits for evaluation and/or treatment of serious oral infections.

From a program implementation perspective, the OHS survey makes the process of entering OHS metrics as efficient and consistent as possible. The simplified objective data collection and criteria may also prove to be appropriate for oral assessments done in "visual exam only" scenarios, which may increase its use in non-clinical, oral health evaluation settings.

OHS classifications (a classification is current if an OHS survey has been done within the past 24 months):

- OHS 1 – Excellent. No dental treatment is required.
- OHS 2 – Moderate/Good. The patient has moderate dental treatment needs.
- OHS 3 – Compromised. Urgent dental treatment is indicated.
- OHS 4 – Poor. Very urgent dental treatment is indicated.
- OHS 5 – Poor. For a class 4 patient, it has been 24-36 months since the last completed OHS survey.

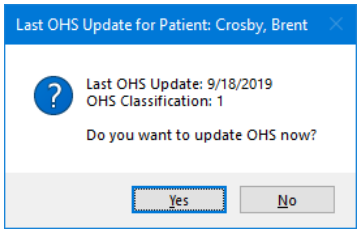
  Note: This classification allows you to track class 4 patients for another 12 months for continued identification and, therefore, treatment.

- OHS 6 – Unknown. One of the following conditions is met:
  - The patient does not have a completed OHS survey.
  - For a class 1, 2, or 3 patient, it has been 24 months since the last completed OHS survey.
  - For a class 5 patient, it has been 36 months since the last completed OHS survey.

To enter or update OHS

1. Sign a clinical note.

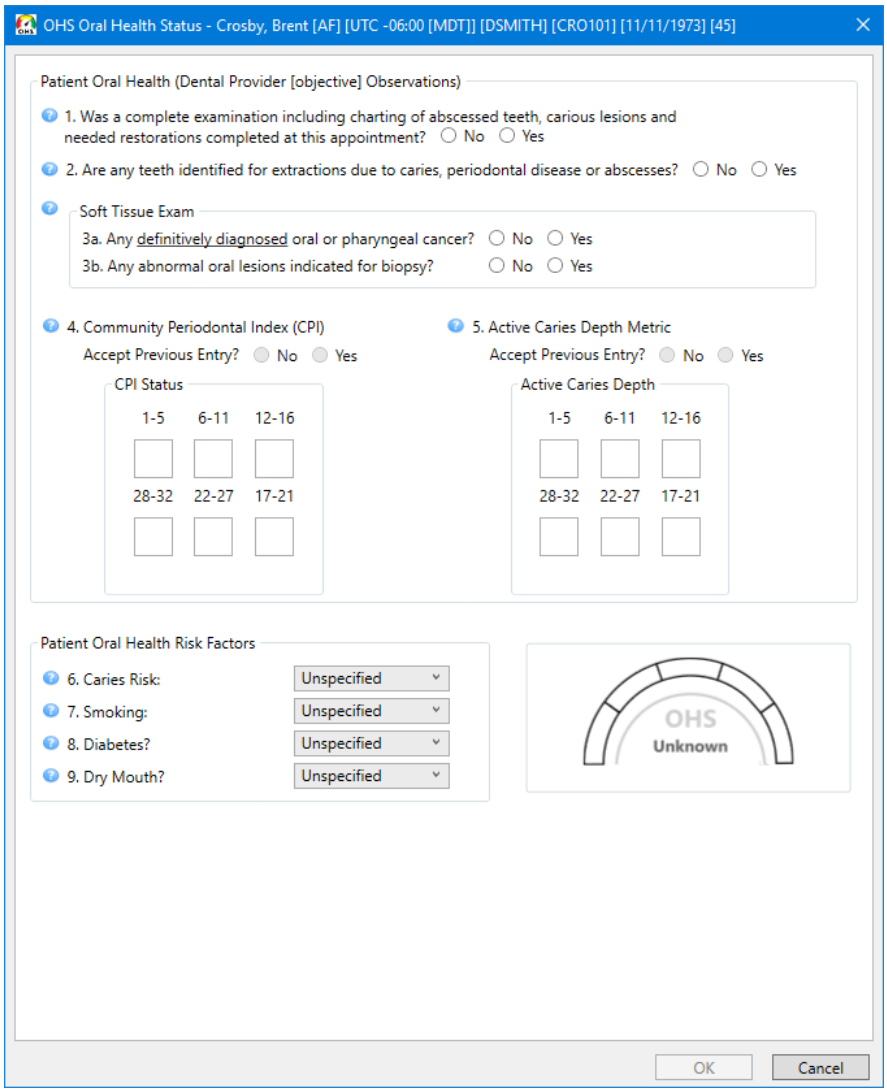
   If the patient has a prior completed OHS survey, a message appears and displays the date of that OHS survey and the classification that was calculated from that survey. Proceed to step 2; otherwise, skip to step 3.



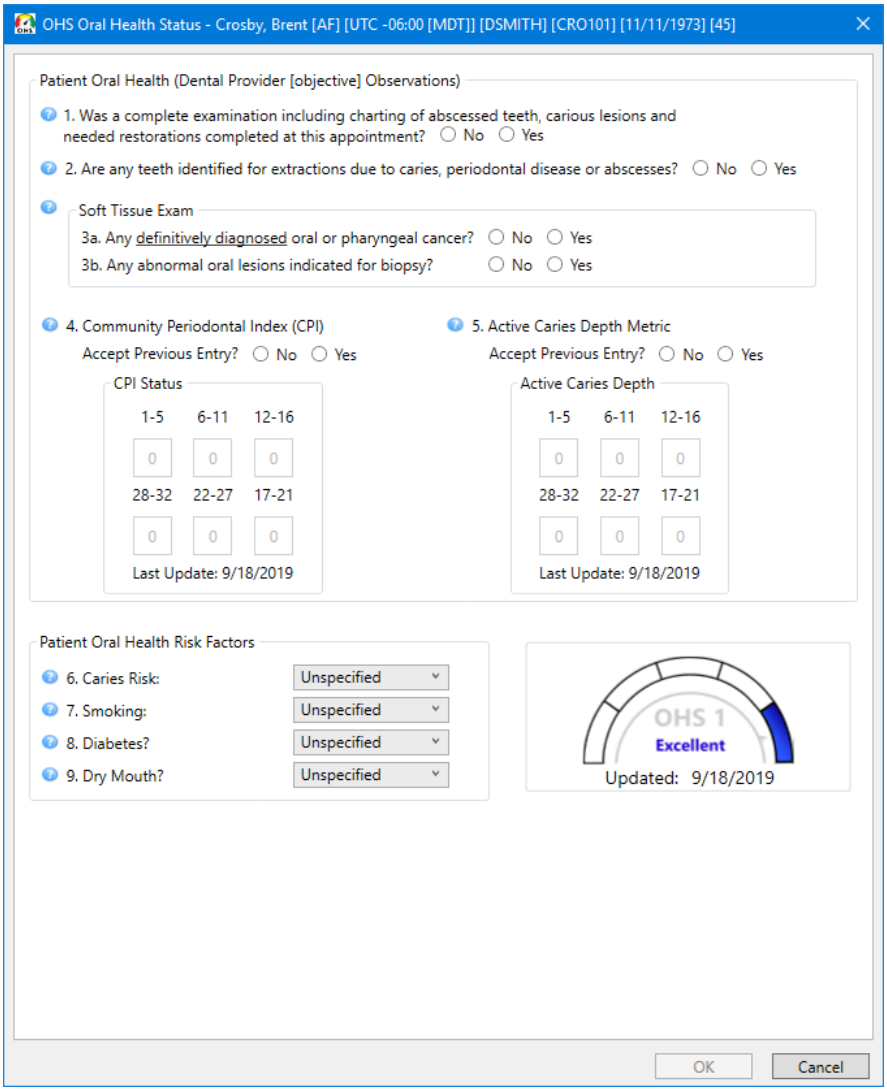
2. To update the OHS, click **Yes**.

   The **OHS Oral Health Status** dialog box appears.

Patient does not have a completed OHS survey



Patient has a prior completed OHS survey



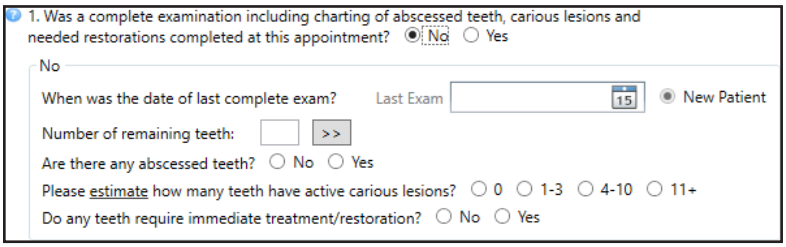
3. Enter responses for the following:

#1 Was a complete examination including charting of abscessed teeth, carious lesions and needed restoration completed at this appointment? – Select **No** or **Yes**.

Notes:

- Charting of all conditions is not required. Treatment planning of proposed procedures by specific appointments is not required. An immediate treatment/restoration query applies to caries-related procedures and elective (non-caries related) restorative, endodontic, surgical, or prosthetic procedures.
- Your response does not affect the overall OHS status.

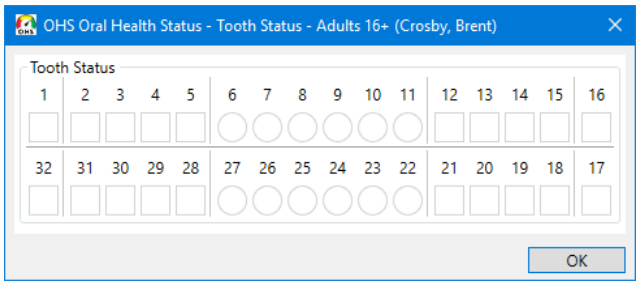
If you select **No**, other options become available.



- **When was the date of last complete exam?** – Enter or select the **Last Exam** date.

  Note: You cannot select **New Patient** manually, so it is always unavailable. **New Patient** is selected automatically if the patient does not have a prior completed survey or a survey was not completed on the specified **Last Exam** date.

- **Number of remaining teeth** – Enter a value, or click the search button >> to select the missed teeth (the correct number of remaining teeth will be inserted into the **Number of remaining teeth** box automatically).

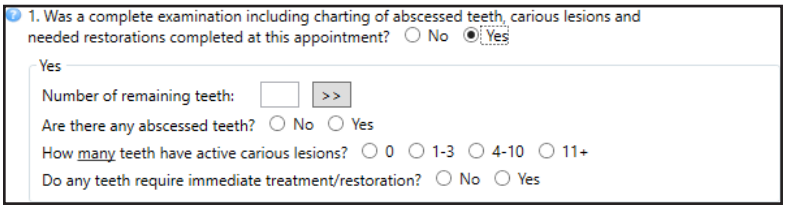


  Note: The options in the tooth selection dialog box vary according to the age of the patient.

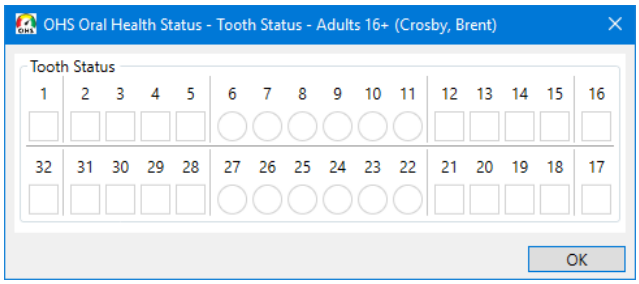
- **Are there any abscessed teeth?** – Select **No** (class 1) or **Yes** (class 4).
- **Please estimate how many teeth have active carious lesions?** – Select all that apply: **0** (class 1), **1-3** (class 2), **4-10** (class 3), and **11+** (class 4).
- **Do any teeth require immediate treatment/restoration?** – Select **No** (class 1) or **Yes** (class 4).

  Note: If you select **Yes** for this survey, if **No** is selected for the next survey, the current date will be inserted as the **Last Exam** date.

If you select **Yes**, other options become available.



- **Number of remaining teeth** – Enter a value, or click the search button >> to select the missed teeth (the correct number of remaining teeth will be inserted into the **Number of remaining teeth** box automatically).



Note: The options in the tooth selection dialog box vary according to the age of the patient.

Note: If you select **Yes** for this survey, if **No** is selected for the next survey, the current date will be inserted as the **Last Exam** date.

- **Are there any abscessed teeth?** – Select **No** (class 1) or **Yes** (class 4).
- **How many teeth have active carious lesions?** – Select all that apply: **0** (class 1), **1-3** (class 2), **4-10** (class 3), and **11+** (class 4).
- **Do any teeth require immediate treatment/restoration?** – Select **No** (class 1) or **Yes** (class 4).

#2 Are any teeth identified for extractions due to caries, periodontal disease or abscesses? – Select **No** or **Yes**.

Note: This includes any teeth that are recommended for extraction due to problematic exfoliation (deciduous teeth), non-restorable caries, periodontal bone loss, periodontal or periapical abscess, or any other non-elective reason. This includes third molars with probability for urgent treatment within 24 months.

#3 Soft Tissue Exam:

#3a Any definitively diagnosed oral or pharyngeal cancer? – Select **No** or **Yes**.

#3b Any abnormal oral lesions indicated for biopsy? – Select **No** or **Yes**.

Note: A **Yes** response to oral or pharyngeal cancer requires definitive diagnosis by biopsy.

#4 Community Periodontal Index (CPI):

- If there is a prior OHS survey for the patient, **Accept Previous Entry?** is available, and the community periodontal indexes (CPI) that were entered in the previous survey appear. If no changes are needed, select **Yes**. To update any of the entries, select **No**, and then enter the one of the following community periodontal indexes for the applicable sextants:
  - **X** – No teeth in sextant.
  - **0** – No pockets > 3.5mm (black band fully visible).
  - **1** – No pockets > 3.5mm, bleeding on probing (black band fully visible).
  - **2** – No pockets > 3.5mm, calculus present (black band fully visible).
  - **3** – Pocket > 3.5mm but < 5.5mm (black band partially visible).
  - **4** – Pocket > 5.5mm (blank band not visible).
- If there is not a prior OHS survey for the patient, **Accept Previous Entry?** is not available. Enter one of the following community periodontal indexes for each sextant:
  - **X** – No teeth in sextant.
  - **0** – No pockets > 3.5mm (black band fully visible).
  - **1** – No pockets > 3.5mm, bleeding on probing (black band fully visible).

- **2** – No pockets > 3.5mm, calculus present (black band fully visible).
- **3** – Pocket > 3.5mm but < 5.5mm (black band partially visible).
- **4** – Pocket > 5.5mm (blank band not visible).

The class is determined according to the following criteria:

- **Class 1** – No more than one CPI score of 3 and no CPI score of 4.
- **Class 2** – Three or fewer CPI scores of 3 and no CPI score of 4.
- **Class 3** – Four or more CPI scores of 3 and three or fewer CPI scores of 4.
- **Class 4** – Four or more CPI scores of 4.

Notes:

- Third molars are excluded unless they are in the functional position of second or first molars. As a general rule for scoring, if in doubt, enter the lower score. When heavy extrinsic stain is present in the absence of calculus or pockets, the sextant may be scored as 2 if dental services are needed to remove the stains.
- The CPI options are available only if the patient is 15 years old or older.

#5 Active Caries Depth Metric:

- If there is a prior OHS survey for the patient, **Accept Previous Entry?** is available, and the active caries depths that were entered in the previous survey appear. If no changes are needed, select **Yes**. To update any of the entries, select **No**, and then enter one of the following active caries depths for the applicable sextants:
  - **X** – All teeth in sextant are missing.
  - **0** – No caries are present in sextant.
  - **1** – Caries present; deepest caries does not penetrate past DEJ.
  - **2** – Deepest caries penetrating past DEJ (includes any root surface caries).
  - **3** – Deepest carious lesions encroaching on pulp chamber (from any surface).
  - **4** – Deepest carious lesion penetrating into pulp chamber.
- If there is not a prior OHS survey for the patient, **Accept Previous Entry?** is not available. Enter one of the following active caries depths for each sextant.
  - **X** – All teeth in sextant are missing.
  - **0** – No caries are present in sextant.
  - **1** – Caries present; deepest caries does not penetrate past DEJ.
  - **2** – Deepest caries penetrating past DEJ (includes any root surface caries).
  - **3** – Deepest carious lesions encroaching on pulp chamber (from any surface).
  - **4** – Deepest carious lesion penetrating into pulp chamber.

The class is determined according to the following criteria:

- **Class 1** – All depth scores are X or 0.
- **Class 2** – All depth scores are X, 0, 1 or 2 (no 3 or 4).
- **Class 3** – All depth scores are X, 0, 1, 2 or 3 (no 4).
- **Class 4** – Any depth score of 4.

Note: As a general rule for scoring, if in doubt, enter the lower score.

#6 Caries Risk – Select an option:

- **Unspecified**.
- **Low** – No restorations or new active carious lesions within last 36 months.
- **Medium** – 1–2 replacement restorations or new active carious lesions within 36 months.
- **High** – 3 or more replacement restorations or new active carious lesions within 36 months.

Note: Your response does not affect the overall OHS status.

#7 Smoking – Select an option:

- **Unspecified**
- **Never smoked tobacco**
- **Tobacco smoking consumption unknown**
- **Occasional tobacco smoker (does not smoke every day but smokes almost every week)**
- **Light tobacco smoker (1 cigar or fewer than 10 cigarettes per day)**
- **Heavy tobacco smoker (more than one pack per day)**
- **Smokes tobacco daily**
- **E-cigarette user**
- **Smokeless tobacco user**
- **Ex-smoker**

Notes:

- Your response does not affect the overall OHS status.
- The smoking option is available only if the patient is 10 years old or older.

#8 Diabetes? – Select an option:

- **Unspecified**
- **No patient history of diabetes**
- **Type I; well controlled**
- **Type I; not well controlled**
- **Type II; well controlled**
- **Type II; not well controlled**

Notes:

- A laboratory test/report is not required. Input is based on the provider's discussion with the patient.
- Your response does not affect the overall OHS status.
- The diabetes option is available only if the patient is 5 years old or older.

#9 Dry Mouth? – Select an option:

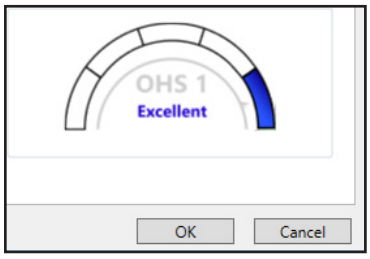
- **Unspecified**
- **Normal saliva**
- **Reduced saliva flow**
- **Very dry mouth**

- **Patient using saliva substitute**
- **Patient Using fluoride rinse**
- **Patient using prescription strength fluoride toothpaste**
- **Patient using fluoride trays**
- **None**

Notes:

- A laboratory test/report is not required. Input based on the provider's discussion with the patient.
- Your response does not affect the overall OHS status.
- The dry mouth option is available only if the patient is 7 years old or older.

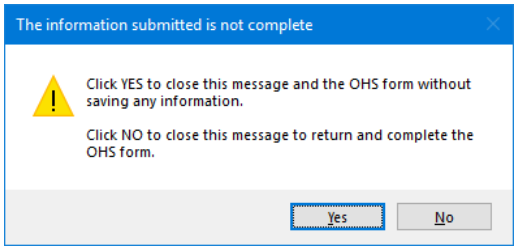
The indicator reflects the OHS status as determined by the responses on the survey.



4. Click **OK**. This button is available only if the survey is complete.

Notes:

- If you attempt to close the dialog box before the survey is complete, a message appears and asks if you want to close without saving or if you want to return to the survey to complete it.



- If you close the module from which you opened the **Clinical Notes** window (Family File, Ledger, Chart, or Appointment Book), the **OHS Oral Health Status** dialog box closes too.
- If you close the **Clinical Notes** window, the **OHS Oral Health Status** dialog box remains open.

OHSS – Electronic Screening Form and Report

With the electronic Oral Health Screening Survey (OHSS) form, you can collect details regarding a patient's oral health, such as the condition of his or her teeth and the urgency of treatment. Also, you can export the data from screenings to a file that you can view in a spreadsheet program, such as Microsoft Excel.

This section covers the following topics:

- Prerequisites
- Setting Up Clinics
- Completing Electronic Screening Forms
- Generating Electronic Screening Reports

Prerequisites

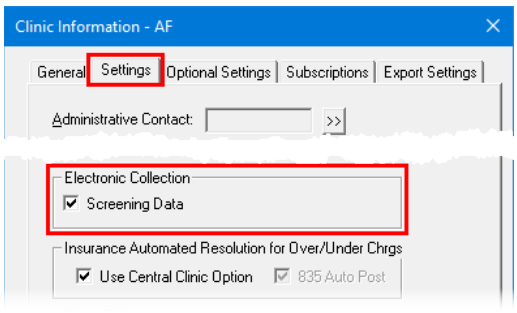
- These features are available in Dentrix Enterprise versions 8.0.5.257, 8.0.7.553 (CU7), 8.0.9, and later.
- These features are available only if the "Electronic Collection Reports" global setting has been enabled. Contact Dentrix Enterprise Customer Support to have a technician enable this global setting. Then, you can activate the functionality per clinic.

Setting Up Clinics

With the correct global setting enabled, you can activate the electronic screening form and report on a clinic-by-clinic basis.

To set up a clinic

1. While logged in to the Central clinic, in Office Manager, on the **Maintenance** menu, point to **Practice Setup**, and then click **Enterprise Setup**.
2. In the **Enterprise Setup** dialog box, select a clinic in the **Clinics** list, and then click **Edit**.
3. In the **Clinic Information** dialog box, select the **Settings** tab.



4. Under **Electronic Collection**, select the **Screening Data** check box. With the electronic collection of screening data activated, the buttons to access the screening form and report appear on Chart toolbar.
5. Click **OK**.

Completing Electronic Screening Forms

If electronic screenings are activated for your clinic, you can complete an electronic screening form for a patient.

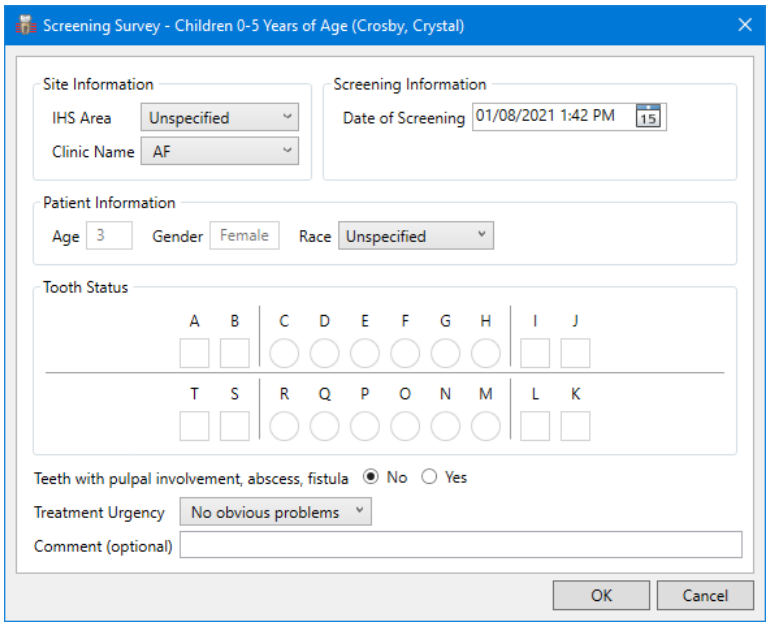
To complete an electronic screening form

1. With a patient selected in Chart, change the provider for the charting session if applicable. On the **File** menu, click **Change Provider**. In the **Select Provider** dialog box, search for and select a provider, and then click **OK**.
2. Click the **Screening Forms** button  .

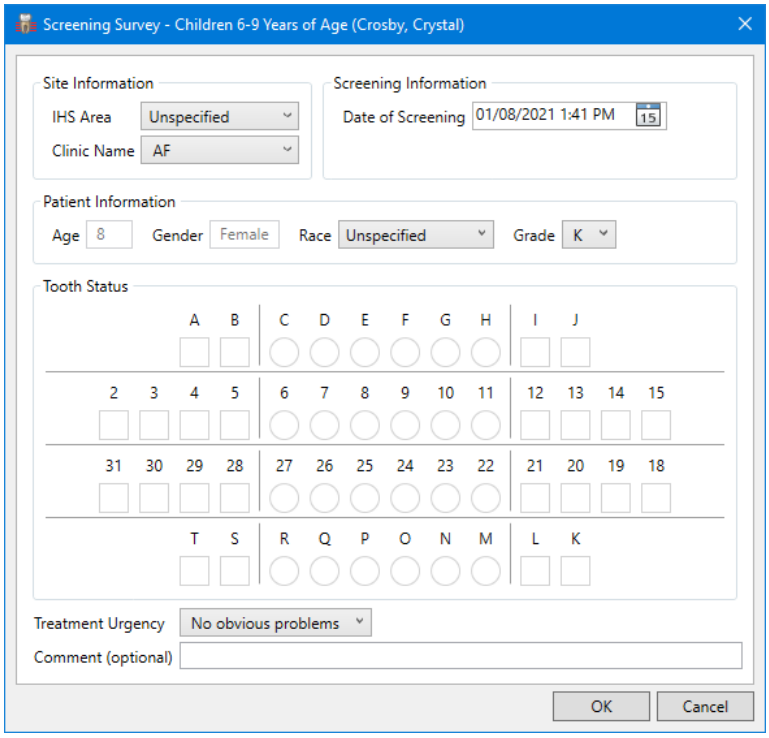
   Note: This button is available only if the electronic collection of screening data has been activated for the clinic that you are logged in to.

   The age-appropriate **Screening Survey** dialog box appears.

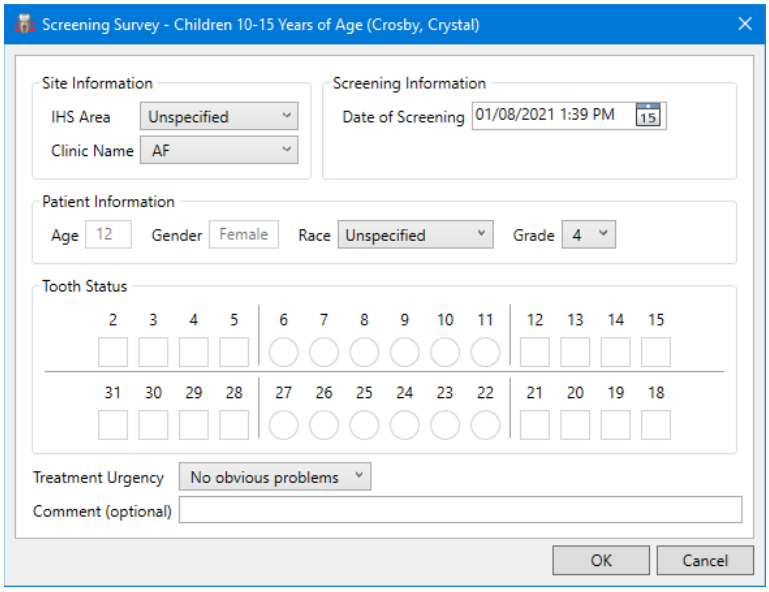
   For a patient who is 0 to 5 years old



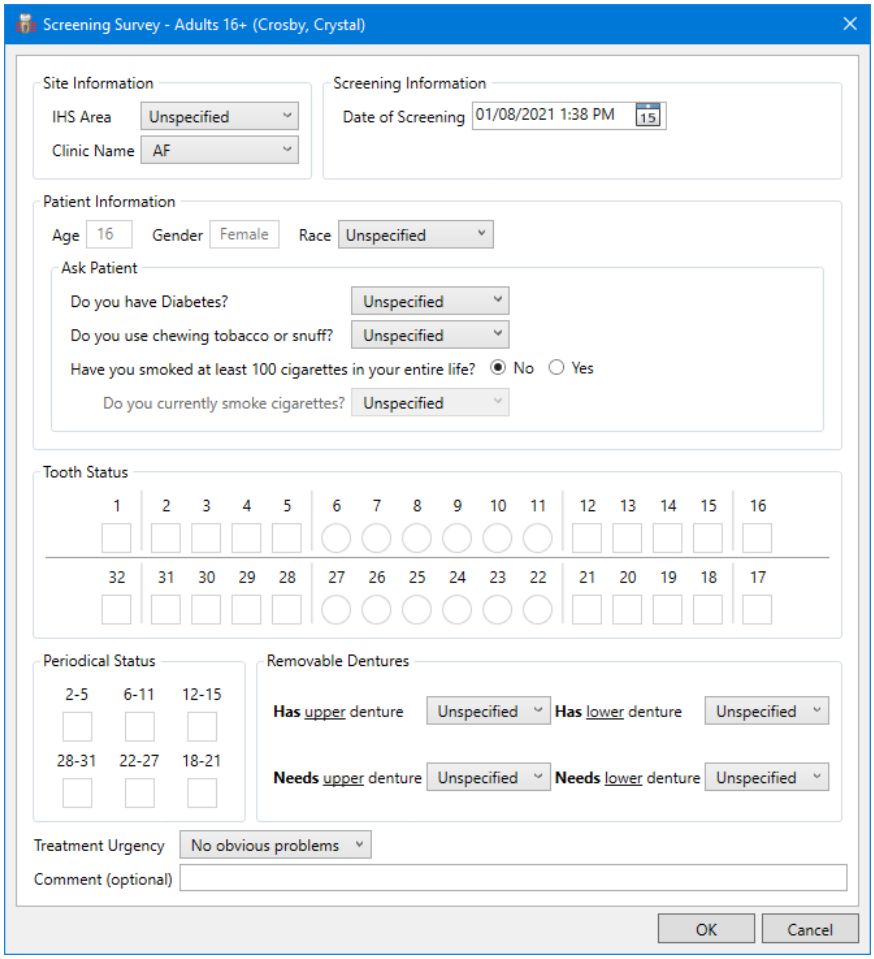
For a patient who is 6 to 9 years old



For a patient who is 10 to 15 years old



For a patient who is 16 or more years old



3. Specify the following information:
   - **IHS Area** – The state where the patient is being screened.
   - **Clinic Name** – The clinic where the patient is being screened. By default, this is the patient's preferred clinic, but you can change it as needed.
   - **Date of screening** – The date of the screening. By default, this is today's date, but you can select a different date as needed.
   - **Age** – The patient's age at the time of the screening. To change the age, you must change the patient's **Birth date** in the Family File.
   - **Gender** – The patient's gender. To change the gender, you must change the patient's **Sex** in the Family File.
   - **Race** – The patient's race. By default, this is the Race that is entered in the patient's Family File record, but you can select a different race as needed.

     Note: Selecting a different race for the form does not update the patient's record, but the next time you screen the patient, the prior Race selection will be selected by default on the form.

   - **Grade** – The patient's grade level in school.

     Note: This question is available only if the patient is 6 to 15 years old.

- **Do you have Diabetes?** – Select the patient's response to this question.

  Note: This question appears only if the patient is 16 or more years old.

- **Do you use chewing tobacco or snuff?** – Select the patient's response to this question.

  Note: This question appears only if the patient is 16 or more years old.

- **Have you smoked at least 100 cigarettes in your entire life?** – Select the patient's response to this question.

  Note: This question appears only if the patient is 16 or more years old.

- **Do you currently smoke cigarettes?** – Select the patient's response to this question.

  Note: This question appears only if the patient is 16 or more years old, and this question is available only if **Yes** is selected for the **Have you smoked at least 100 cigarettes in your entire life?** question.

- **Tooth Status** – For each tooth, right-click the corresponding box, and then click one of the following statuses:
  - **None** – Clears the tooth box.
  - **Sound** – Inserts a check mark in the tooth box.
  - **Sealant** – Inserts "S" in the tooth box.
  - **Decayed** – Inserts "D" in the tooth box.
  - **Filled** – Inserts "F" in the tooth box.
  - **Crown** – Inserts "C" in the tooth box.
  - **Extracted due to decay** – Inserts "X" in the tooth box.
  - **Unerupted** – Inserts "UE" in the tooth box.

    Note: This status is available only if the patient is 0 to 15 years old.

  - **Missing – NOT because of decay** – Inserts "Z" in the tooth box.

    Note: This status is available only if the patient is 0 to 9 years old.

  - **Ortho extraction** – Inserts "O" in the tooth box.

    Note: This status is available only if the patient is 10 to 15 years old.

  - **Missing for any other reason** – Inserts "M" in the tooth box.

    Note: This status is available only if the patient is 16 or more years old.

  - **Fractured or restored (injury/trauma)** – Inserts "I" in the tooth box.

    Note: This status is available only if the patient is 0 to 5 years old or 10 or more years old.

  - **Hypoplasia** – Inserts "H" in the tooth box.

    Note: This status is available only if the patient is 0 to 5 years old or 10 or more years old.

  - **Fixed dental prosthesis/crown abutment** – Inserts "P" in the tooth box.

    Note: This status is available only if the patient is 16 or more years old.

Notes:

- You can select a status only one tooth at a time. There is not a way to select a status for multiple teeth at the same time.
- If the patient is 6 to 9 years old, you can "double enter" statuses on primary and permanent teeth.

- **Teeth with pulpal involvement, abscess, fistula** – Select **Yes** or **No**.

  Note: This option is available only if the patient is 0 to 5 years old.

- **Treatment Urgency** – Select **No obvious problems**, **Early care needed**, or **Urgent care needed**.
- **Comments** – Enter any comments regarding the screening.

4. Click **OK**.

Generating Electronic Screening Reports

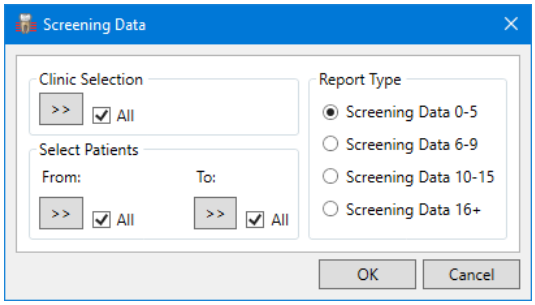
If electronic screenings are activated for your clinic, you can generate a report that contains screening data for patients. The report contains patient information, such as ages and genders, and contains details regarding each patient's oral health, such as the condition of his or her teeth and the urgency of treatment. The report does not contain any patient names or birth dates.

Tip: You may want to view the report every day to ensure that data is being entered correctly.

To generate the report

1. With or without a patient selected in Chart, click the **Screening Forms Report** button  .

   The **Screening Data** dialog box appears.

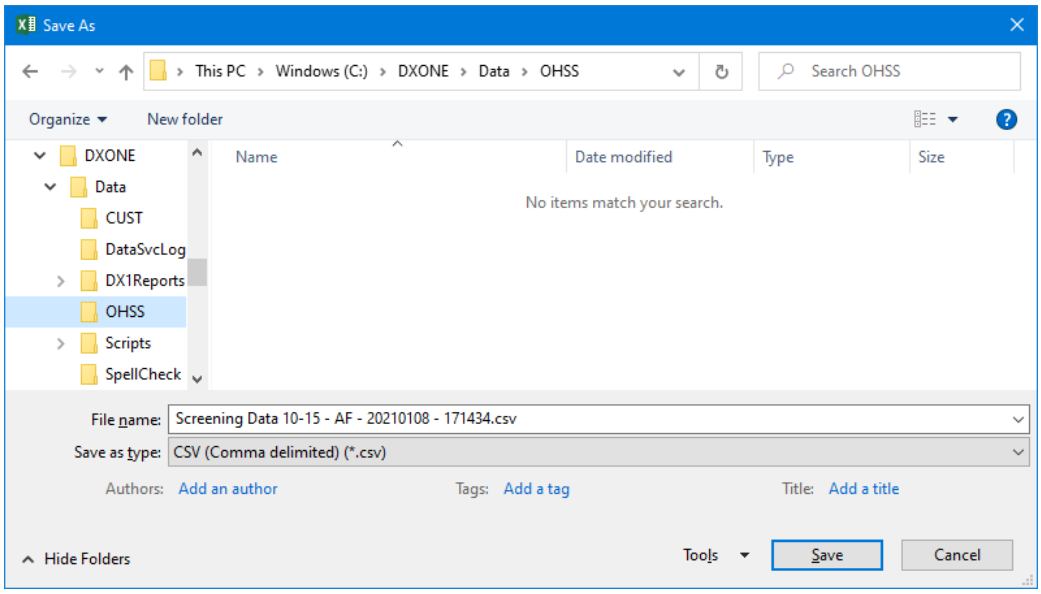


2. Set up the following options:

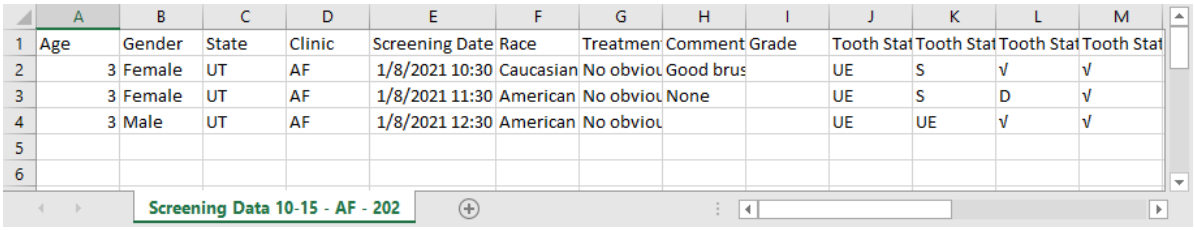
   - **Clinic Selection** – Click the search button >> to select the clinics where patients were screened to include their screening data, or select the **All** check box to include screening data for patients who were screened in any clinic.
   - **Select Patients** – Click the **From** and/or **To** search buttons >> to select the range of patients who may have been screened in the specified clinics to include their screening data (the range can be open-ended), or select both **All** check boxes to include screening data for all patients who were screened in the specified clinics.
   - **Report Type** – Select whether you want to include screening data for patients who were 0 to 5, 6 to 9, 10 to 15, or 16 or more years old at the time of screening.

3. Click **OK**.

The **Save As** dialog box appears.



4. Select where you want to save the file, change the **File name** (which contains the age range, clinic name or "Multiple", and date by default) as needed, make sure that the **Save as type** is .csv, and then click **Save**.
5. You can open the file in a spreadsheet program, such as Microsoft Excel.



	A	B	C	D	E	F	G	H	I	J	K	L	M
1	Age	Gender	State	Clinic	Screening Date	Race	Treatmen	Comment	Grade	Tooth Stat	Tooth Stat	Tooth Stat	Tooth Stat
2	3	Female	UT	AF	1/8/2021 10:30	Caucasian	No obviou	Good brus		UE	S	√	√
3	3	Female	UT	AF	1/8/2021 11:30	American	No obviou	None		UE	S	D	√
4	3	Male	UT	AF	1/8/2021 12:30	American	No obviou			UE	UE	√	√
5													
6													

Screening Data 10-15 - AF - 202

Printing from Chart

You can print the following from Chart:

- Patient's Chart
- Patient's Progress Notes and Chart
- Referral Recap Report
- Referral Slip

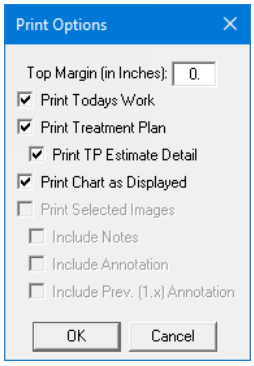
Patient's Chart

You can print a patient's dental chart.

To print a patient's chart

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

   The **Print Options** dialog box appears.



2. Select the desired print option(s):
   - **Print Todays Work** – To print completed work posted on the current system date.
   - **Print Treatment Plan** – To print treatment-planned work that was posted on the current system date. Then, 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** – To include the graphical chart.
3. Click **OK**.

Patient's Progress Notes and Chart

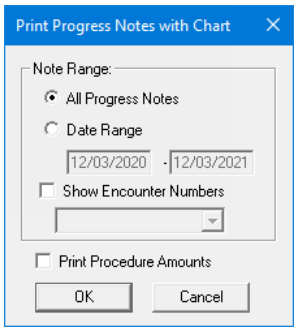
You can print the progress notes and graphical chart as they are currently being viewed in Chart.

Tip : If you want to print the progress notes without the graphical chart, switch to the progress notes view in Chart, and then complete the steps that follow. For instruction on how to switch Chart view, see the "Working with views" topic in the Dentrix Enterprise Help.

To print the progress notes with the chart

1. In 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 enter a date range.
   - **Print Procedure Amounts** – To include amounts for procedures that appear on the report.
3. Click **OK**.

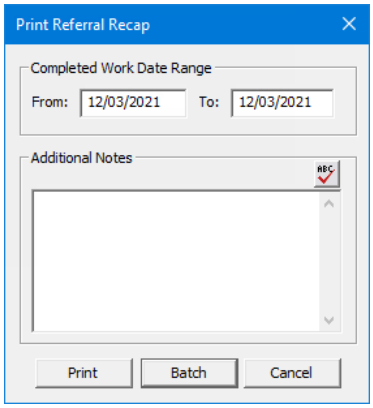
Referral Recap Report

The Referral Recap Report shows any completed work within a specified date range that has been flagged as "Referred By Doctor." Treatment-planned work that has been referred to the practice by the same provider is also included. For information about attaching a referral to a procedure, see the "Editing treatment" topic in the Dentrix Enterprise Help.

To print a referral recap

1. In Chart, with a patient selected, from the **File** menu, point to **Print Referral**, and then click **Referral Recap**.

   The **Print Referral Recap** dialog box appears.



2. Under **Completed Work Date Range**, enter the date range for the completed referred procedures you want to print. Only procedures that were completed within the specified date range and are flagged as "RC" (Referred Completed) will be included on the report.
3. Enter any necessary **Additional Notes** that you want to have print on the report.
4. Click **Print** to send the report to Chart printer or **Batch** to send the report to the Batch Processor.

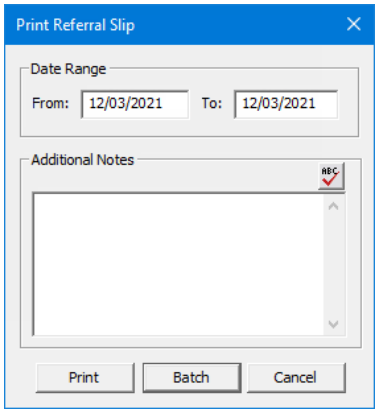
Referral Slip

You can print a referral slip for patients to give to the doctor they are being referred to. All procedures that have been flagged as "RTP" (Referred Treatment Planned procedure) and are within the specified date range will be included on the slip. The referral slip will also include the patient, provider, and referral's information, as well as any notes you have entered. For information about attaching a referral to a procedure, see the "Editing treatment" topic in the Dentrix Enterprise Help.

To print a referral slip

1. In Chart, with a patient selected, from the **File** menu, point to **Print Referral**, and then click **Referral Slip**.

   The **Print Referral Slip** dialog box appears.



2. Under **Date Range**, enter the date range for the referred procedures you want to print. Only procedures that fall within the specified date range and are flagged as "RTP" (Referred Treatment Planned procedure) will be included on the referral slip.
3. Enter any necessary **Additional Notes** that you want to have printed on the slip.
4. Click **Print** to send the slip to Chart printer or **Batch** to send the slip to the Batch Processor.

Chapter 5: Perio Chart

The Dentrix Enterprise Perio Chart is a clinical tool that allows you to record mobility, furcation grades, plaque, calculus, bone loss, pocket depths, bleeding and suppuration points, gingival margins, CAL levels, and MGJ measurements. Automatic calculation formulas allow you to expedite the charting process by eliminating the need to measure multiple indicators.

Once entered, you can view data numerically or graphically. Also, you can print custom reports, charts, and letters for an insurance consultant or the referring dental professional.

This chapter covers the following topics:

- Opening Perio Chart
- The Perio Chart Window
- Entering New Perio Exams
- Viewing Perio Exams
- Changing the Perio Exam View
- Comparing Perio Exams
- Printing Perio Chart Reports

Opening Perio Chart

You can open Perio Chart from a patient's Chart.

To open Perio Chart

In Chart, with a patient selected, click the **Perio** button:

- If the selected patient does not have an exam, the button is gray  .
- If the selected patient has an existing exam, the button is blue  .

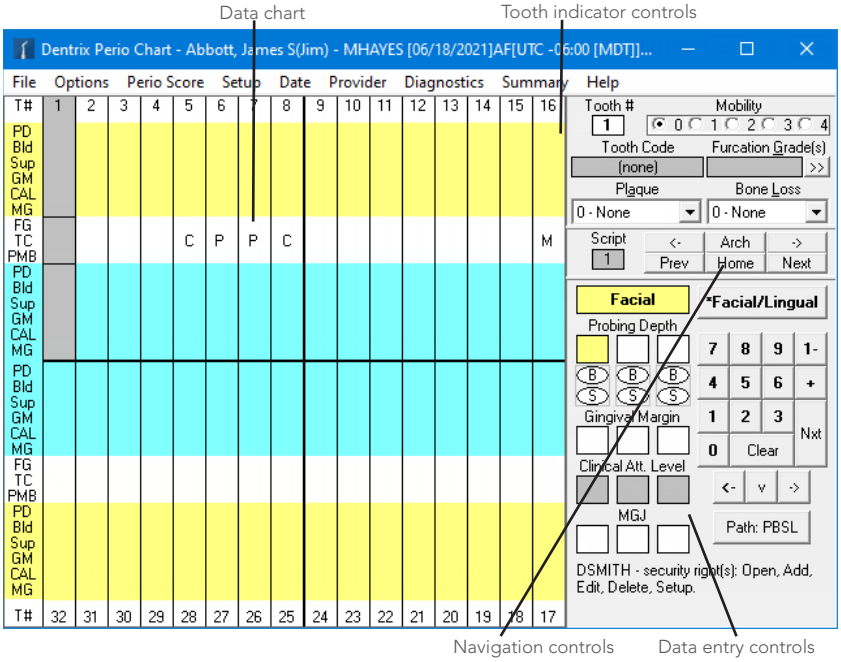
Perio Chart opens. If the patient does not have a perio exam for today, a new exam is started.

Notes:

- The Perio Chart provider is the provider who is selected in the Patient Chart.
- If the patient has a past exam, the data chart displays the data from that exam; otherwise, the data chart is blank.
- When you open 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 Perio Chart that is prohibited, a user with adequate security rights can override the restriction temporarily so you can complete the task.

The Perio Chart Window

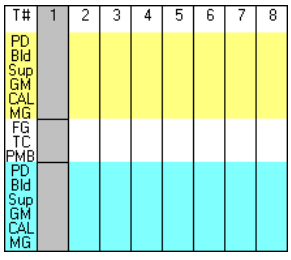
The **Perio Chart** window is divided into the following areas: the data chart, tooth indicator controls, navigation controls, and data entry controls.



This section covers the following topics about how to use the **Perio Chart** window:

- The Data Chart
- The Tooth Indicator Controls
- The Navigation Controls
- The Data Entry Controls

The Data Chart



You can use the data chart to input and display all periodontal data relevant to the current perio exam in a numerical format. The column that extends down the left side of the data chart indicates each measurement type.

The following list provides an explanation of the abbreviations used in the left column:

- **T# (Tooth Number)** – Indicates the tooth number to which the displayed information belongs.
- **PD (Pocket Depth)** – Indicates the depth of the periodontal pocket in millimeters.
- **Bld (Bleeding)** – A red oval in this row indicates a bleeding point.
- **Sup (Suppuration)** – A yellow oval indicates suppuration (infection) at that site.
- **GM (Gingival Margin)** – Indicates the gingival margin (recession) measurement in millimeters.
- **CAL (Clinical Attachment Level)** – Indicates the CAL measurement in millimeters.

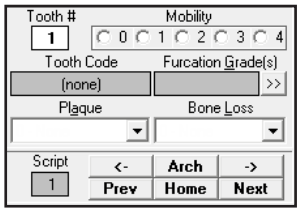
- **MGJ (Mucogingival Junction)** – Indicates the MGJ measurement in millimeters.
- **FG (Furcation Grade)** – Indicates the furcation involvement for the tooth.
- **TC (Tooth Code)** – Indicates special conditions relevant to the tooth. Conditions can include the following: C for crown, P for pontic, I for implant, U for unerupted, M for missing, ID for impacted distal, and IM for impacted mesial.
- **PMB (Plaque, Mobility, and Bone Loss)** – Indicates plaque, mobility, and bone loss measurements specific to the tooth.

The shading within the data chart has special significance:

- **Yellow areas** – Represent measurements taken from the facial (buccal) side of the tooth.
- **Blue areas** – Represent measurements taken from the lingual side of the tooth.
- **White areas** – Represent measurements that correspond to the tooth in general.

Within the yellow and blue areas, you can input six measurements (three on the facial side and three on the lingual side) for each tooth.

The Tooth Indicator Controls



The tooth indicator controls provide options for inputting data specific to a selected tooth. The information input through the tooth indicator controls is displayed in the white areas of the data chart. From the tooth indicator controls, you can input mobility, furcation grade, plaque, and bone loss. In addition, you can reference the tooth number currently selected and a text description of any codes associated with that tooth (for example, a crown, pontic, or implant).

The following list explains the function of each control:

- **Tooth #** – This box references the current tooth being charted.
- **Mobility** – Click the desired mobility classification. The number appears in the center placement of the PMB line on the data chart.
- **Tooth Code** – This box displays applicable condition information about the tooth.
- **Furcation Grade** – Click the search button >> to open the **Furcation Grade** dialog box, which displays the furcation grades relevant to the selected tooth. Select the appropriate furcation, and then click **OK**.
- **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.

The Navigation Controls

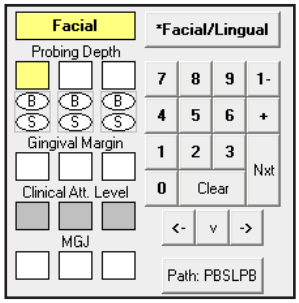
For quick entry of perio exam data and to facilitate different charting styles, Perio Chart allows you to set up a "paths" and "scripts" to indicate the tooth order, site to site movement on each tooth, and the measurement to be taken (for example, PD, GM, or CAL) at each site. For information about setting up charting paths and scripts, see the "Customizing perio entry settings" topic in the Dentrix Enterprise Help.



The navigation controls work in conjunction with the script settings. The following list outlines the function of each control:

- **Script** – This box displays the tooth number of the current position of the active script. It is a reference point in case the script is overridden by a different selection, so you know where the script stopped and where to recommence.
- **Left Arrow (<-)** – Click this button to move from the current tooth to the previous tooth.
- **Right Arrow (->)** – Click this button to move from the current tooth to the next tooth.
- **Arch** – Click this button to switch between the upper and lower arch (or vice versa).
- **Prev** – Click this button to rewind the script from the current tooth to the previous tooth.
- **Next** – Click this button to advance the script from the current tooth to the next tooth in the script.
- **Home** – Click this button to return to the first tooth in the script.

The Data Entry Controls



The data entry controls allow you to input data specific to different sites on the selected tooth: pocket depths, bleeding and suppuration points, gingival margins, clinical attachment levels, and mucogingival junction measurements.

The following list outlines the function of each control:

- **Facial/Lingual** – Click this button to switch from the facial side to the lingual side of a tooth (or vice versa).
- **Probing Depth** – Enter the pocket depth measurements.
- **B (Bleeding)** – Click the "B" oval, or press "B" on your keyboard, 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 the "S" oval, or press "S" on your keyboard, to indicate an infection point on the tooth. A yellow oval that corresponds to the selected tooth and site appears on the data chart.

  Tip: To add both suppuration and bleeding to the same tooth, while hold down the Ctrl key, press "B".

- **Gingival Margin** – Enter the gingival margin measurements.
- **Clinical Att. Level** – Enter the clinical attachment level.
- **MGJ** – Enter the mucogingival junction measurements.
- **0 – 9** – Click these buttons to enter charting measurements.

- **1-** – To enter a measurement that is greater than nine millimeters, click 1- button followed by the appropriate number (for example, to enter a pocket depth of 12 millimeters, click the 1- button followed by the **2** button). Measurements greater than nine millimeters appear as a greater than sign (>) on the data chart.
- **+** – To record a gingival margin that is above the CEJ, click the + button followed by the appropriate number. To indicate that the GM is a positive number, the number appears on the data chart as a white number in a black square.
- **Nxt** – Click this button to move from the current site to the next site of the script.
- **Clear** – Click this button to clear all entries on the current tooth.
- **Left**, **Down**, **and Right Arrows (<-**, **v**, **->)** – Click these buttons to move around the data entry area (**Probing Depth**, **B**, **S**, **Gingival Margin**, **Clinical Att. Level**, and **MGJ**) without advancing to another tooth.
- **Path** – This button always displays the current path being used (for example, PBSL, PBSR, or none). To manually switch between paths while charting, click the button until the desired path appears on the button.

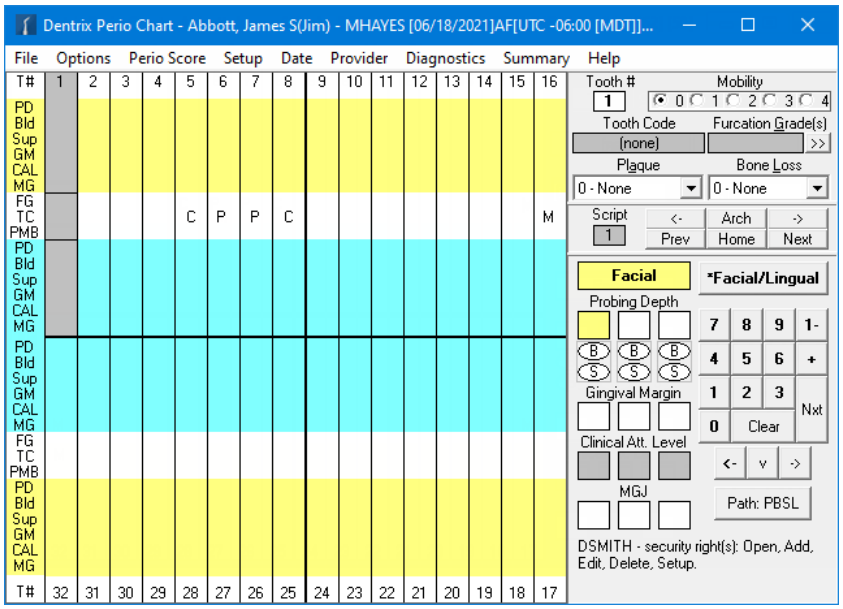
Entering New Perio Exams

Dentrix Enterprise offers a great deal of flexibility when you are creating a perio exam. You can enter only the most basic information, such as pocket depths. Or, if you want to do a more comprehensive exam, almost every perio classification and measurement is available to be charted and noted.

To enter a new perio exam

1. In Chart, with a patient selected, click the **Perio** button  .

   Perio Chart opens.



   Note: If a patient has an existing perio exam, Dentrix Enterprise automatically opens the most recent exam as a reference. You can save time by entering only the measurements that have changed since the last exam.

2. In Perio Chart, to select the script that you want to use for charting the exam, on the **Options** menu, point to **Select Script**, and then click an option.

   Note: 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.

3. Enter perio measurements, following the selected path and script. To enter information not included in the script, use the controls located on the right side of Perio Chart.

   The following list contains the keyboard commands that can be used if you prefer using the keyboard for data entry:

   - **Numeric key pad** – Works the same as the number buttons on the data entry controls.
   - **Number keys** – Work the same as the number buttons on the data entry controls.
   - **PAGE UP** – Works the same as the **Prev** button on the data entry controls.
   - **PAGE DOWN** – Works the same as the **Next** button on the data entry controls.
   - **HOME** – Works the same as the **Home** button on the data entry controls.
   - **DELETE** – Clears all entries in the current selection. Works the same as the **Clear** button on the data entry controls.

- **Arrow keys** – Works the same as the arrow buttons in the data entry controls.
- **Asterisk** (*) – Works the same as the **Facial/Lingual** button on the data entry controls. It toggles between the two surfaces of the selected tooth.
- **ENTER** – Advances the selection through the current script settings.

4. From the **File** menu, click **Save Exam**.

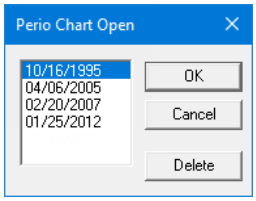
Viewing Perio Exams

Once an exam has been saved, it can be viewed at any time.

To view an existing exam

1. In Perio Chart, from the **File** menu, click **Open Existing Exam**.

   The **Perio Chart Open** dialog box appears.



2. Select the exam that you want to view.
3. Click **OK**.

Note: If you make any changes to the exam and then attempt to save those changes, a confirmation message appears. You must click **Yes** to save the changes.

Changing the Perio Exam View

From Perio Chart, you can view perio data in several different formats. This section covers the following view options:

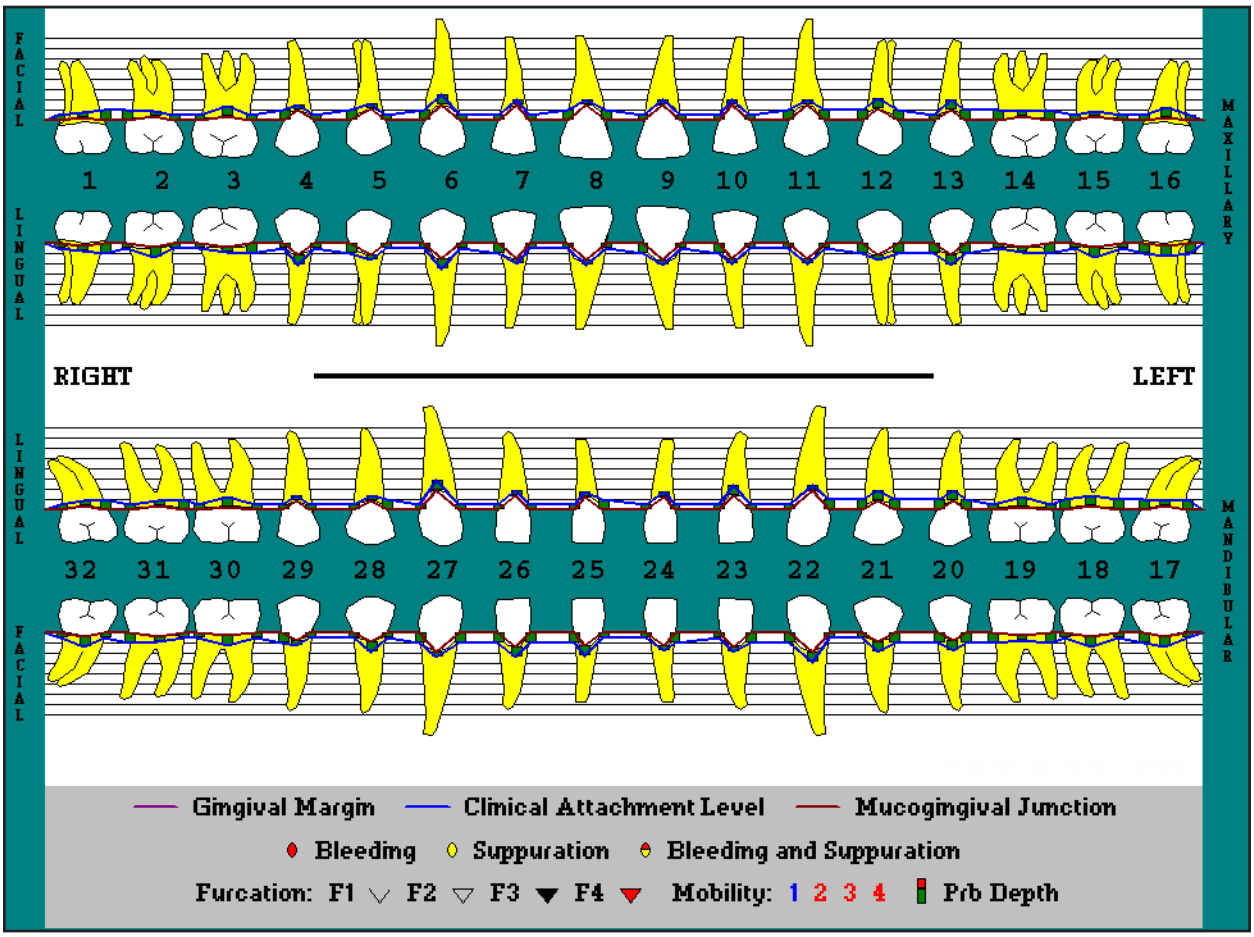
- Viewing the Graphic Chart
- Viewing the Combined Graphic and Data Chart
- Viewing Quadrants

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

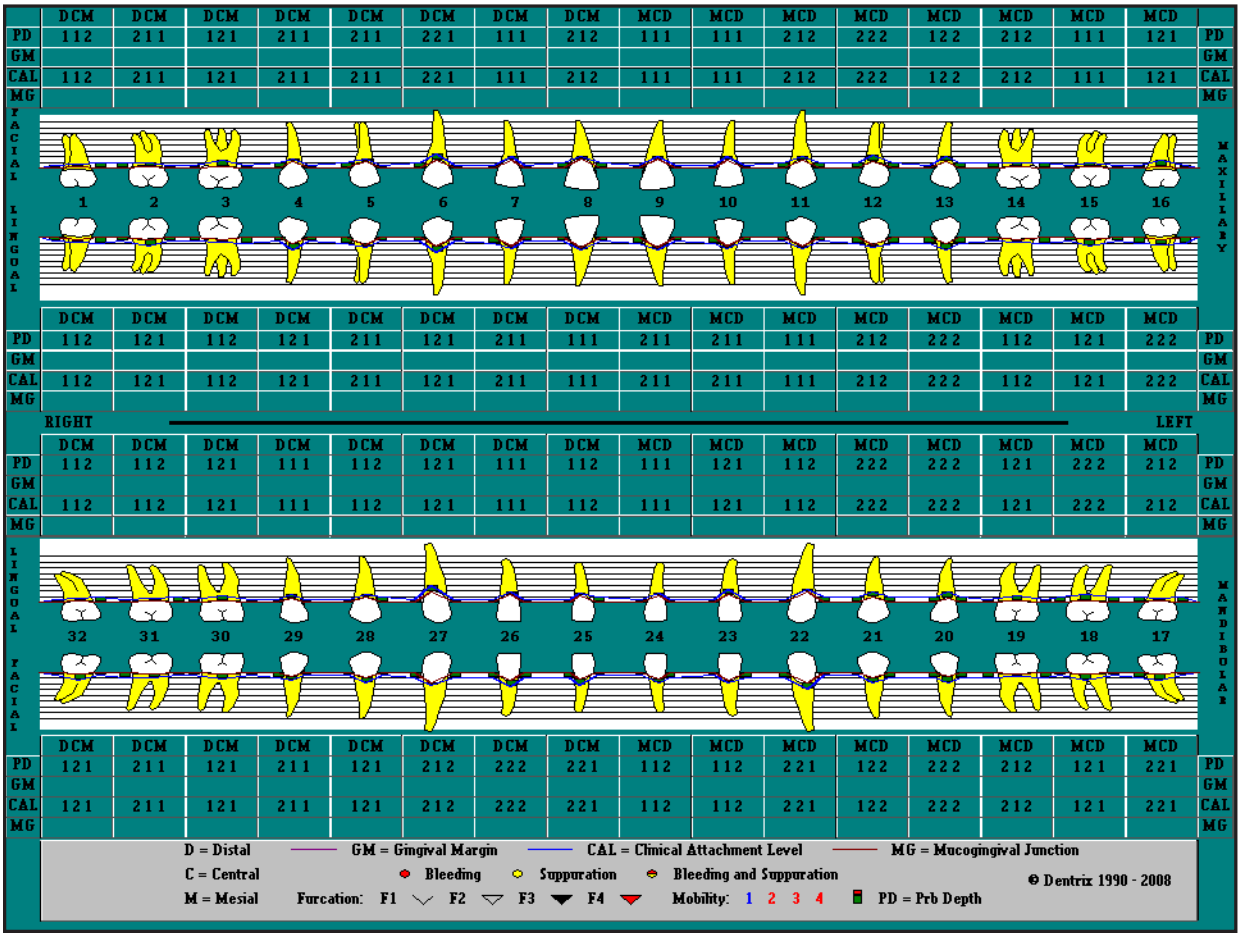


Viewing the Combined Graphic and Data Chart

In 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 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.

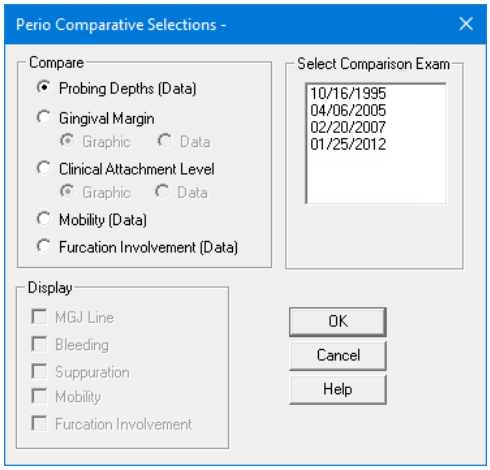
Comparing Perio Exams

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

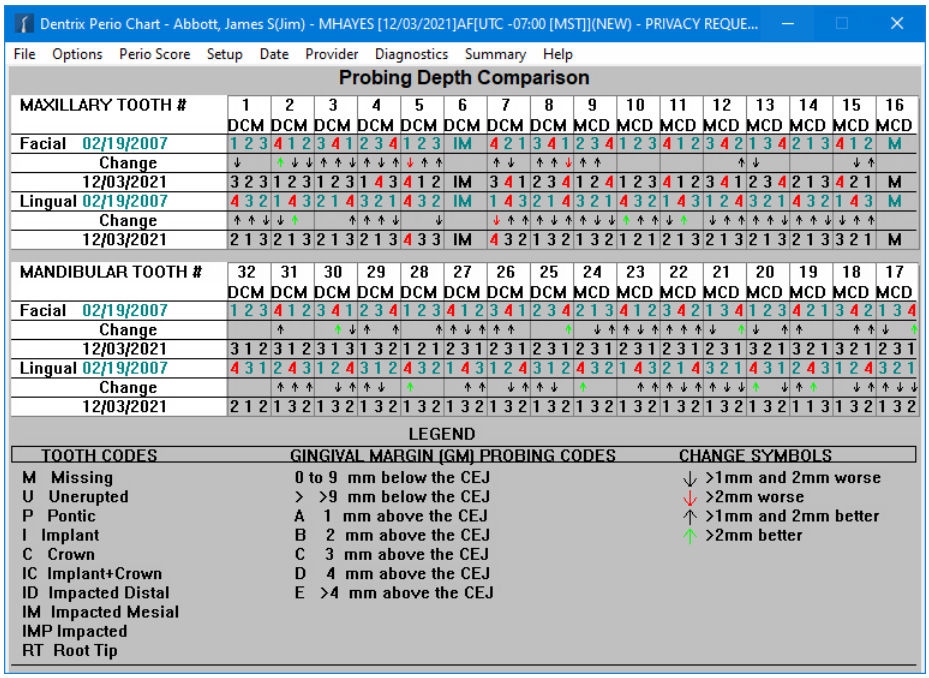
1. In Perio Chart, from the **Options** menu, click **Exam Comparison**.

   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.



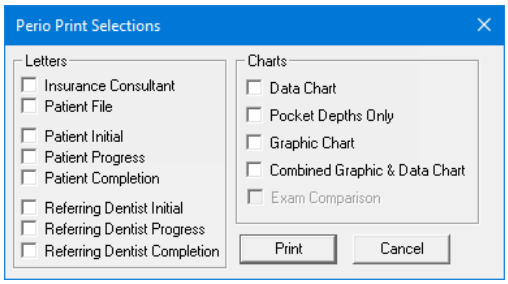
Printing Perio Chart Reports

From Perio Chart, you can print a variety of different charts and letters with periodontal exam information.

To print the Perio Chart reports

1. In Perio Chart, while viewing the exam you want to print, from the **File** menu, click **Print**.

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



2. Specify the letters and information you want to print:
   - **Letters** – Select any of the following letters that you want to print (Microsoft Word must be installed):
     - **Insurance Consultant Letter** – Prints a letter that can be sent as documentation of Perio disease diagnosis to an insurance carrier.
     - **Patient File** – Prints a document that can be placed in the patient's chart that documents the perio diagnosis for the selected exam.
     - **Patient Initial** – Prints a letter that can be sent to the patient to remind him or her of perio diagnosis and to suggest home care aids.
     - **Patient Progress** – Prints a follow-up letter that can be sent to provide an update for the patient on his or her perio status.
     - **Patient Completion** – Prints a congratulatory letter that can be sent to a patient on the completion of his or her perio treatment. The letter contains several helpful reminders to aid the patient in maintaining perio health.
     - **Referring Dentist Initial** – Prints a letter that can be sent as documentation of Perio disease diagnosis to the referring dentist.
     - **Referring Dentist Progress** – Prints a letter that contains updated diagnostic information for the referring dentist.
     - **Referring Dentist Completion** – Prints a letter that contains final diagnostic information and explains that the patient should be returning to the referring dentist for general dental care.
   - **Charts** – Select any of the following perio chart information that you want to print:
     - **Data Chart** – Prints the data chart.
     - **Pocket Depths Only** – Prints the data chart but only includes pocket depths.
     - **Graphic Chart** – Prints the graphic chart (will print in color if sent to a color printer).
     - **Combined Graphic & Data Chart** – Prints the graphic and data chart (will print in color if sent to a color printer).
     - **Exam Comparison** – Prints the exam comparison chart. This option is available only if you are viewing an exam comparison.
3. Click **Print**.

Chapter 6: Treatment Planner

Treatment Planner can help you provide your patients with easy-to-understand treatment options. When Treatment Planner is opened for a selected patient, his or her entire treatment plan is used to create a default treatment plan case. You can set up additional cases and visits, and you can view detailed treatment and insurance information. Also, you can group procedures in a treatment plan case by visit or by case to provide patients with different treatment options.

This chapter covers the following topics:

- Opening Treatment Planner
- The Treatment Planner Window
- Customizing Case Settings
- Selecting the Case Details to Display
- Working with Treatment Plan Cases
- Viewing Case Status History
- Adding Consent Forms to Cases
- Signing Consent Forms
- Treatment Consent Forms (Enhanced)
- Editing and Deleting Procedures
- Posting Completed Procedures
- Updating Treatment Plan Fees
- Generating Treatment Planner Reports

Opening Treatment Planner

You can open the Treatment Planner from the Family File, Patient Chart, Ledger, and Appointment Book.

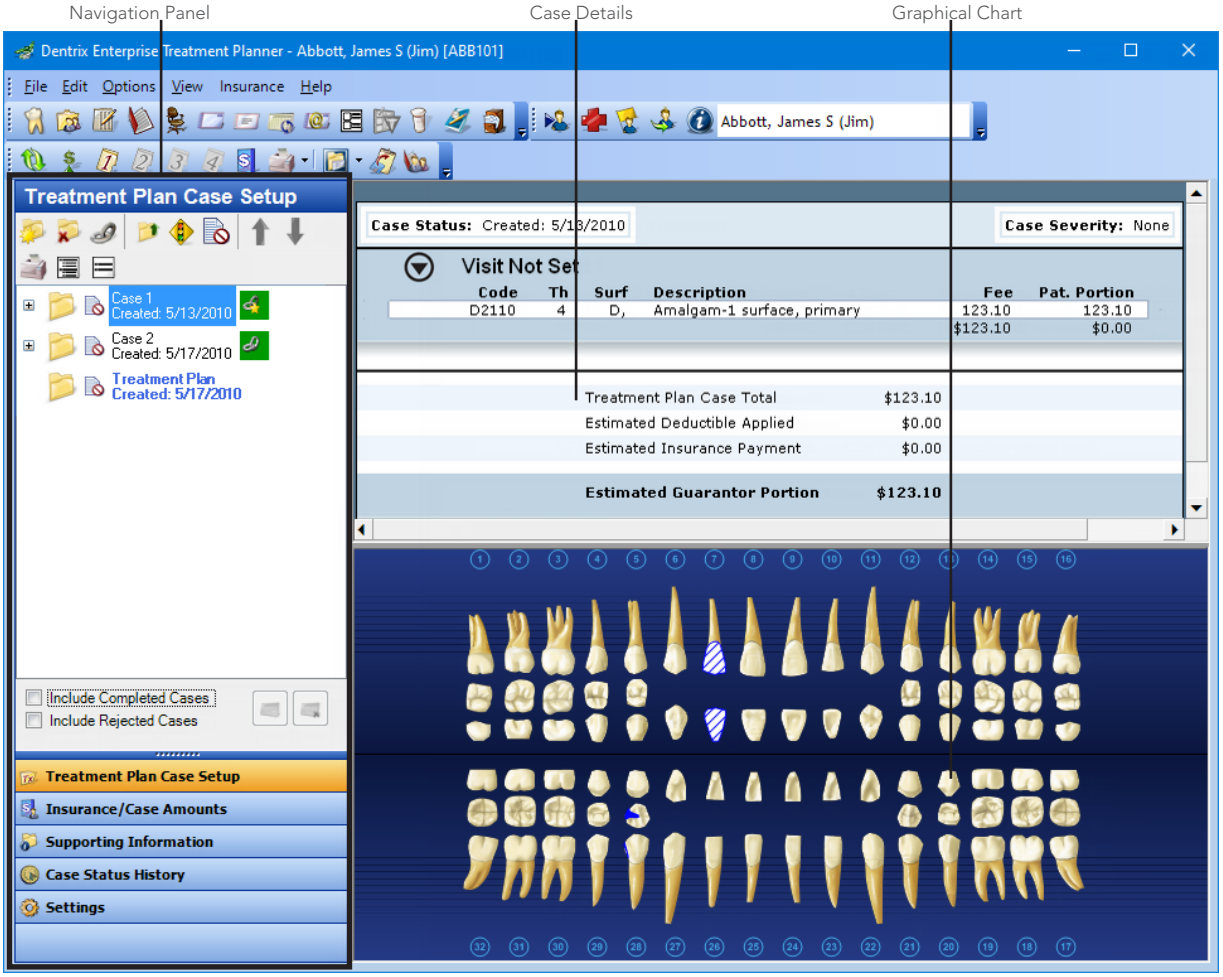
To open the Treatment Planner

Do one of the following:

- In Chart or Ledger, with a patient selected who has treatment-planned procedures, click the **Treatment Planner** button  .
- With a patient's appointment selected in Appointment Book, click the **Treatment Planner** button  .
- In Family File, with a patient selected, click the **Treatment Planner** button  .

The Treatment Planner Window

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



This section covers the following topics on how to use the **Treatment Planner** window:

- The Treatment Planner Toolbar
- The Navigation Panel

The Treatment Planner Toolbar

Treatment Planner includes toolbars with buttons you can click to access certain areas or features of Dentrix Enterprise.



The function of the buttons specific to Treatment Planner are explained in the following table.

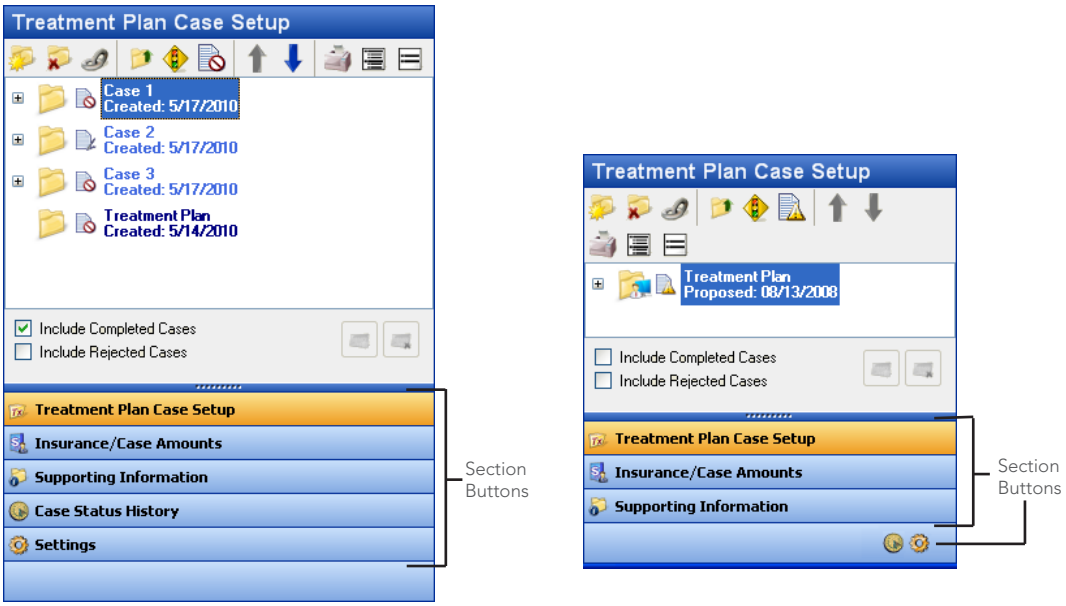
	Click the **Refresh** button to update the data from other modules, such as the Ledger or Patient Chart.
	Click the **Update Treatment Plan Fees** button to update the treatment plan fees manually to reflect any fee schedule changes.
 	Click the **Primary Dental Insurance Notes** button to view the primary dental insurance plan note for the primary dental insurance plan of the patient currently being viewed in Treatment Planner. You also have buttons for secondary, tertiary, and quaternary dental insurance if the current patient has those particular types of insurance coverage.
	Click the **Insurance Benefits** button to view a summary of the current patient's insurance benefits. You also have the option to include all family members.
	Click the **Print** button to print one of the Treatment Planner reports.
	Click the **Treatment Planner View** button to select a Treatment Planner view.
	Click the **Copy Case Detail to Clipboard** button to copy the case detail currently being displayed to the Windows Clipboard so that you can paste the information into a word processing program.
	Click the **Other Appointments** button to view appointments that have been scheduled for the patient selected in Treatment Planner and that patient's family members.

For a comprehensive explanation of all the Treatment Planner toolbars, see the "Using the Treatment Planner toolbars" topic in the Dentrix Enterprise Help.

The Navigation Panel

From the Navigation panel, you can assign treatment to cases, set the order of the visits, create alternate cases, view insurance estimates, add supporting information, view case history statuses, and set up the default settings and required consent forms for new cases.

The Navigation panel consists of several sections that you can open by clicking the corresponding section button.



Note: If you resize the button area so that not all the buttons fit on the panel, a smaller version of any section button that does not fit on the panel in its full size appears at the bottom of the panel.

The following is a brief explanation of each section;

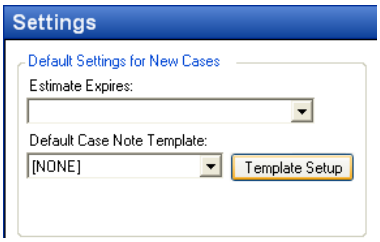
- **Treatment Plan Case Setup** – Open this section to assign treatment to cases, create and link alternate cases, set a recommended case, change the status of a case, set the severity level for a case, set the order of visits for a case, add and sign consent forms, complete procedures, and print Treatment Planner reports.
- **Insurance/Case Amounts** – Open this section to view insurance estimates, treatment plan case totals, insurance plan notes, and patient and family benefit details.
- **Supporting Information** – Open this section to add notes and consent forms to a case.
- **Case Status History** – Open this section to assign and view status changes for a case. You can also create a referral.
- **Settings** – Open this section to set the defaults for all new cases that are created and to manage consent forms.

Customizing Case Settings

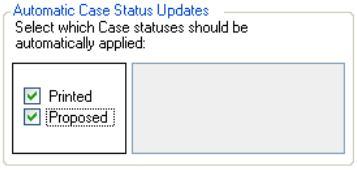
Before treatment planning a case, set up the case defaults. Changes made to the default case settings affect all other computers on your practice's network, and the selected settings will be used for every new case that is created.

To customize case settings

In Treatment Planner, on the Navigation panel, from the **Settings** section, set up the following options:



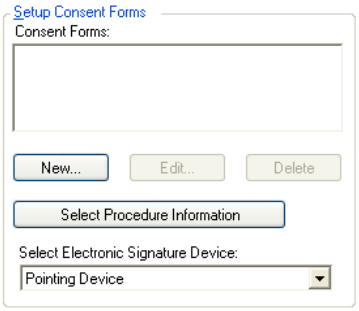
- **Default Settings for New Cases**
  - **Estimate Expires** – Select the default expiration date for all cases: "1 year from current date," "3 months from current date," "1 month from current date," "Beginning of next calendar year," "Beginning of next fiscal year," "Beginning of next month," or "Prim. Ins. Benefit renewal month."
  - **Default Case Note Template** – Select the default that will be used to create case notes from a template. "[NONE]" is the only option that is available until another template has been set up. To add, modify, or delete a template, click **Template Setup**.
- **Automatic Case Status Updates** – Select the case statuses that you want to be added automatically to the case status history:



  - **Printed** – A case will be updated with the "printed" status when the case is printed.
  - **Proposed** – A case will be updated with the "proposed" status to present or propose the case to the patient.

  Note: If you select a status, the status is automatically applied to the current case.

- **Setup Consent Forms** – Any existing consent forms that will be used for new cases appear in the list box. Do any of the following:



  - **New** – To add a consent form, click **New**.
  - **Edit** – To edit an existing consent form, select that consent form, and then click **Edit**.
  - **Delete** – To delete a consent form, select that form, click **Delete**, and then click **Yes** to confirm the deletion.
  - **Select Procedure Information** – To select what procedure information is allowed on consent forms by default, click **Select Procedure Information**.
  - **Select Electronic Signature Device** – Select the device that will be used to sign cases at this computer.

    Important: If you are using Terminal Services or Citrix on this computer to connect remotely to a computer with Dentrix Enterprise installed, an ePad will not work for signing consent forms from this computer.

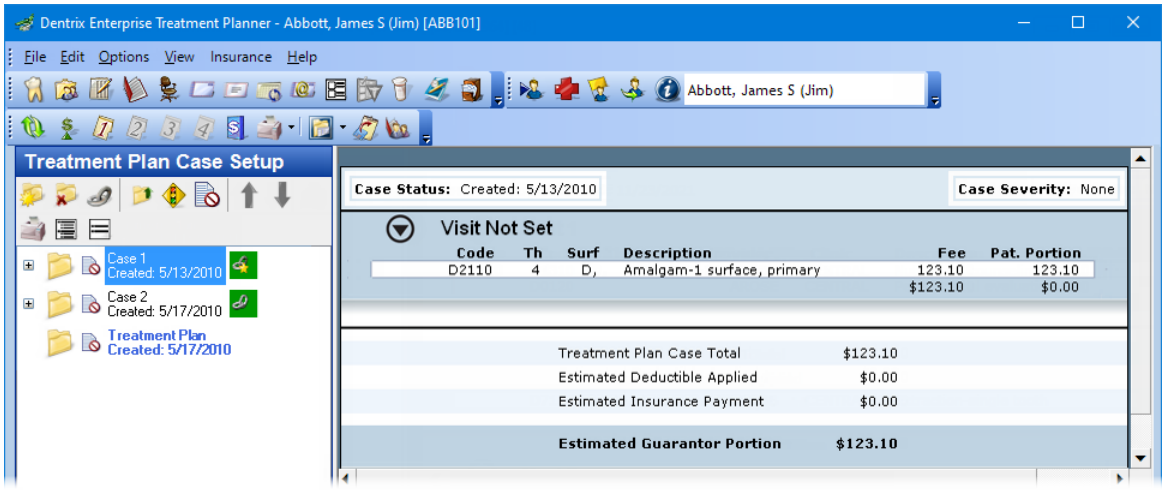
For a comprehensive explanation of all the available case settings, see the "Customizing case settings" topic in the Dentrix Enterprise Help.

Selecting the Case Details to Display

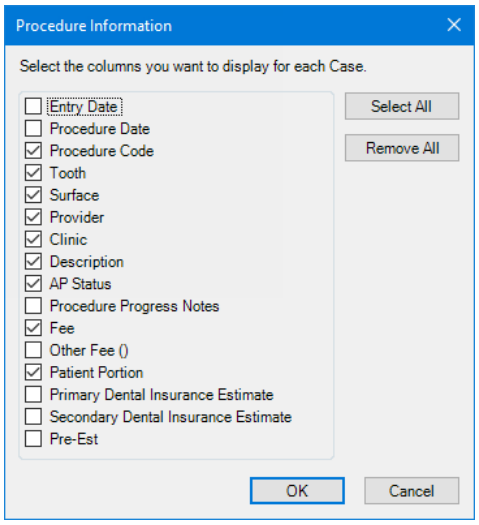
You can specify what, if any, procedure information you want to be displayed in the case details area.

To select the procedure information to display

1. In Treatment Planner, from the **View** menu, click **Procedure Information**.



The **Procedure Information** dialog box appears.



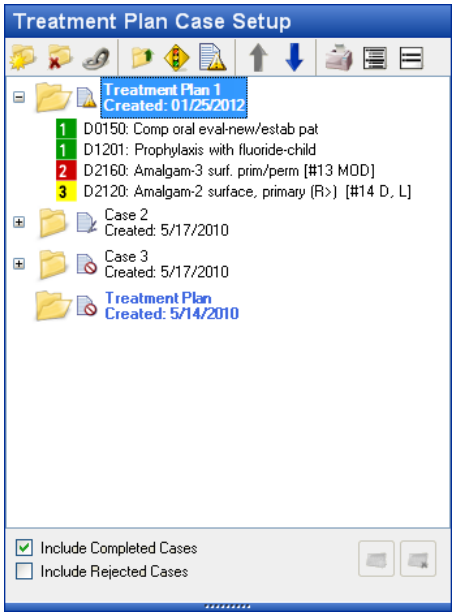
2. Select the information you want to display in the case details. The case details will have a column for each information item that is selected.
3. Click **OK**.

Working with Treatment Plan Cases

Treatment-planned procedures can be grouped into a case. This section covers the following topics about treatment plan cases:

- The Treatment Plan Case Setup Section
- Creating New Cases
- Creating Alternate Cases
- Linking Alternate Cases
- Setting the Recommended Case
- Ordering Procedures by Visit

The Treatment Plan Case Setup Section



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

As you select a case in the list, the other sections (except for **Settings**) on the panel and the case details are updated to reflect the information for the selected case.

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

	Click the **New Case** button to create a new treatment plan case you can use to group treatment-planned procedures.
	Click the **Delete Case** button to delete the selected treatment plan case.
	Click the **Link Alternate Cases** button to link alternate treatment plan cases together so that, when one of the cases is accepted, the others are automatically rejected. You can also set the recommended case.
	Click the **Update Case Status** button to change the status of the selected treatment plan case.
	Click the **Set Case Severity** button to specify a severity for the selected treatment plan case.
	Click the consent forms button to add, sign, or view consent forms for the selected case. The appearance and functionality of the button varies depending on the status of the consent forms for the case:  There are no consent forms attached to the case. Click the **No Consent Forms** button to add consent forma to the selected case.  The case has at least one unsigned consent form. Click the **Case Has Unsigned Consent Forms** button to sign the consent forms.  The case has at least one consent form that is missing one of the two required signatures. Click the **Consent Forms Missing Signature** button to sign the consent forms.  All the consent forms for the case have been signed. Click the **All Consent Forms Have Been Signed** button to review the consent forms.
	Click the **Move Case Up** button to move the selected case up one place in the list. Click the **Move Case Down** button to move the selected case down one place in the list.

	Click the **Print** button to select a Treatment Planner report you want to print.
	Click the **Expand All** button to view all the treatment-planned procedures for every case listed.
	Click the **Collapse All** button to show only the name and date of every case listed.

You also have the following options at the bottom of the **Treatment Plan Case Setup** section:

- **Include Completed Cases** – Selecting this option includes completed treatment plan cases in the case list.
- **Include Rejected Cases** – Selecting this option includes rejected treatment plan cases in the case list.
- **Create Visit** – When procedures that have not been assigned a visit number are selected, clicking this button  creates a new visit that is given the next available number for the corresponding case.
- **Delete Visit** – When procedures that have been assigned a visit number are selected, clicking this button  deletes the visit from the corresponding case.

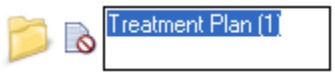
Creating New Cases

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 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, create alternative treatment options, or provide different patient payment estimates, for example. You can create a customized patient experience all while maintaining an efficient workflow.

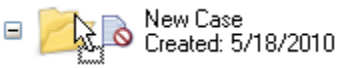
To create a new case

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

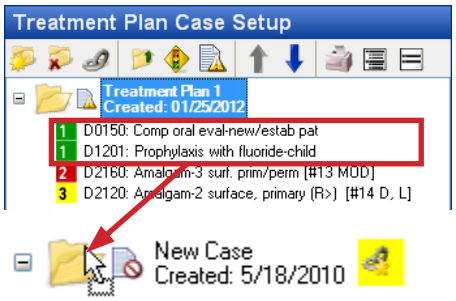
   The new case appears in the case list.

2. Enter 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.

Creating Alternate Cases

Customizing the patient experience is a huge part of providing customer service. One way to give your patients options in their treatment is to use alternate cases in Treatment Planner. You can create alternate cases for a treatment-planned procedure in order to provide the patient with multiple treatment options, such as root canal therapy and a crown, versus an extraction, an implant, and a crown. When you create an alternate case, it is linked to the original case as an alternative treatment option.

To create an alternate case

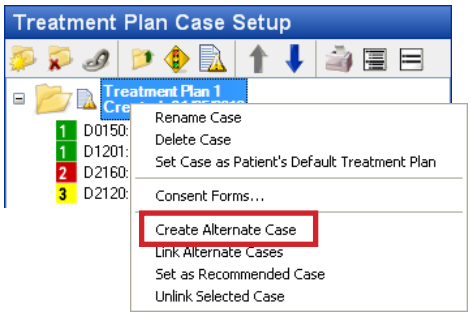
In Treatment Planner, on the Navigation panel, from the **Treatment Plan Case Setup** section, the default treatment plan folder ("Treatment Plan," if it has not been renamed) currently includes all of the possible treatment options that are not already assigned to a case. Use one of the following methods to create an alternate case:

To create an alternate case if each case has different treatment options

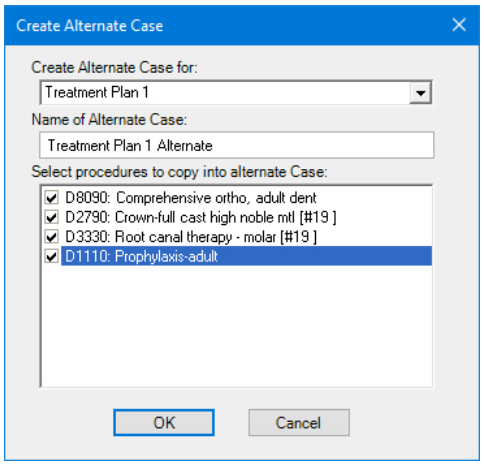
1. Create a new case folder for the alternate case (such as "Extraction and Implant").
2. Select the procedures in the default treatment plan folder that need to be moved to the alternate case folder. Then, drag those procedures to the alternate case.
3. Rename the default treatment plan folder to be more descriptive (such as "Root Canal and Crown").

To create an alternate case if the cases have one or more treatment options in common

1. Select the case for which you want to create an alternate case. Right-click that case, and then click **Create Alternate Case**.



The **Create Alternate Case** dialog box appears.



2. Verify that the case being displayed in the **Create Alternate Case For** list is the case for which an alternate case is being created.

   Note: The selected case is the case that will be flagged as the recommended case. If you do not want this case to be the recommended one, you can select a different case while in this dialog box, or you can change the recommended case later.

3. In the **Name of Alternate Case** box, enter a name for the alternate case.
4. Leave the check boxes selected for the procedures that need to be completed regardless of which of the other treatment options the patient chooses. Deselect the others. For example, a restoration (such as a three-surface composite filling) may need to be placed on a tooth regardless of whether the patient chooses to have a crown or an implant on a different tooth.
5. Click **OK**.

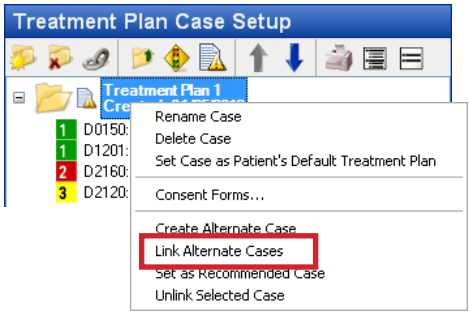
Linking Alternate Cases

When you create alternate cases with shared treatment, the alternate case is automatically linked to the original case. If you have created cases that are all alternate cases for each other but are not linked, you can link them manually. You can link as many treatment plan cases together as is necessary; however, if you want to link several cases together, make sure each case is functioning as an alternate treatment plan being offered to a patient.

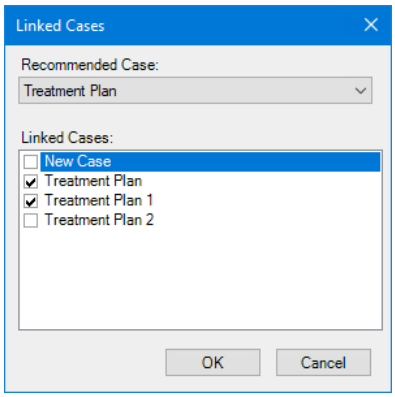
Additionally, linking cases can be beneficial for updating statuses. For example, if a case is applied an Accepted status, the other linked cases are automatically given a Rejected status.

To link alternate cases

1. In Treatment Planner, on the Navigation panel, from the **Treatment Plan Case Setup** section, either select the case that is already linked to another cases, or select the case that you want to be the recommended case and link to other cases. Right-click that case, and then click **Link Alternate Cases**.



   The **Linked Cases** dialog box appears.



2. If you right-clicked a case that is not already linked, from the **Recommended Case list,** select the recommended case; otherwise, this list is unavailable and displays the recommended case you right-clicked or the recommended case for the case you right-clicked.
3. Select the cases you want to link. At least two cases must be selected.
4. Click **OK**.

Notes:

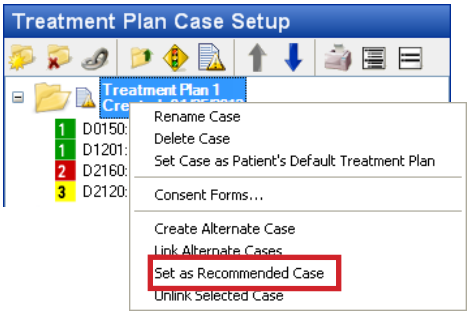
- Linked cases have link icons (or) after them. The background color of the icon varies, depending on how many sets of linked cases exist for the patient; for example, you could have two cases linked together and two other cases linked together, and the background color of the link icon for both of those sets will be different
- When linked treatment cases exist, the recommended case will appear in the Patient Chart.

Setting the Recommended Case

The recommended case is the case that contains the recommended treatment plan. The recommended case can be changed after alternate cases have been created.

To set the recommended case

In Treatment Planner, on the Navigation panel, from the **Treatment Plan Case Setup** section, select the case you want to set as the recommended case. Right-click that case, and then click **Set as Recommended Case**. This option is available only if the case is linked to an alternate case.



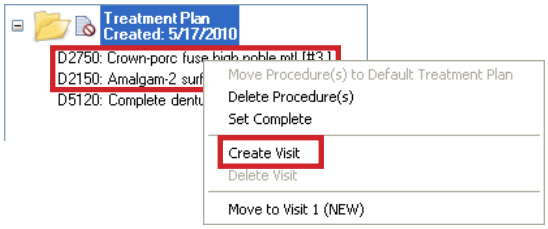
Note: The link icon after the case becomes starred. The starred link icon after the prior recommended case becomes a normal link icon.

Ordering Procedures by Visit

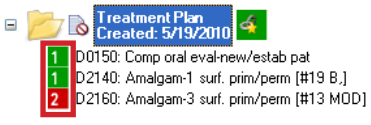
Sometimes a course of treatment requires multiple visits. For example, a patient could have a root canal performed and a temporary crown placed on the first visit and then the final crown seated on another visit. When more than one visit is required to complete a treatment plan case, you can organize 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 Treatment Planner, on the Navigation 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**. The visit number appears next to the procedures.



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).

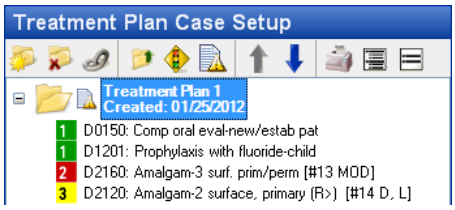


Viewing Case Status History

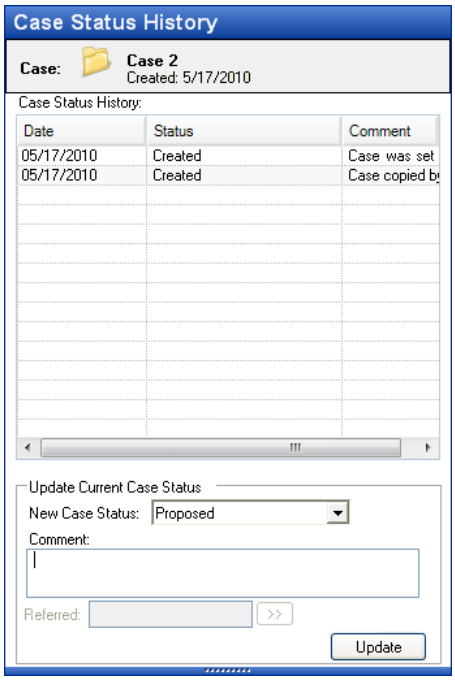
As a case is created and modified, Treatment Planner tracks the changes in status and provides a way for you to view those changes. After reviewing the status history of a case, you can update the case status.

To view and update the status history of a case

1. In Treatment Planner, on the Navigation panel, from the **Treatment Plan Case Setup** section, select a case.



2. Open the **Case Status History** section for the selected case, which is shown at the top of the section.



The **Case Status History** table displays the status history for the selected case, which includes the date of the change, the current status of the case, and any comments made at the time of that particular change.

3. If necessary, to update the status of the case, under **Update Current Case Status**, from the **New Case Status** list, select the appropriate status, and then click **Update**.

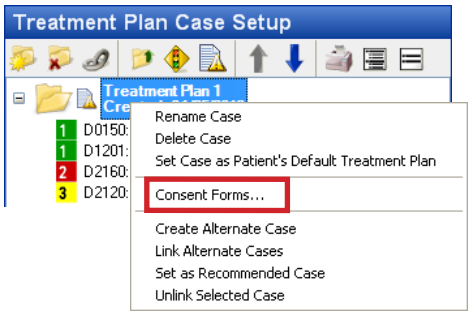
Tip: You can also update the status for a selected case by clicking the **Update Case Status** button on the **Treatment Plan Case Setup** section's toolbar.

Adding Consent Forms to Cases

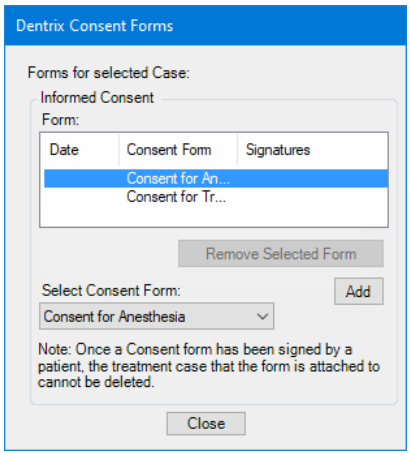
You can add consent forms to cases for a patient and provider to sign. You can set up consent forms from the **Settings** sections of the Navigation panel.

To add a consent form to a case

1. In Treatment Planner, on the Navigation panel, from the **Treatment Plan Case Setup** section, select a case. Next, right-click the case, and then click **Consent Forms**.

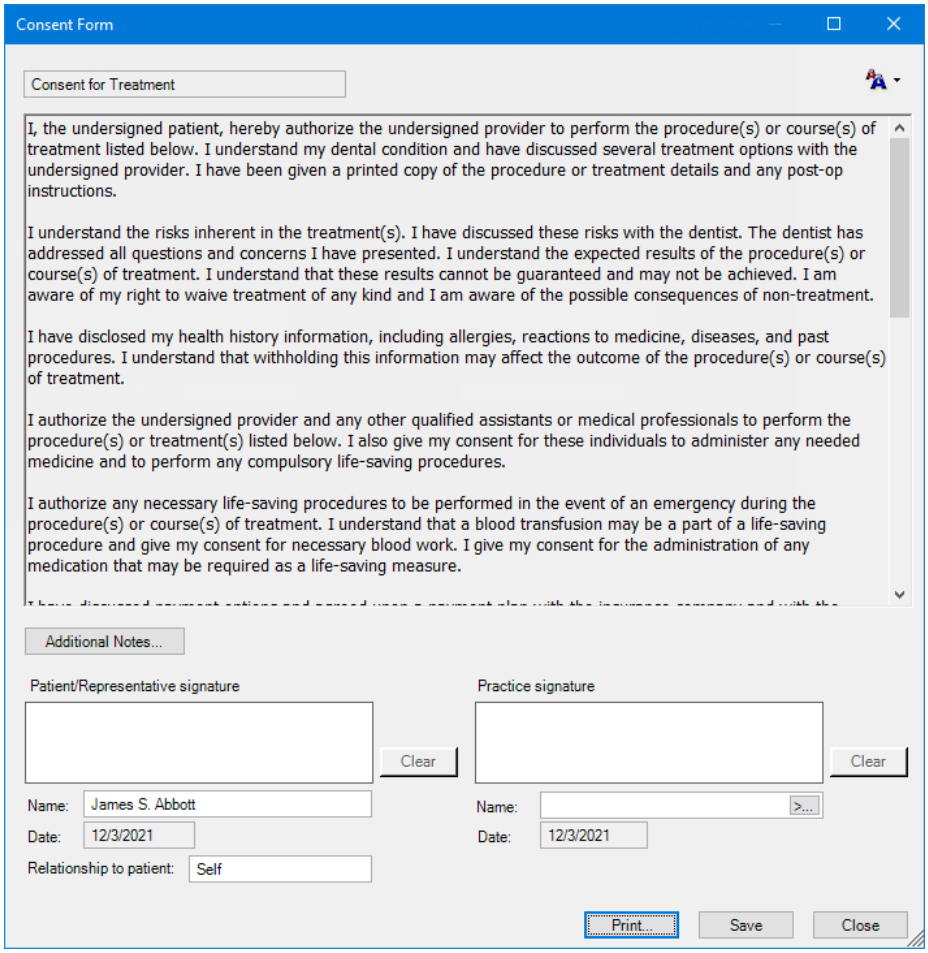


   The **Dentrix Consent Forms** dialog box appears.



2. From the **Select Consent Form** list, select the form you want to add to the selected case.
3. Click **Add**.

   The **Consent Form** dialog box appears.



4. Under **Patient/Representative signature**, the patient selected in Treatment Planner is entered in the **Name** box but can be changed. Also, the **Relationship to patient** has "Self" entered by default but can be changed (for example, you can enter "Spouse" or "Parent" if the person signing the form is the patient's spouse or parent). The name and relationship can be edited at a later time (for instance, when the consent form is going to be signed).
5. Under **Practice signature**, click the **Name** search button >... to select the provider (primary or secondary) who will sign the form, or you can enter the provider's name in the box. The name can be entered at a later time (for instance, when the consent form is going to be signed).

   Tip: The consent form can be signed by the patient and provider at a later time. Also, both signatures do not need to be acquired at the same time. For information about signing consent forms, see "Signing Consent Forms" in this chapter.

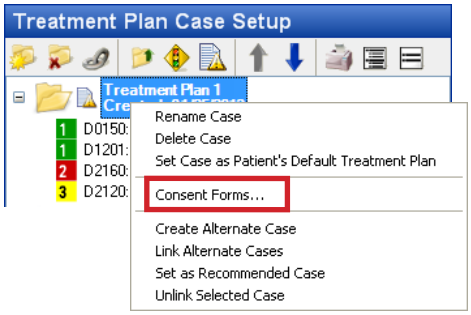
6. Click **Save**.
7. To print the consent form, click **Print**. You can print any consent form, signed or not.

Signing Consent Forms

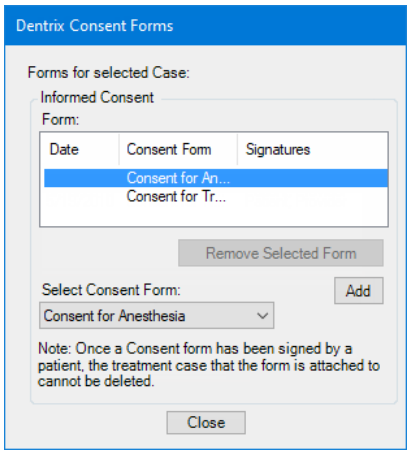
The patient and provider can electronically sign consent forms attached to a treatment plan case. Once a signature is added to a consent form and the form is saved, the signature cannot be removed. The consent form is considered locked once both parties have signed it (both parties do not have to sign on the same date).

To sign a consent form

1. In Treatment Planner, from the **Treatment Plan Case Setup** section of the Navigation panel, select a case that needs to be signed. Next, right-click the case, and then click **Consent Forms**.

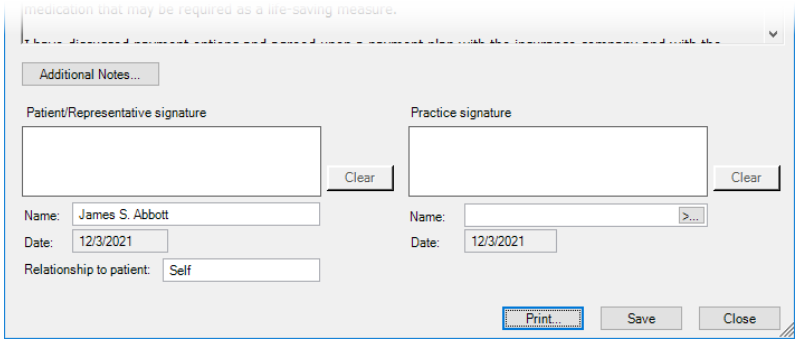


The **Dentrix Consent Forms** dialog box appears.



2. Double-click the consent form you want to sign.

   The **Consent Form** dialog box appears.



3. Under **Patient/Representative signature**, if the correct patient is not already entered in the **Name** box, enter the name of the person who will sign the form. Also, if the correct **Relationship to patient** is not already entered, enter a relationship (for example, "Self," "Spouse," or "Parent"). Then, have the patient or patient's representative sign in the box using an input device.

   Note: You can click **Clear** if the patient needs to re-sign. This button is unavailable if the consent form has been saved with a signature (even the slightest mark registers as a signature) or no signature has been added yet. Once the form is saved, the signature, name, and relationship cannot be changed.

4. Under **Practice signature**, if the correct provider is not already entered in the **Name** box, click the search button >... to select the provider (primary or secondary) who will sign the form, or you can enter the provider's name in the box. Then, sign in the box using an input device.

   Note: You can click **Clear** if you need to re-sign. This button is unavailable if the consent form has been saved with a signature (even the slightest mark registers as a signature) or no signature has been added yet. Once the form is saved the signature and name cannot be changed.

5. Click **Save**.
6. To print the consent form, click **Print**.

Treatment Consent Forms (Enhanced)

With a certain global setting enabled, there are changes to the consent form interface and functionality in Treatment Planner. Using a consent form template as a guide, you can quickly and accurately create a custom consent form with minimal typing or editing. Dentrix Enterprise comes with a default template, but you can modify it to suit your needs or create new ones. Templates are grouped by category. Also, each template can have any number of prompts, which are messages that prompt you to enter responses to user-defined questions.

Important: Enable this functionality only if your workflow allows for creating a form and immediately signing it. With this functionality, when you add a consent form to a case, before you can save the form, the patient (or his or her representative), someone from the practice (such the dentist), and a witness (or interpreter) must sign it.

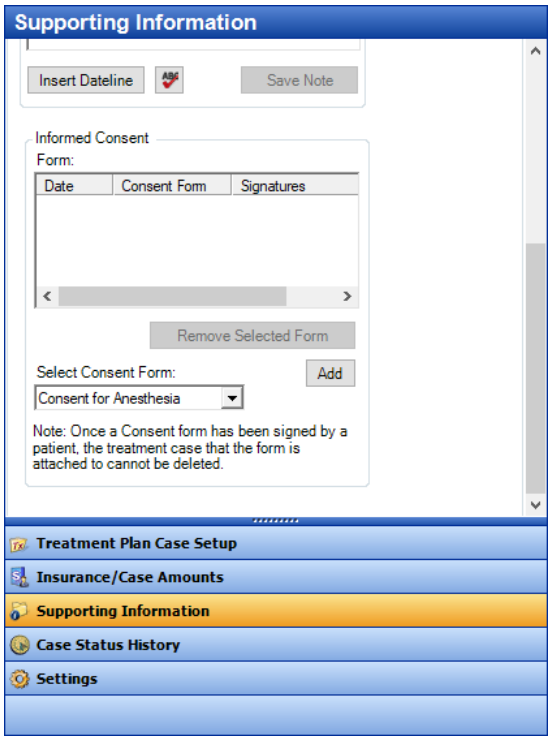
Setting Up Consent Form Template Categories

You can customize the categories for organizing consent form templates.

Note: Only users with the "Consent Forms, Template Setup" security right enabled can set up consent form categories.

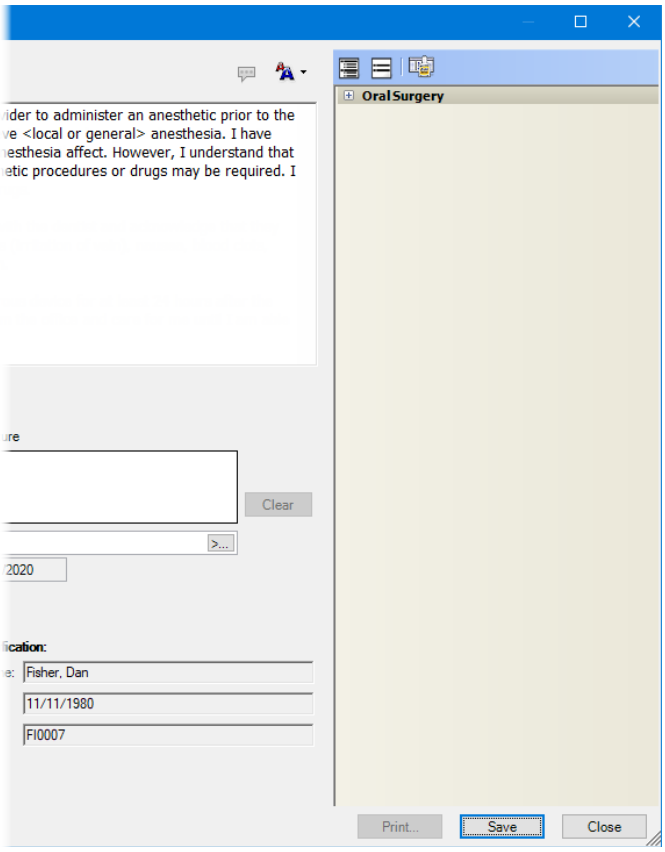
To set up a consent form template category

1. In Treatment Planner, on the Navigation panel, open the **Supporting Information** section.



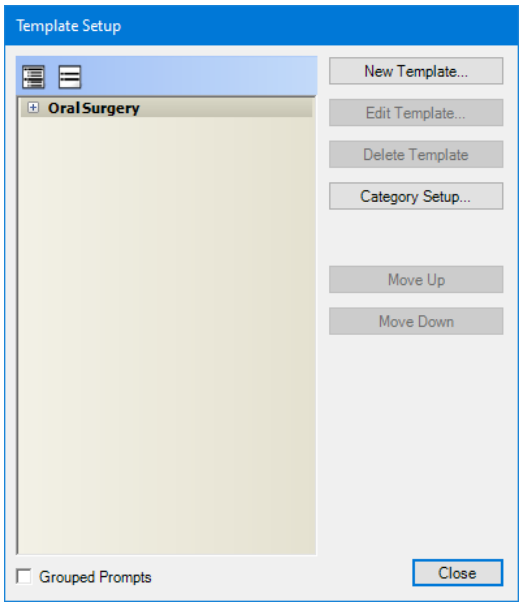
2. Under **Informed Consent**, click **Add**.

   The **Consent Form** dialog box appears.



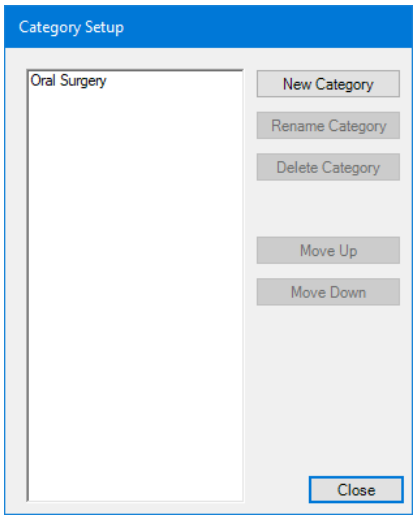
3. Click the **Template Setup** button  .

   The **Template Setup** dialog box appears.



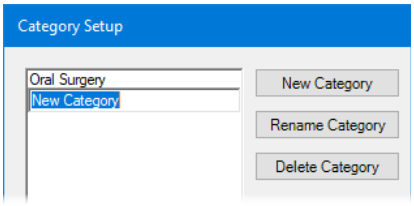
4. Click **Category Setup**.

   The **Category Setup** dialog box appears.

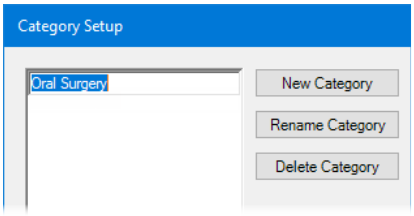


5. Do any of the following as needed:

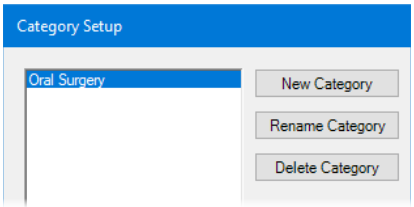
- **Create a new category** – Click **New Category**, enter the category name in the box that appears at the bottom of the list, and then press Tab (or Enter if you want to close the **Category Setup** dialog box after making the new category).



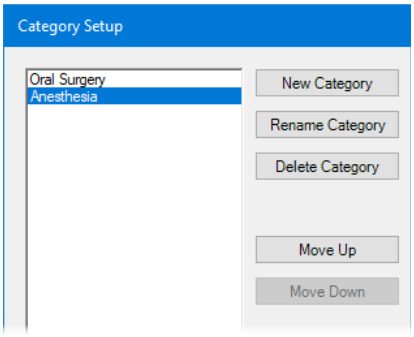
- **Rename a category** – Select the category that you want to rename, click **Rename Category** to make the name editable, change the name, and then press Tab (or Enter if you want to close the **Category Setup** dialog box after making the change).



- **Delete a category** – You can only delete a category if it does not contain any templates. Select the category that you want to delete, click **Delete Category**, and then click **Yes** to confirm the deletion.



- **Change the order of the categories** – Select a category, and then click **Move Up** or **Move Down** until you achieve the desired order. Repeat this process for any other categories that you want to move.



6. If the **Category Setup** dialog box is still open, click **Close**.
7. In the **Template Setup** dialog box, click **Close**.
8. In the **Consent Form** dialog box, click **Close** because you do not want to attach the consent form to the case; you were only accessing a form so that you could set up template categories.

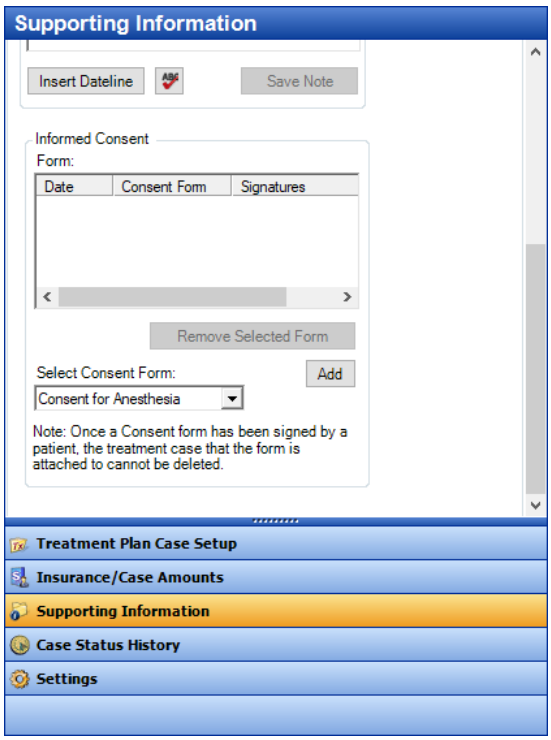
Creating Consent Form Templates

You can create consent form templates to use for adding consent forms to treatment plans.

Note: Only users with the "Consent Forms, Template Setup" security right enabled can create consent form templates.

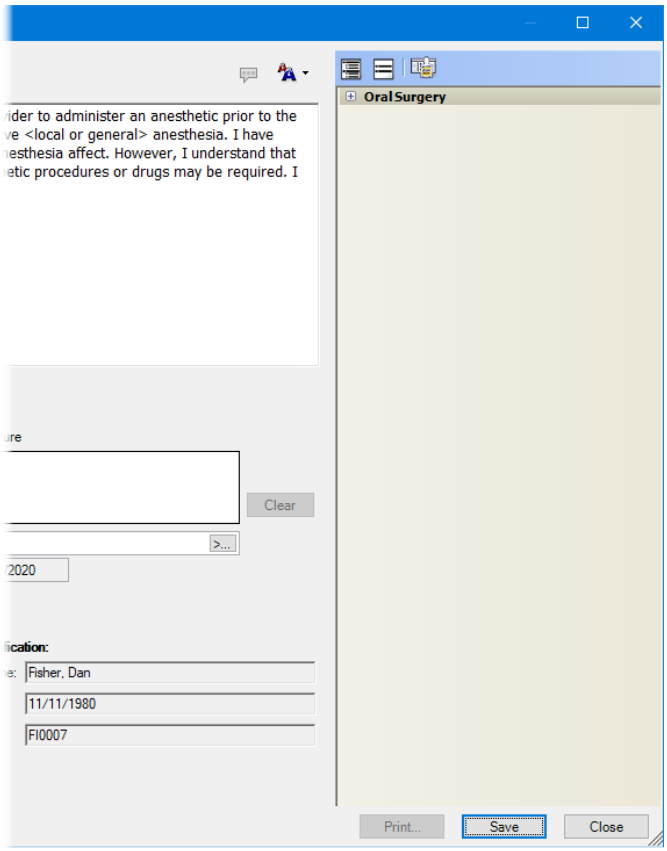
To create a consent form template

1. In Treatment Planner, on the Navigation panel, open the **Supporting Information** section.



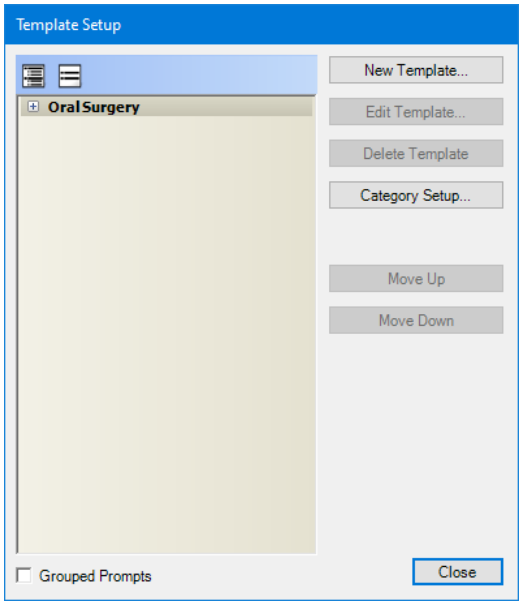
2. Under **Informed Consent**, click **Add**.

The **Consent Form** dialog box appears.



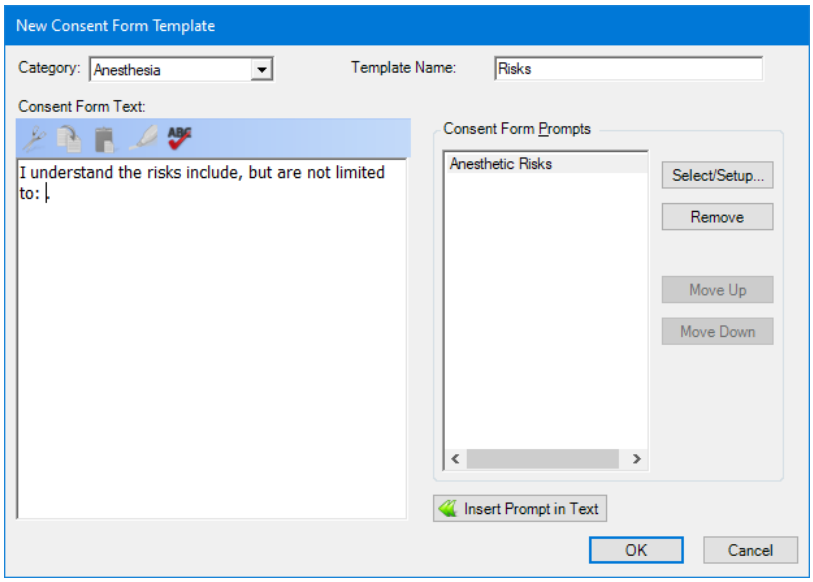
3. Click the **Template Setup** button  .

   The **Template Setup** dialog box appears.



4. Optionally, select the category that you want to add the template to. (Or, you can select a category later on.)
5. Click **New Template**.

The **New Consent Form Template** dialog box appears.



6. If you selected a category in step 4, that category is selected by default in the **Category** list, but you can change it; otherwise, select the **Category** that you want to add the template to.
7. In the **Template Name** box, enter a name for the template.
8. Do any of the following as needed:
   - Add prompts to the template (see "Adding Prompts to and Removing Prompts from Consent Form Templates").

     Note: A consent form template can have multiple prompts with an odontogram to select teeth, quadrants, or sextants, but the text of a consent form can have only one odontogram. If you use a template with multiple odontograms, one consolidated odontogram will be inserted into the form text with all the applicable selections. If an odontogram has already been inserted into the form text, you cannot use another template with an odontogram for the same form.

   - In the **Consent Form Text** box, enter the default text of the consent form template.

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

   - To insert a prompt where the text cursor is located in the **Consent Form Text** box, select a prompt from the **Consent Form Prompts** list, and then click **Insert Prompt in Text**.

     Tip: You may need to add a space before and after the prompt placeholder (which uses the format "~[prompt name]~"), so the completed consent form will be displayed properly.

   - If you have added multiple prompts to the template, to change the order of the prompts, under **Consent Form Prompts**, select a prompt, and then click **Move Up** or **Move Down** to move the prompt up or down by one item in the list. When you add text to a form using this template, the prompts will appear in the specified order regardless of where they are inserted in the text.
9. Click **OK**.
10. In the **Template Setup** dialog box, click **Close**.
11. In the **Consent Form** dialog box, click **Close** because you do not want to attach the consent form to the case; you were only accessing a form so that you could set up a template.

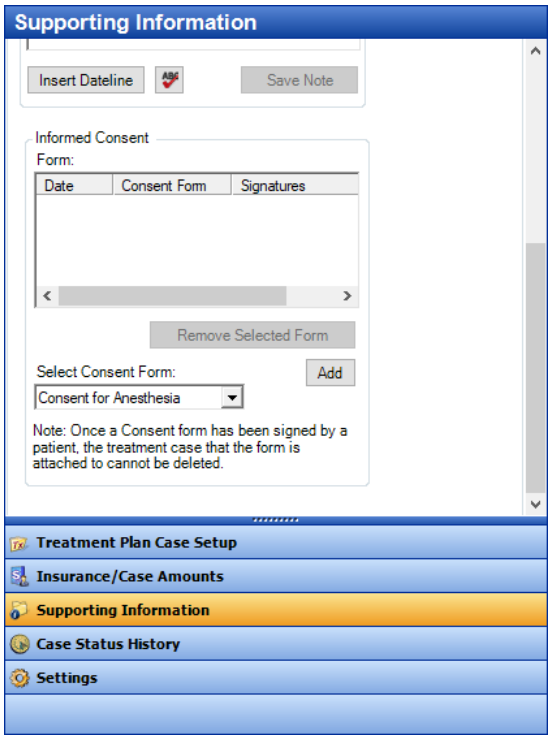
Editing Consent Form Templates

You can edit consent form templates as needed. Any changes will not affect consent forms that have already been added to patient records using the same template.

Note: Only users with the "Consent Forms, Template Setup" security right enabled can modify consent form templates.

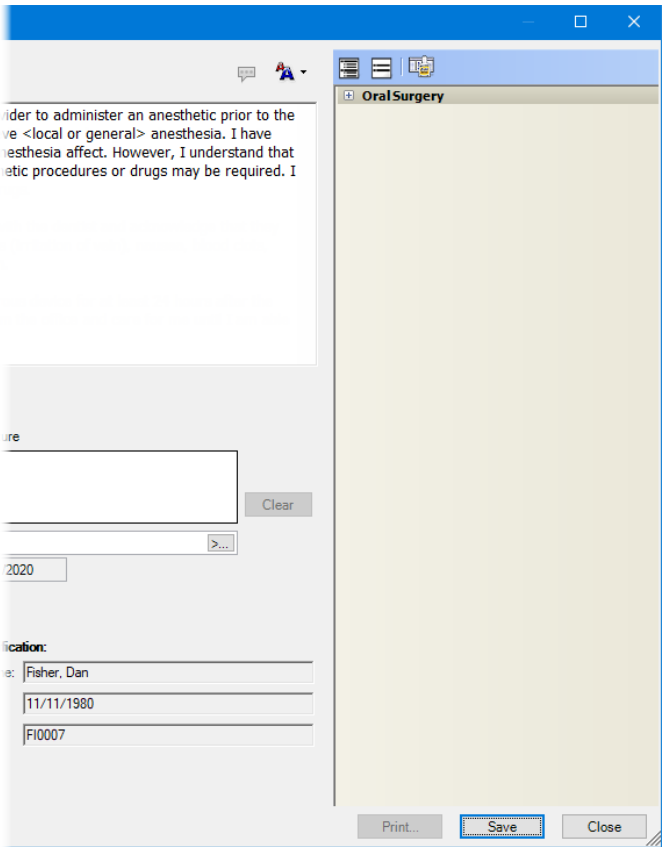
To edit a consent form template

1. In Treatment Planner, on the Navigation panel, open the **Supporting Information** section.



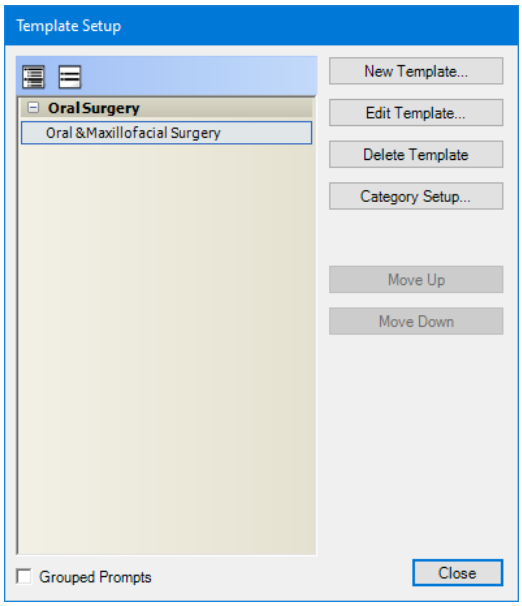
2. Under **Informed Consent**, click **Add**.

   The **Consent Form** dialog box appears.



3. Click the **Template Setup** button  .

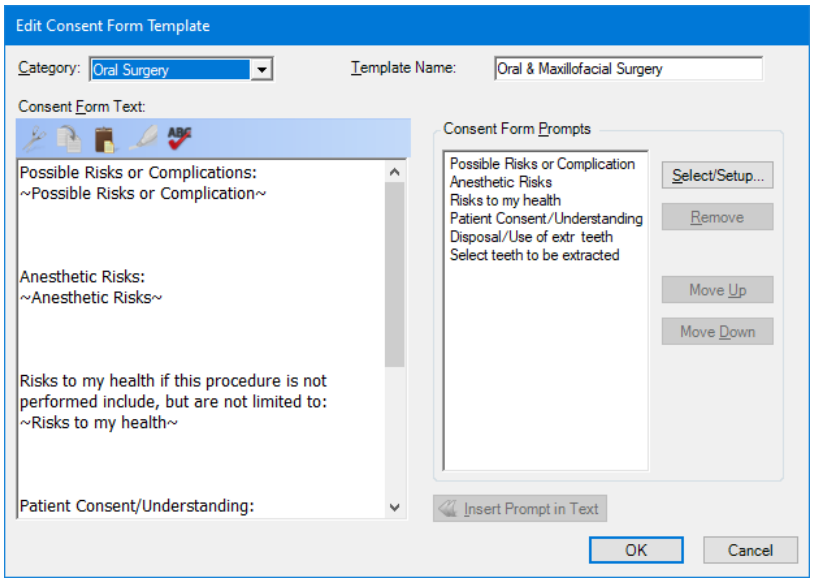
   The **Template Setup** dialog box appears.



4. Expand a category, and select the template that you want to edit.
5. Click **Edit Template**.

   Note: This button is available only if a template is selected.

The **Edit Consent Form Template** dialog box appears.



6. Do any of the following as needed:
   - Select a different **Category** to move the template to that category.
   - In the **Template Name** box, change the name for the template.
   - Add or remove prompts (see "Adding Prompts to and Removing Prompts from Consent Form Templates").

     Note: A consent form template can have multiple prompts with an odontogram to select teeth, quadrants, or sextants, but the text of a consent form can have only one odontogram. If you use a template with multiple odontograms, one consolidated odontogram will be inserted into the form text with all the applicable selections. If an odontogram has already been inserted into the form text, you cannot use another template with an odontogram for the same form.

   - In the **Consent Form Text** box, change the default text of the consent form template.

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

   - To insert a prompt where the text cursor is located in the **Consent Form Text** box, select a prompt from the **Consent Form Prompts** list, and then click **Insert Prompt in Text**.

     Tip: You may need to add a space before and after the prompt placeholder (which uses the format "~[prompt name]~"), so the completed consent form will be displayed properly.

   - To change the order of the prompts, under **Consent Form Prompts**, select a prompt, and then click **Move Up** or **Move Down** to move the prompt up or down by one item in the list. When you add text to a form using this template, the prompts will appear in the specified order regardless of where they are inserted in the text.
7. Click **OK**.
8. In the **Template Setup** dialog box, click **Close**.
9. In the **Consent Form** dialog box, click **Close** because you do not want to attach the consent form to the case; you were only accessing a form so that you could edit a template.

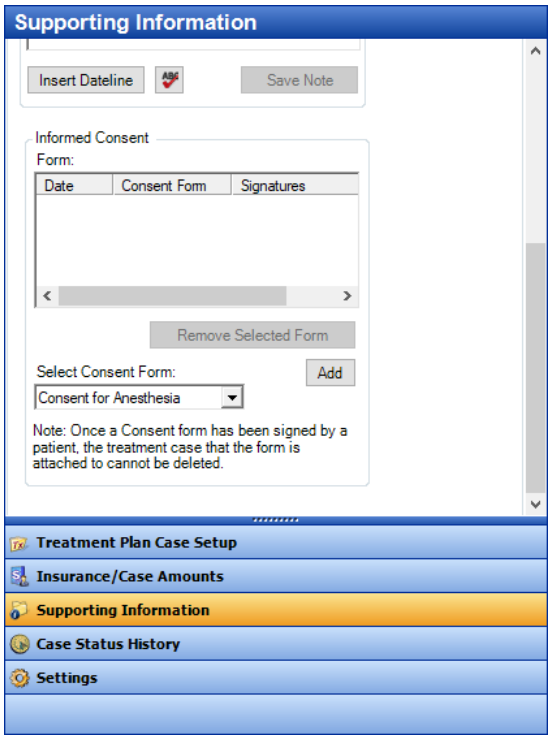
Deleting Consent Form Templates

You can delete a consent form template as needed. This does not affect any consent forms that were entered using that template.

Note: Only users with the "Consent Forms, Template Setup" security right enabled can delete consent form templates.

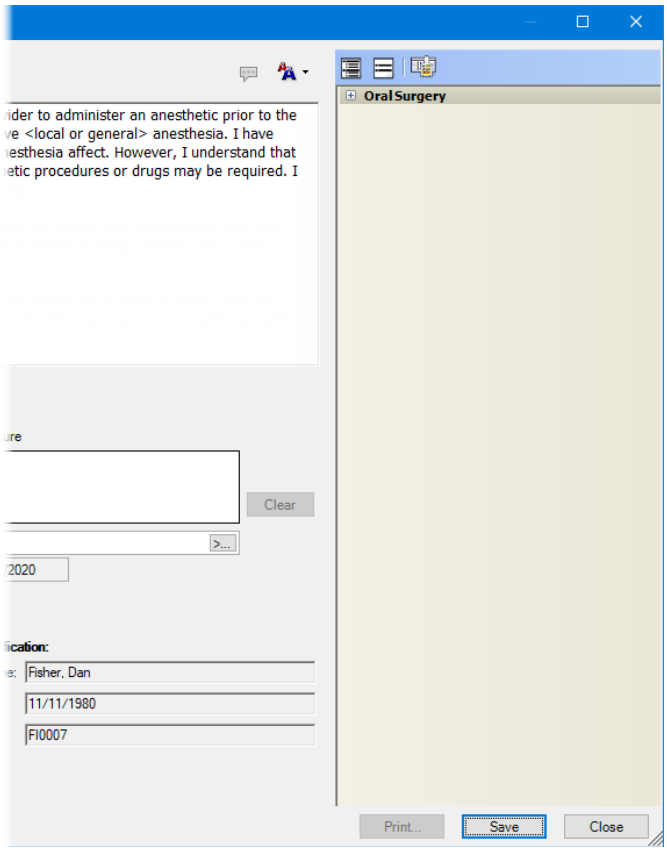
To delete a consent form template

1. In Treatment Planner, on the Navigation panel, open the **Supporting Information** section.



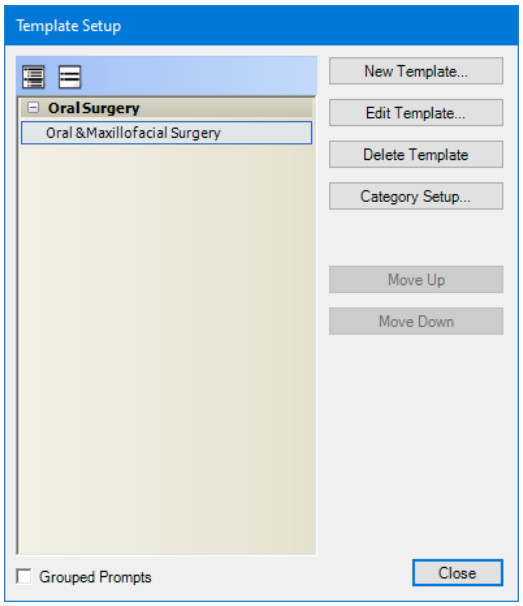
2. Under **Informed Consent**, click **Add**.

   The **Consent Form** dialog box appears.



3. Click the **Template Setup** button  .

   The **Template Setup** dialog box appears.



4. Expand a category, and select the template that you want to delete.
5. Click **Delete Template** (this button is only available if a template is selected). Then, on the confirmation message that appears, click **Yes**.
6. In the **Template Setup** dialog box, click **Close**.
7. In the **Consent Form** dialog box, click **Close** because you do not want to attach the consent form to the case; you were only accessing a form so that you could delete a template.

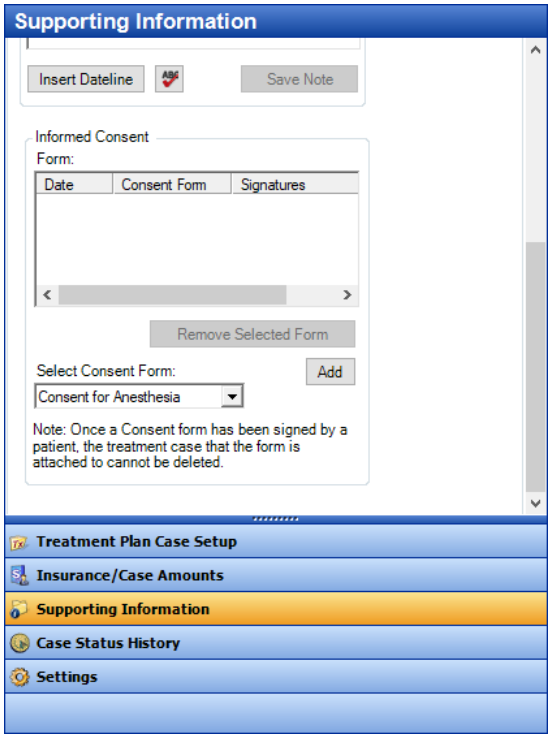
Creating Consent Form Prompts

You can create a consent form from a template dynamically using consent form prompts. When you add text to a consent form using a template that has prompts, Dentrix Enterprise will show messages that prompt you to enter responses to user-defined questions.

Note: Only users with the "Consent Forms, Template Setup" security right enabled can create consent form prompts.

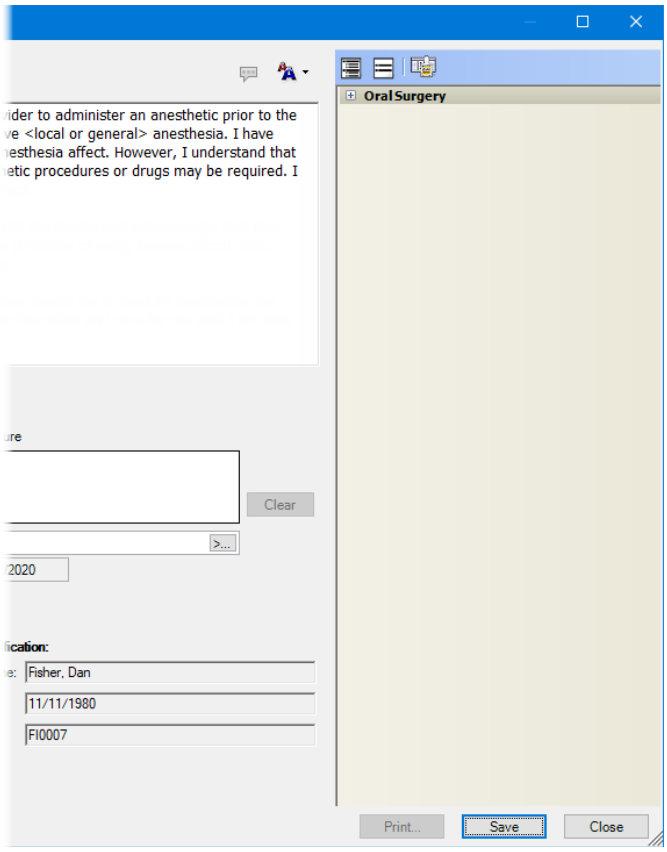
To create a consent form prompt

1. In Treatment Planner, on the Navigation panel, open the **Supporting Information** section.



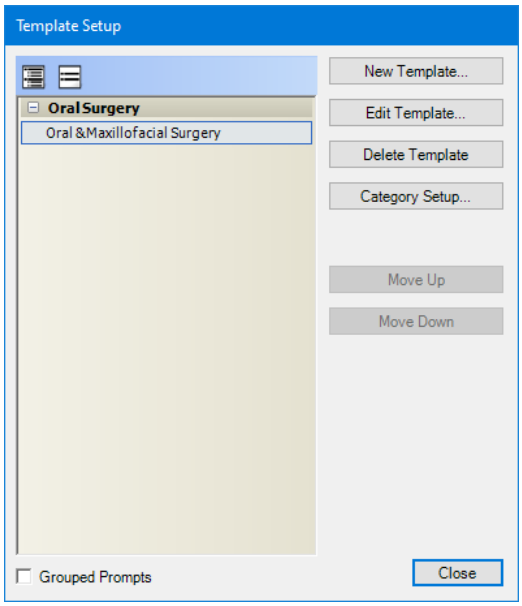
2. Under **Informed Consent**, click **Add**.

   The **Consent Form** dialog box appears.



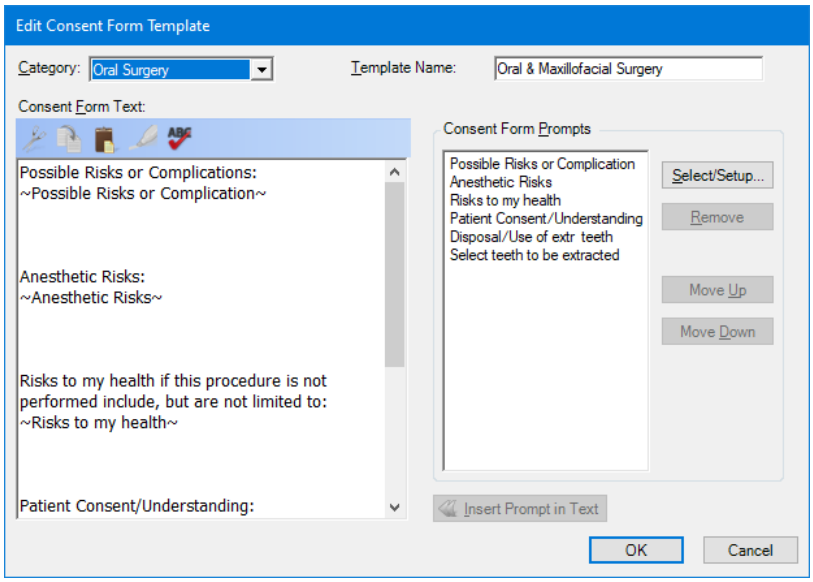
3. Click the **Template Setup** button  .

   The **Template Setup** dialog box appears.



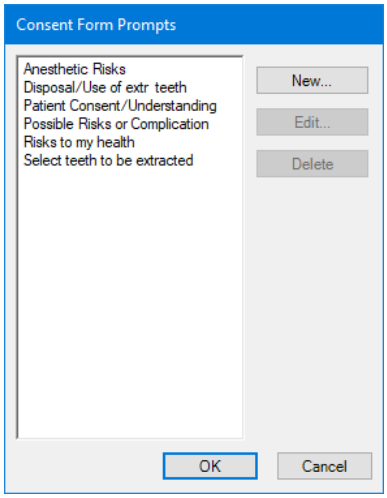
4. Do one of the following:
   - Expand a category, select a template, and then click **Edit Template**.
   - Click **New Template**.

The **Edit Consent Form Template** or **New Consent form Template** dialog box appears.



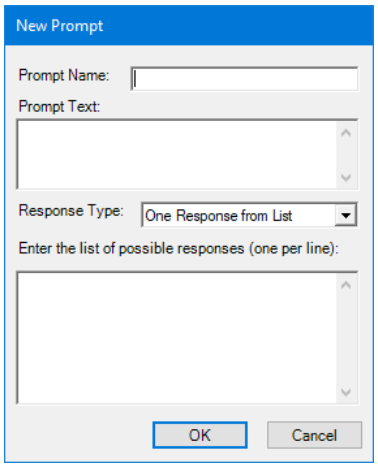
5. Under **Consent Form Prompts**, click **Select/Setup**.

   The **Consent Form Prompts** dialog box appears.



6. Click **New**.

   The **New Prompt** dialog box appears.



7. Set up the following options:
   - **Prompt Name** – This name is used to identify the prompt in the list and template text.

     Note: When you insert a prompt into the text of a template, a placeholder (which uses the format "~[prompt name]~") appears in the text.

   - **Prompt Text** – This is a question or statement that explains how to respond to the prompt. When you are adding text to a consent form using a template with this prompt, you will see this text when the prompt appears. This text does not get inserted into the consent form text.
   - **Response Type** – The selected type and its corresponding options (if applicable) determine how you can respond. Select one of the following types, and then set up the options for it as applicable:
     - **Confirmation Only** – To provide a yes or no response to the prompt text.
     - **One Response from List** – To provide a list of options from which you can select only one response to the prompt text. Enter a list of possible responses (one per line) in the lower box.
     - **Checkbox Responses** – To provide a list of options from which you can select one or more responses to the prompt text. Enter a list of possible responses (one per line) in the lower box.
     - **Date** – To provide a date response to the prompt text. Do one of the following: enter a date in the **Select a default date** box if you want the prompt to use that date, clear the date from the **Select a default date** box if you want the prompt to not have a default date, or select the **Default to "Today"** check box if you want the prompt to use the system date by default. When you are adding text to a consent form using a template with this prompt, you will be able to change the date.
     - **Number/Amount** – To provide a number or an amount as a response to the prompt text. Optionally, enter a number that you want to be the default response to the prompt text. When you are adding text to a consent form using a template with this prompt, you will be able to change the number.
     - **Text** – To provide text as a response to the prompt text. Optionally, enter the text you want to be the default response to the prompt text. When you are adding text to a consent form using a template with this prompt, you will be able to change the text.
     - **Select Tooth** – To provide a way to select teeth as a response to the prompt text. To allow only one tooth to be selected, leave the **Allow multiple selections** check box cleared. To allow more than one tooth to be selected, select the **Allow multiple selections** check box.
     - **Select Surfaces** – To provide a way to select surfaces as a response to the prompt text.
     - **Select Quadrant** – To provide a way to select quadrants as a response to the prompt text. To allow only one quadrant to be selected, leave the **Allow multiple selections** check box cleared. To allow more than one quadrant to be selected, select the **Allow multiple selections** check box.
     - **Select Sextant** – To provide a way to select sextants as a response to the prompt text. To allow only one sextant to be selected, leave the **Allow multiple selections** check box cleared. To allow more than one sextant to be selected, select the **Allow multiple selections** check box.
8. Click **OK**.
9. In the **Consent Form Prompts** dialog box, click **OK**.
10. In the **Edit Consent Form Template** or **New Consent form Template** dialog box, click **Cancel** because you do not want to attach the prompt to the template; you were only accessing a template so that you could create a prompt.
11. In the **Template Setup** dialog box, click **Close**.
12. In the **Consent Form** dialog box, click **Close** because you do not want to attach the consent form to the case; you were only accessing a form so that you could create a prompt.

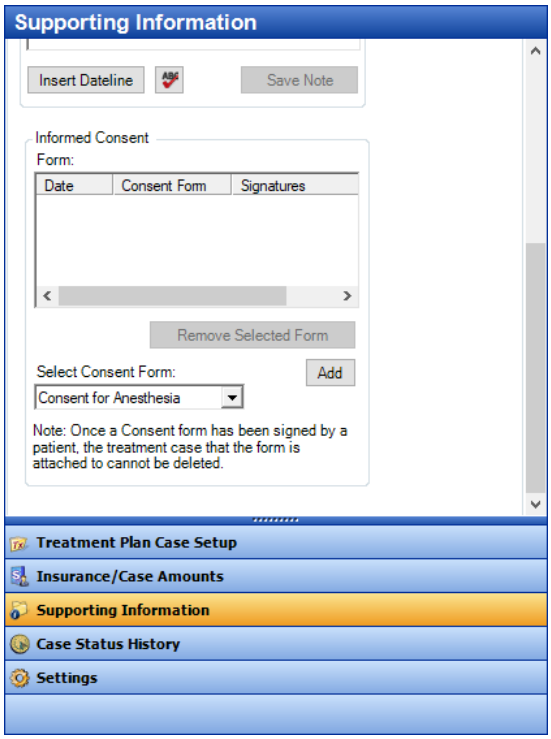
Editing Consent Form Prompts

You can edit consent form prompts as needed. Any changes to a prompt will not affect consent forms attached to patient records that used the same prompt.

Note: Only users with the "Consent Forms, Template Setup" security right enabled can modify consent form prompts.

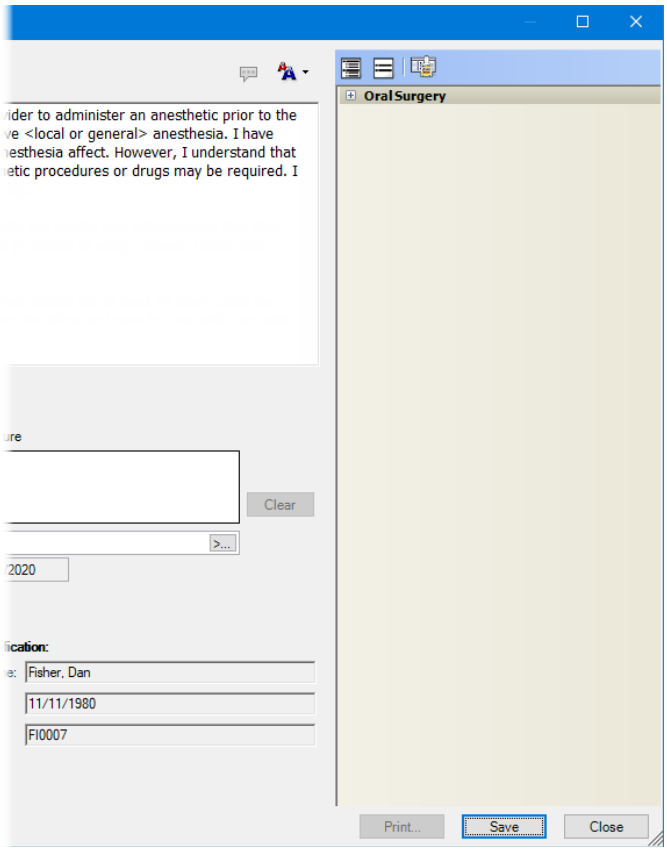
To edit a consent form prompt

1. In Treatment Planner, on the Navigation panel, open the **Supporting Information** section.



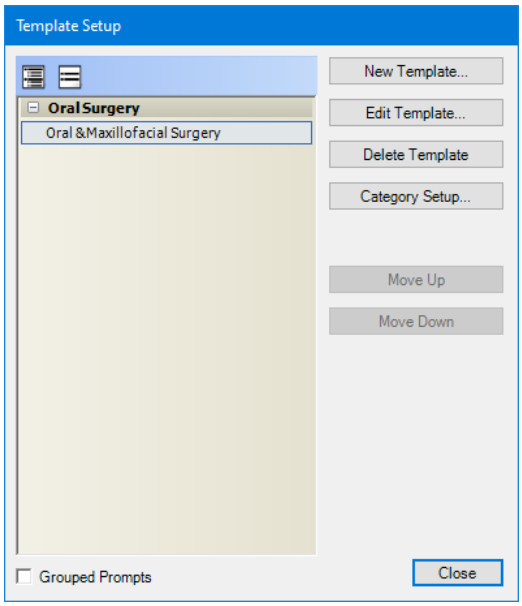
2. Under **Informed Consent**, click **Add**.

   The **Consent Form** dialog box appears.



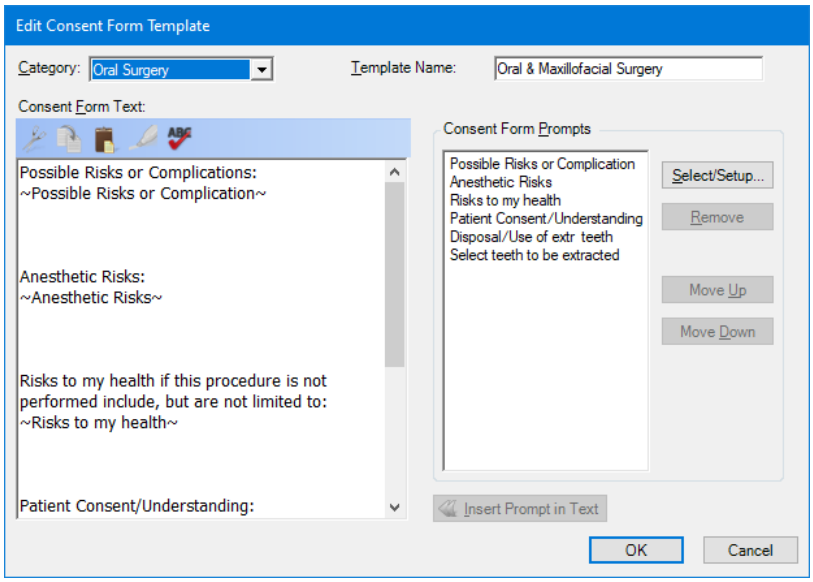
3. Click the **Template Setup** button  .

   The **Template Setup** dialog box appears.



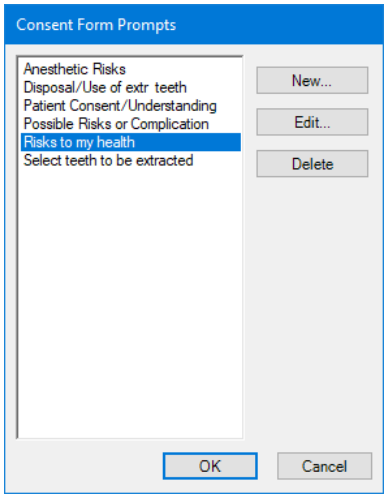
4. Do one of the following:
   - Expand a category, select a template, and then click **Edit Template**.
   - Click **New Template**.

The **Edit Consent Form Template** or **New Consent form Template** dialog box appears.



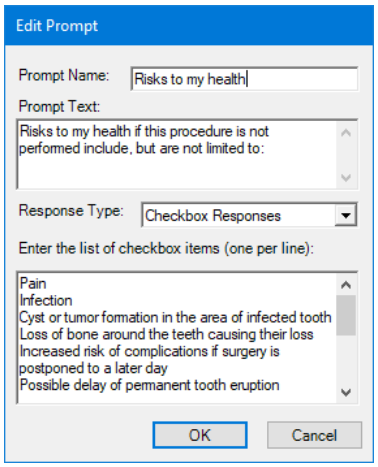
5. Under **Consent Form Prompts**, click **Select/Setup**.

   The **Consent Form Prompts** dialog box appears.



6. Select the prompt that you want to edit, and then click **Edit** (this button is only available if a prompt is selected).

   The **Edit Prompt** dialog box appears.



7. Make changes to any of the following options as needed:
   - **Prompt Name** – This name is used to identify the prompt in the list and consent form text.
     Note: When you insert a prompt into the text of a template, a placeholder (which uses the format "~[prompt name]~") appears in the text.
   - **Prompt Text** – This question or statement explains how to respond to the prompt. When you are adding text to a consent form using a template with this prompt, you will see this text when the prompt appears. This text does not get inserted into the consent form text.
   - **Response Type** – The selected type and its corresponding options (if applicable) determine how you can respond, but you can change them as needed:
     - **Confirmation Only** – To provide a yes or no response to the prompt text.
     - **One Response from List** – To provide a list of options from which you can select only one response to the prompt text. Enter a list of possible responses (one per line) in the lower box.
     - **Checkbox Responses** – To provide a list of options from which you can select one or more responses to the prompt text. Enter a list of possible responses (one per line) in the lower box.
     - **Date** – To provide a date response to the prompt text. Do one of the following: enter a date in the **Select a default date** box if you want the prompt to use that date, clear the date from the **Select a default date** box if you want the prompt to not have a default date, or select the **Default to "Today"** check box if you want the prompt to use the system date by default. When you are adding text to a consent form using a template with this prompt, you will be able to change the date.
     - **Number/Amount** – To provide a number or an amount as a response to the prompt text. Optionally, enter a number that you want to be the default response to the prompt text. When you are adding text to a consent form using a template with this prompt, you will be able to change the number.
     - **Text** – To provide text as a response to the prompt text. Optionally, enter the text you want to be the default response to the prompt text. When you are adding text to a consent form using a template with this prompt, you will be able to change the text.
     - **Select Tooth** – To provide a way to select teeth as a response to the prompt text. To allow only one tooth to be selected, leave the **Allow multiple selections** check box cleared. To allow more than one tooth to be selected, select the **Allow multiple selections** check box.
     - **Select Surfaces** – To provide a way to select surfaces as a response to the prompt text.

- **Select Quadrant** – To provide a way to select quadrants as a response to the prompt text. To allow only one quadrant to be selected, leave the **Allow multiple selections** check box cleared. To allow more than one quadrant to be selected, select the **Allow multiple selections** check box.
- **Select Sextant** – To provide a way to select sextants as a response to the prompt text. To allow only one sextant to be selected, leave the **Allow multiple selections** check box cleared. To allow more than one sextant to be selected, select the **Allow multiple selections** check box.

8. Click **OK**.
9. In the **Consent Form Prompts** dialog box, click **OK**.
10. In the **Edit Consent Form Template** or **New Consent form Template** dialog box, click **Cancel** because you do not want to attach the prompt to the template; you were only accessing a template so that you could edit a prompt.
11. In the **Template Setup** dialog box, click **Close**.
12. In the **Consent Form** dialog box, click **Close** because you do not want to attach the consent form to the case; you were only accessing a form so that you could edit a prompt.

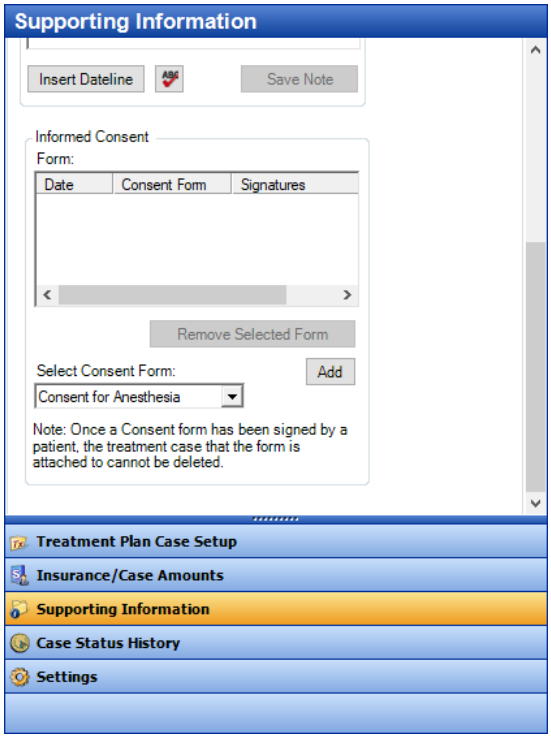
Deleting Consent Form Prompts

You can delete a consent form prompt that is not attached to a consent form template. Any deletion of a prompt will not affect consent forms attached to patient records that used the same prompt.

Note: Only users with the "Consent Forms, Template Setup" security right enabled can delete consent form prompts.

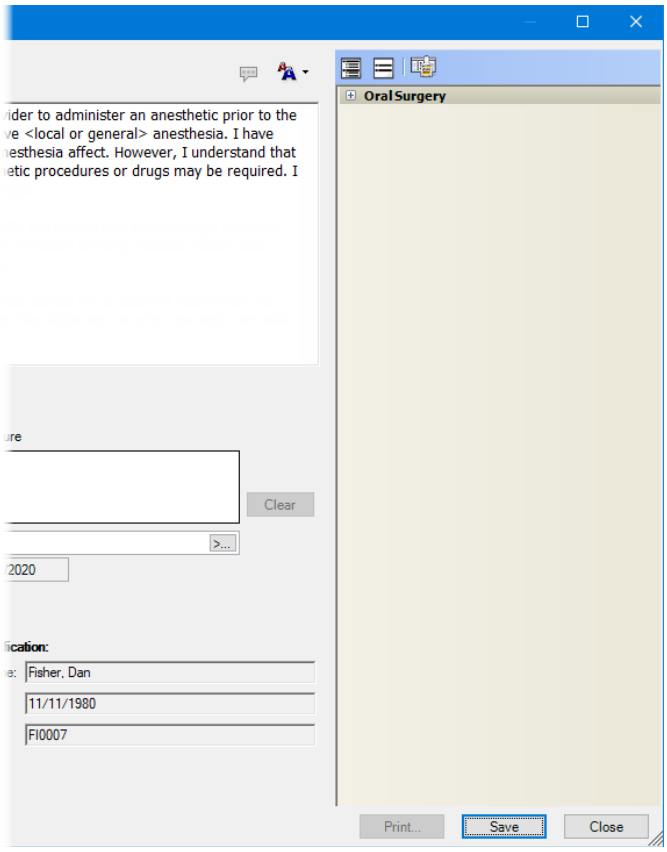
To delete a consent form prompt

1. In Treatment Planner, on the Navigation panel, open the **Supporting Information** section.



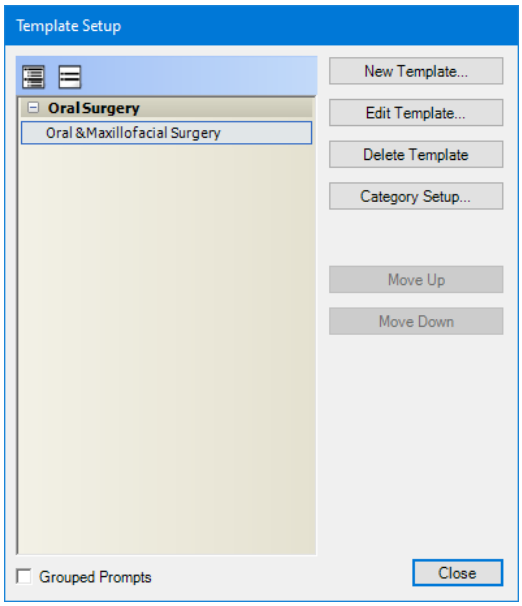
2. Under **Informed Consent**, click **Add**.

   The **Consent Form** dialog box appears.



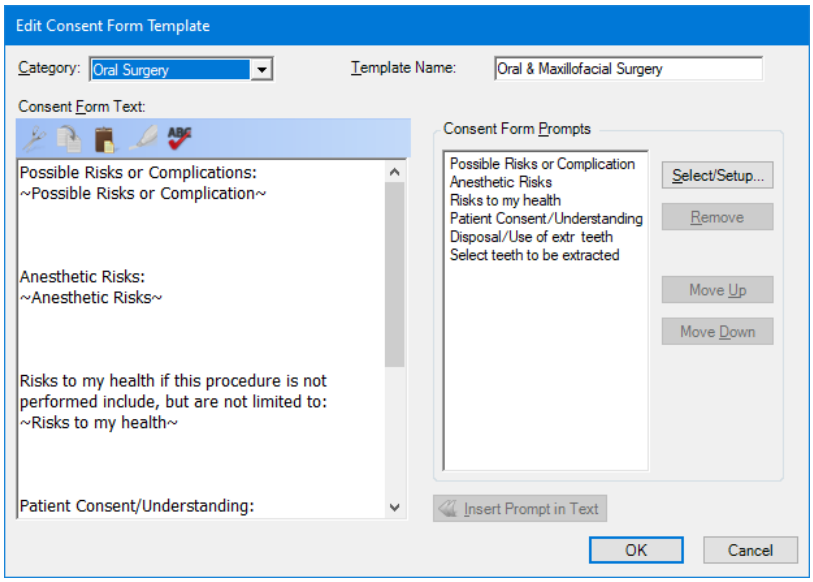
3. Click the **Template Setup** button  .

   The **Template Setup** dialog box appears.



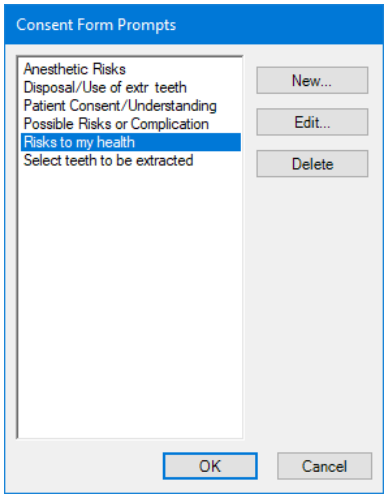
4. Do one of the following:
   - Expand a category, select a template, and then click **Edit Template**.
   - Click **New Template**.

The **Edit Consent Form Template** or **New Consent form Template** dialog box appears.



5. Under **Consent Form Prompts**, click **Select/Setup**.

   The **Consent Form Prompts** dialog box appears.



6. Select the prompt that you want to delete, and then click **Delete** (this button is only available if a prompt is selected). If the prompt is not being used by a template, on the confirmation message that appears, click **Yes**.

   Note: You can delete a prompt only if it is not attached to a consent form template. If you try to delete a prompt that is attached to any templates (inserted in the text or not), a message will appear with a list of templates that are using the prompt; you must remove the prompt from those templates before you can delete the prompt.

7. Click **OK**.
8. In the **Edit Consent Form Template** or **New Consent form Template** dialog box, click **Cancel** because you do not want to attach the prompt to the template; you were only accessing a template so that you could delete a prompt.
9. In the **Template Setup** dialog box, click **Close**.
10. In the **Consent Form** dialog box, click **Close** because you do not want to attach the consent form to the case; you were only accessing a form so that you could delete a prompt.

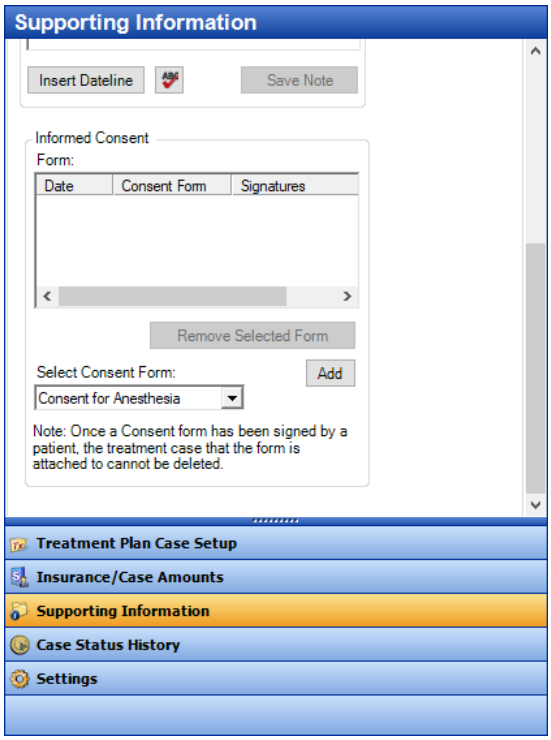
Adding Prompts to and Removing Prompts from Consent Form Templates

You can add prompts to and remove prompts from a consent form template as needed. This does not affect consent forms that were created previously using the same template.

Note: Only users with the "Consent Forms, Template Setup" security right enabled can modify a consent form's prompts.

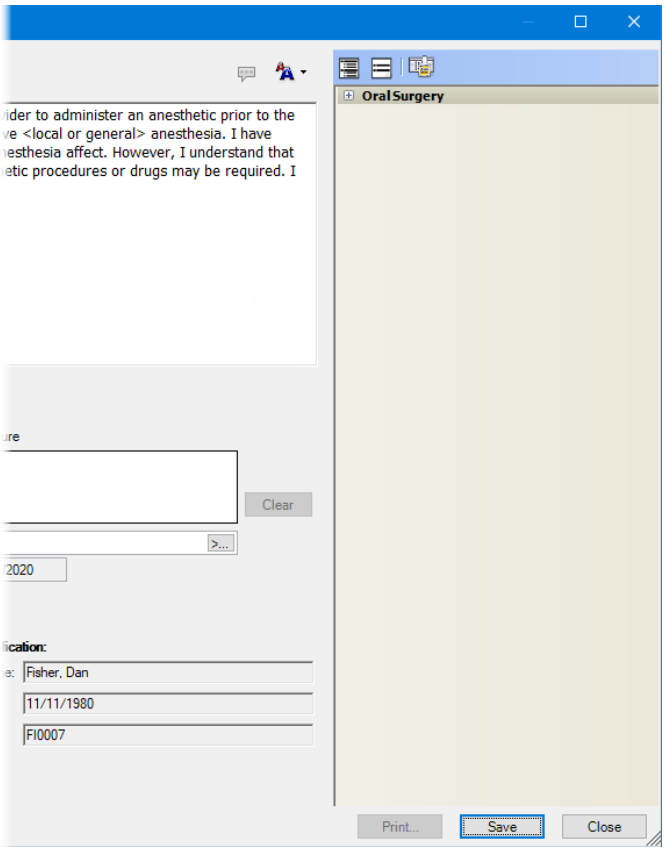
To add and remove prompts

1. In Treatment Planner, on the Navigation panel, open the **Supporting Information** section.



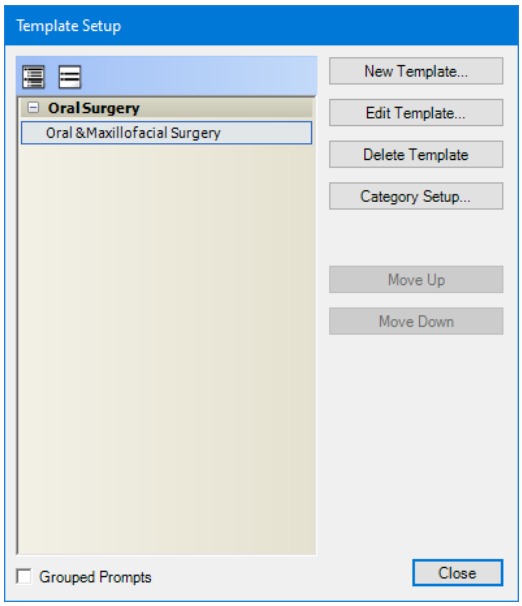
2. Under **Informed Consent**, click **Add**.

   The **Consent Form** dialog box appears.



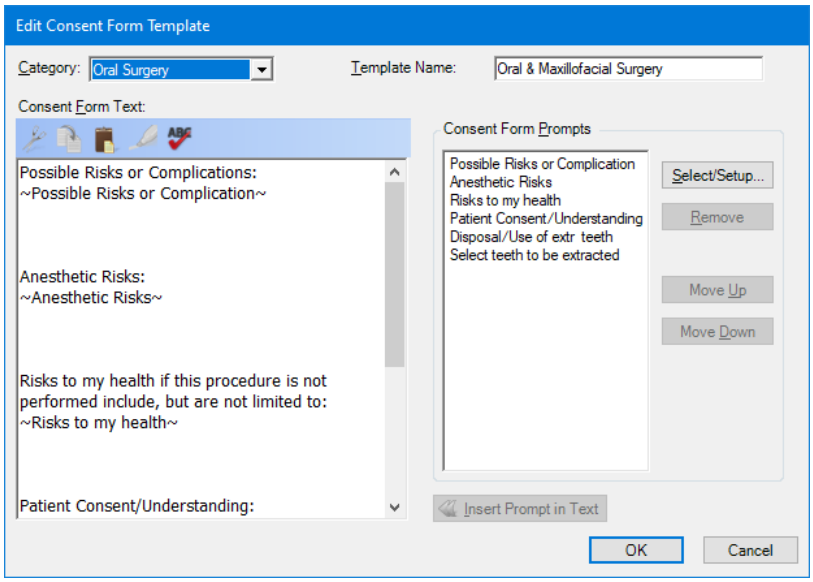
3. Click the **Template Setup** button  .

   The **Template Setup** dialog box appears.



4. Do one of the following:
   - Expand a category, select the template that you want to modify, and then click **Edit Template**.
   - Click **New Template**.

The **Edit Consent Form Template** or **New Consent form Template** dialog box appears.

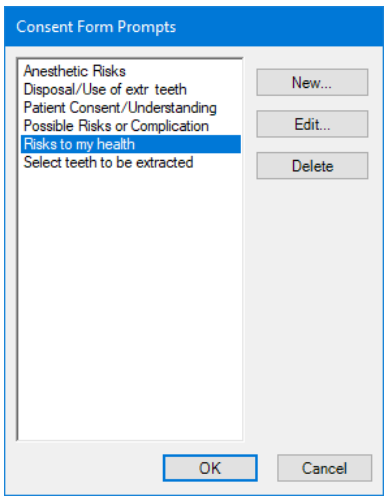


5. Under **Consent Form Prompt**s, do any of the following as needed:

   - **Add a prompt**:

     a. Click **Select/Setup**.

        The **Consent Form Prompts** dialog box appears.



     b. Select the correct prompt, or create a prompt (see “Creating Consent Form Prompts” on page 320).

        Note: A consent form template can have multiple prompts with an odontogram to select teeth, quadrants, or sextants, but the text of a consent form can have only one odontogram. If you use a template with multiple odontograms, one consolidated odontogram will be inserted into the form text with all the applicable selections. If an odontogram has already been inserted into the form text, you cannot use another template with an odontogram for the same form.

c. Click **OK**.

Note: The prompt is added to the bottom of the **Consent Form Prompts** list. To change the order of the added prompt, select the prompt, and then click **Move Up** or **Move Down** to move the prompt up or down by one item in the list. When you add text to a form using this template, the prompts will appear in the specified order regardless of where they are inserted in the text.

d. To insert the added prompt into the text where the text cursor is located, select the prompt from the **Consent Form Prompts** list, and then click **Insert Prompt in Text**.

Tip: You may need to add a space before and after the prompt placeholder, so the completed consent form will be displayed properly.

- **Remove a prompt**:
  a. Select the prompt that you want to remove, and then click **Remove**.

     A confirmation message appears.

  b. Click **Yes**.

6. In the **Edit Consent Form Template** dialog box, click **OK**.
7. In the **Template Setup** dialog box, click **Close**.
8. In the **Consent Form** dialog box, click **Close** because you do not want to attach the consent form to the case; you were only accessing a form so that you could modify a template.

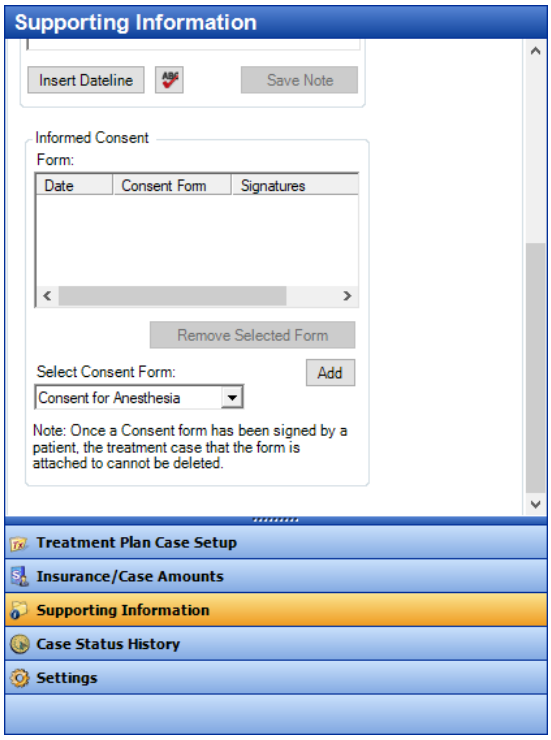
Setting Up the Consent Form Template Preference

You can customize an option for handling consent form template prompts.

Note: Only users with the "Consent Forms, Template Setup" security right enabled can modify the template preference.

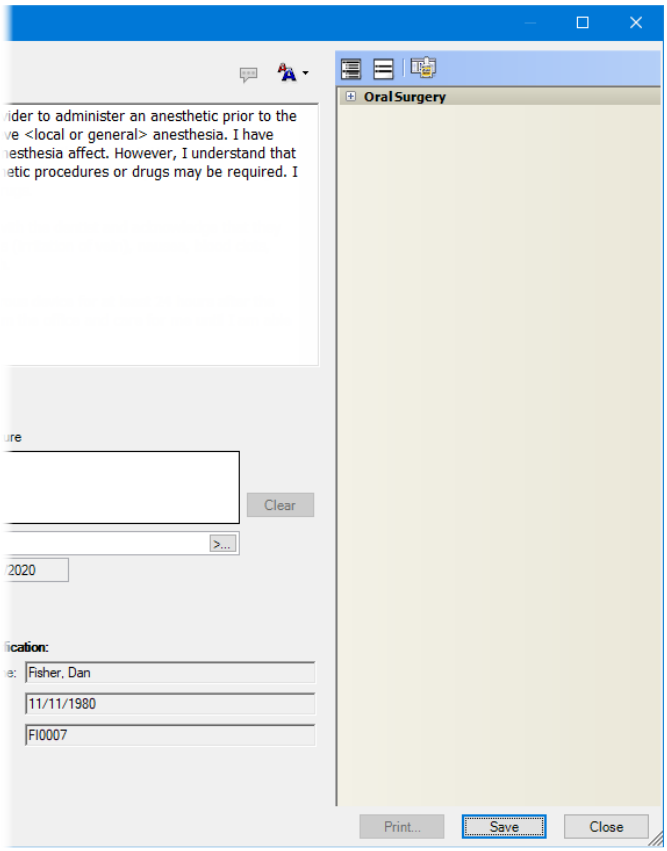
To set up the preference

1. In Treatment Planner, on the Navigation panel, open the **Supporting Information** section.



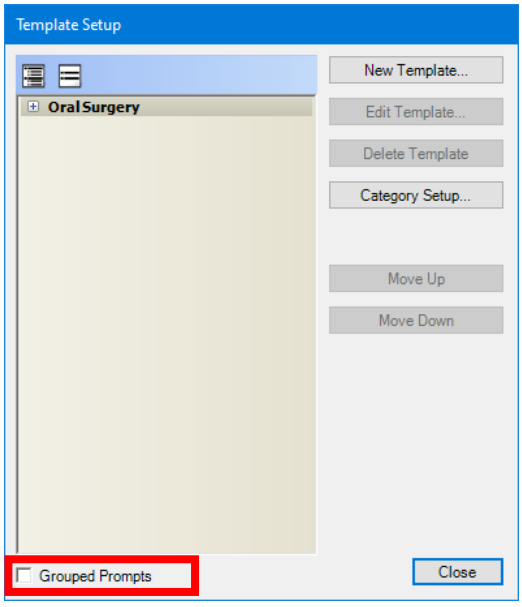
2. Under **Informed Consent**, click **Add**.

   The **Consent Form** dialog box appears.



3. Click the **Template Setup** button  .

   The **Template Setup** dialog box appears.



4. Select or clear the **Grouped Prompts** check box. With this check box clear, if a template has multiple prompts, each prompt will appear in separate dialog boxes for you to respond to in the specified order. With this check box selected, all the prompts for a template will appear in one dialog box.
5. Click **Close**.
6. In the **Consent Form** dialog box, click **Close** because you do not want to attach the consent form to the case; you were only accessing a form so that you could set up the preference.

Default Consent Form Template and Prompts

There are default text and prompts for the consent form template that gets installed with Dentrix Enterprise.

Note: The template text contains prompts, which are enclosed in tildes (~).

Template

- Template Name – Oral and Maxillofacial Surgery
- Category – Oral Surgery
- Template Text:

  "Possible Risks or Complications:

  ~Possible Risks or Complication~

  Anesthetic Risks:

  ~Anesthetic Risks~

  Risks to my health if this procedure is not performed include, but are not limited to:

  ~Risks to my health~

  Patient Consent/Understanding:

  ~Patient Consent/Understanding~

  Disposal/Use of extracted teeth and/or other tissues:

  ~Disposal/Use of extr teeth~

Teeth to be extracted:

~Select teeth to be extracted~"

Prompts

- **Prompt #1**:
  - Prompt Name – Possible Risks or Complication
  - Prompt Text – "Possible Risks or Complications:"
  - Response Type – Checkbox Responses
  - Items:
    - "'Dry socket' or slow healing of an extraction site
    - You may experience local swelling, bleeding, bruising, and/or pain after the procedure
    - Possible infection and/or hospitalization and/or death and/or referral to a specialist for further treatment
    - Injury to nerves in or around the mouth that could cause temporary or permanently numb lips, chin, tongue, or loss of taste sensation
    - Decision to leave a small piece of root in the jaw when its removal would require extensive surgery and an increased risk of complications
    - Sinus involvement that may require surgery at a later date
    - Injury to nearby teeth, soft tissues, or fillings
    - Sore jaw or restricted mouth opening or jaw joint problems
    - Unusual reaction to medications given or prescribed
    - Impaired healing of the bone due to drugs, radiation therapy, or infection"
- **Prompt #2**:
  - Prompt Name – Anesthetic Risks
  - Prompt Text – "Anesthetic Risks:"
  - Response Type – Checkbox Responses
  - Items:
    - "Include discomfort, rapid pulse, swelling, bruising, infection, anxious feelings, allergic reactions, and lip chewing
    - Anesthetics occasionally are not effective in some patients"
- **Prompt #3**:
  - Prompt Name – Risks to my health
  - Prompt Text – "Risks to my health if this procedure is not performed include, but are not limited to:"
  - Response Type – Checkbox Responses
  - Items:
    - "Pain
    - Infection
    - Cyst or tumor formation in the area of infected tooth
    - Loss of bone around the teeth causing their loss
    - Increased risk of complications if surgery is postponed to a later day

    - Possible delay of permanent tooth eruption
    - Other_____
    - A perfect result from recommended treatment cannot be guaranteed. If unexpected problems arise during the procedure the doctor will do what is deemed necessary to correct the condition
    - Medications given or prescribed for pain may cause drowsiness"
- **Prompt # 4**:
    - Prompt Name – Patient Consent/Understanding
    - Prompt Text – "Patient Consent/Understanding:"
    - Response Type – Checkbox Responses
    - Items:
        - "I consent and understand to the above and agree to cooperate with Dr._____ for proposed treatment
        - I will follow post-operative instructions to the best of my ability for my own comfort and safety
        - I have had an opportunity to ask questions about the above treatment
        - I have been counseled not to drive or perform hazardous chores until I have recovered from the effects of these medications"
- **Prompt # 5**:
    - Prompt Name – Disposal/Use of extr teeth
    - Prompt Text – "Disposal/Use of extracted teeth and/or other tissues:"
    - Response Type – One Response from List
    - Items:
        - "I consent to the disposal of my extracted teeth, including other tissues and possible use of my extracted teeth by qualified authorities for scientific or educational purposes
        - I consent to the disposal of my extracted teeth, including other tissues in accordance with clinic policy and regulations. However, I do not authorize the use of my extracted teeth or other tissues for scientific or educational purposes"
- **Prompt #6**:
    - Prompt Name – Select teeth to be extracted
    - Prompt Text – "Select tooth/teeth to be extracted:"
    - Response Type – Select Tooth
    - Allow multiple selections – Yes

Adding Consent Forms (Enhanced) to Cases

In Treatment Planner, from the **Supporting Information** and **Treatment Plan Case Setup** sections on the Navigation panel, you can add a consent form to a case, enter or modify the text of the form as needed, and then have all parties digitally sign it.

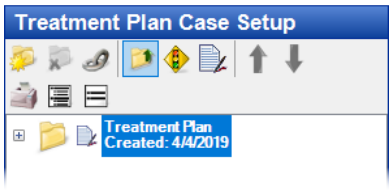
> **Important**: When you add a consent form to a case, before you can save the form, the patient (or his or her representative), someone from the practice (such the dentist), and a witness (or interpreter) must sign it.

Note: The consent form symbol next to a case varies depending on the status of the consent forms for the case.

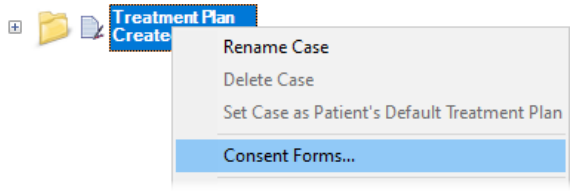
	No consent forms are attached to the case.
	Signed consent forms are attached to the case.

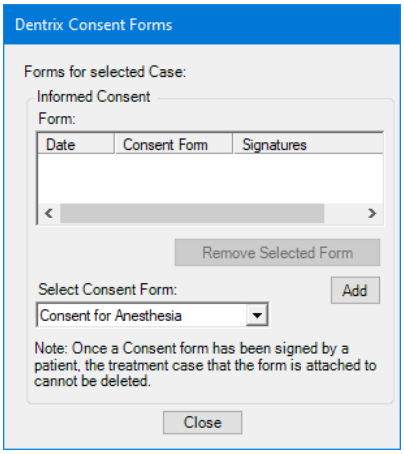
To add a consent form to a case

1. In Treatment Planner, in the **Treatment Plan Case Setup** section on the Navigation panel, select the case to which you want to add a consent form.

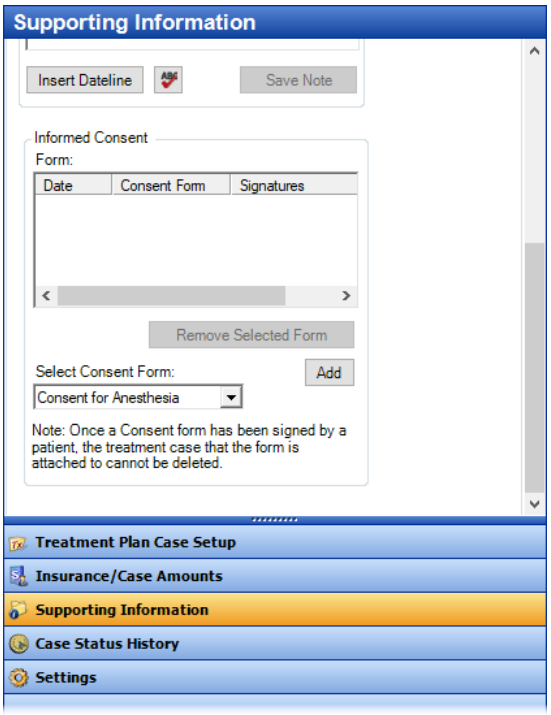


2. Do one of the following:
   - In the **Treatment Plan Case Setup** section, right-click the selected case, and then click **Consent Forms**. The **Dentrix Consent Forms** dialog box appears.





- Open the **Supporting Information** section on the Navigation panel, and then scroll down to **Informed Consent**.

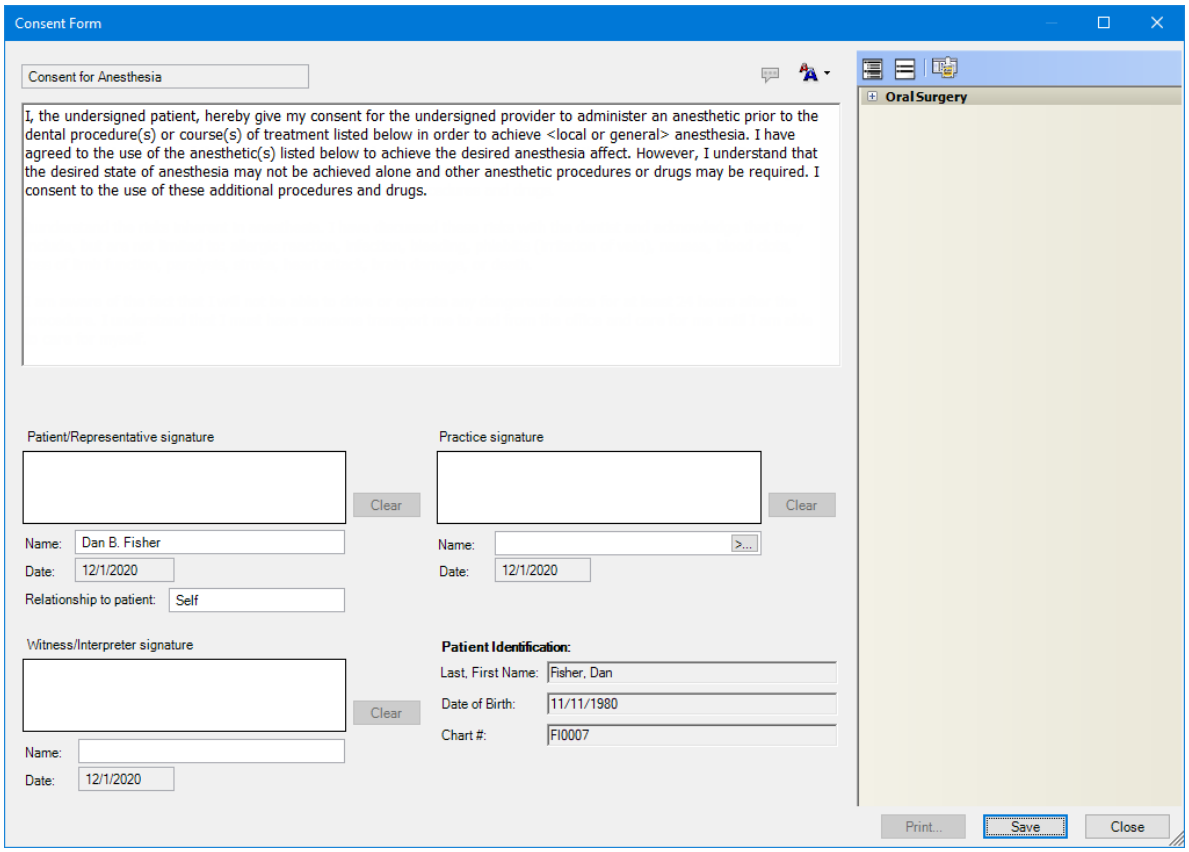


3. From the **Select Consent Form** list, select the form that you want to add to the selected case.

   Note: You can manage the default consent forms from the **Settings** section of the Navigation panel.

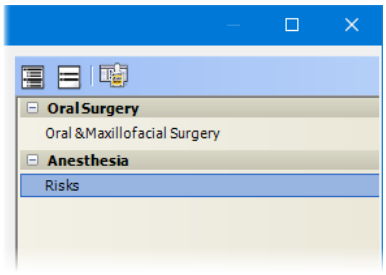
4. Click **Add**.

The **Consent Form** dialog box appears.



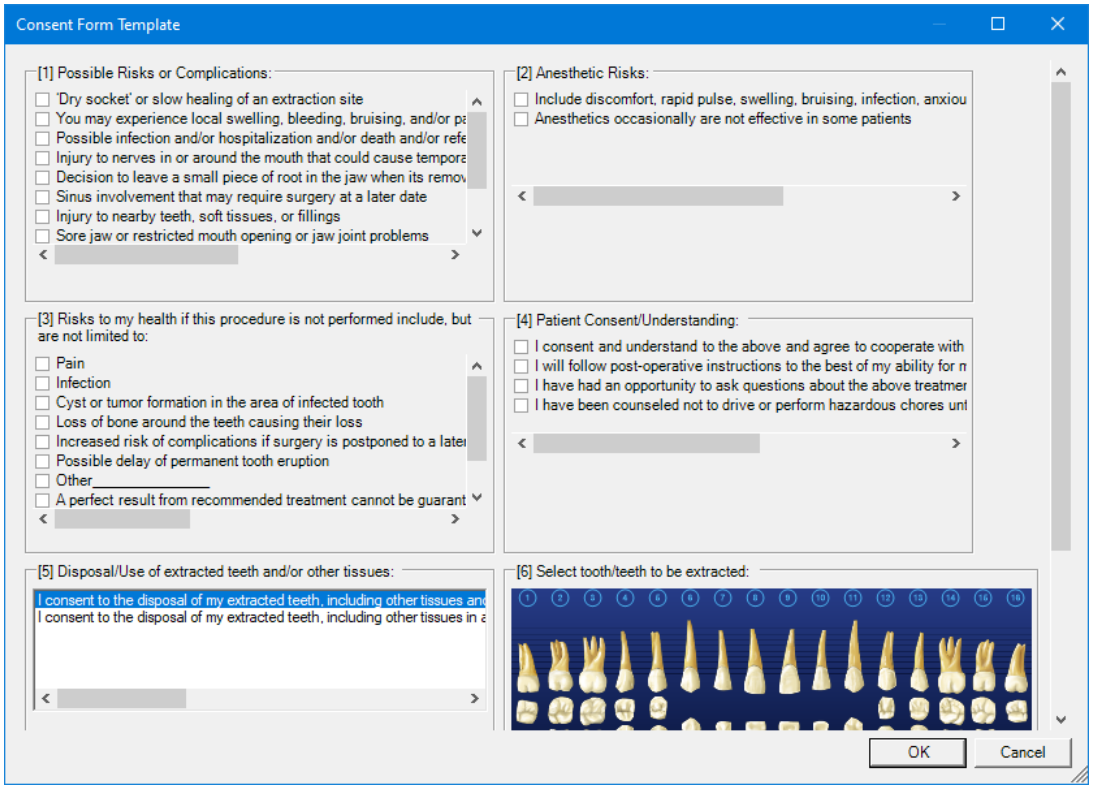
Note: The patient's name, birth date, and chart number appear in the lower-right corner for your reference.

5. Do any of the following as needed:
   - Enter the text of the consent form, or modify any existing text.
   - Use a template to enter text for the consent form:
     a. 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 locate the template that you want to use.



     b. Double-click the desired template.

Any prompts that are associated with the template and that require responses appear. The prompts may appear one at a time in individual dialog boxes, or they may appear grouped together in one dialog box.



Note: A consent form template can have multiple prompts with an odontogram to select teeth, quadrants, or sextants, but the text of a consent form can have only one odontogram. If you use a template with multiple odontograms, one consolidated odontogram will be inserted into the form text with all the applicable selections. If an odontogram has already been inserted into the form text, you cannot use another template with an odontogram for the same form.

c. Respond to the prompts that are associated with the template. If no prompts appear, skip this step.

The template text is automatically appended to any existing text for the consent form.

d. After entering a clinical note using a template, edit the text, or enter additional text as needed.

Note: To save the consent form, it must have text. The text, including procedure information, can be up to 10,000 characters in length.

6. Set up the following signature options:

- **Patient/Representative signature** – The patient selected in Treatment Planner is entered in the **Name** box. Also, "Self" is entered in the **Relationship to patient** box by default. If necessary, edit the patient information (for example, if the person signing is not the patient, enter the name of the patient's spouse or parent, and enter "Spouse" or "Parent").

  Note: The signature, name, and relationship to patient are required to save the form. Once you save the form with a patient or patient representative signature (even the slightest mark registers as a signature), you cannot change the signature, name, and relationship.

- **Practice signature** – By default, Dentrix Enterprise populates the **Name** box automatically with the name of the user who is currently logged in, but you can change it. To specify the name of the provider (primary or secondary) who will sign the form, click the search button >....

  Note: The signature and name are required to save the form. Once you save the form with a practice signature (even the slightest mark registers as a signature), you cannot change the signature and name.

- **Witness/Interpreter signature** – In the **Name** box, enter the name of the witness or interpreter who will sign the form.

  Note: The signature and name are required to save the form. Once you save the form with a witness or interpreter signature (even the slightest mark registers as a signature), you cannot change the signature and name.

7. Have the patient or patient's representative, the provider or staff member, and the witness or interpreter sign the consent form. All parties must sign before you can save the consent form.

   Notes:

   - If someone needs to re-sign, you can click the corresponding **Clear** button to clear the signature.
   - If there is at least one signature, you cannot change the text of the consent form.

8. Click **Save**.

   Note: You can save the consent form only if it has text, all three names, the relationship to the patient, and all three signatures.

9. Click **Print**.

   Note: You can print the consent form only if it is signed.

10. Click **Close**.

    The signed consent form appears in the list of forms for the selected case, and a copy is saved to the patient's record as a Document Center document.

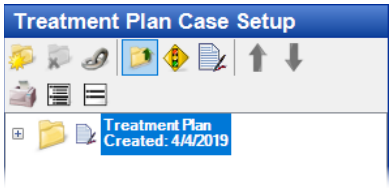
Viewing and Printing Consent Forms (Enhanced) for Cases

In Treatment Planner, from the **Supporting Information** and **Treatment Plan Case Setup** sections on the Navigation panel, you can view and print a consent form that is attached to a case.

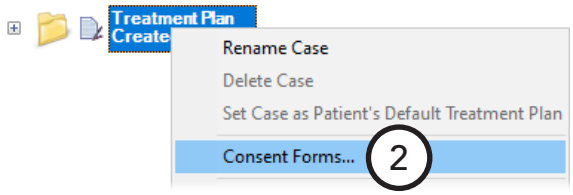
Note: When you view a consent form for a specific case, the information about that case that is listed in the case detail is shown at the bottom of the consent form if the form allows the viewing of procedure information, so patients know exactly which procedures they are giving consent to have performed.

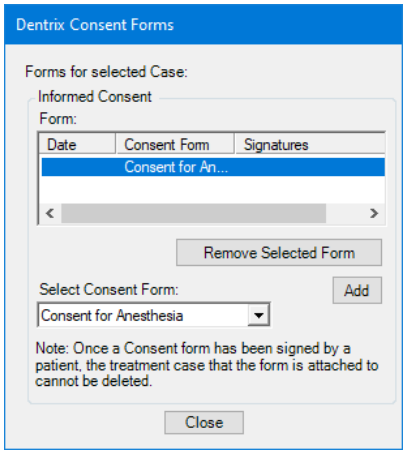
To view and print a consent form for a case

1. In Treatment Planner, in the **Treatment Plan Case Setup** section on the Navigation panel, select the case with the consent form that you want to view.

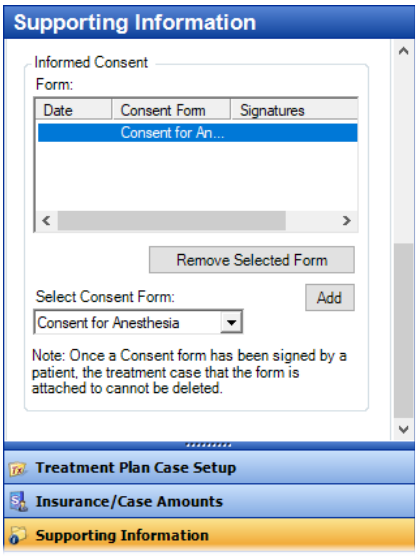


2. Do one of the following:
   - In the **Treatment Plan Case Setup** section, right-click the selected case, and then click **Consent Forms**. The **Dentrix Consent Forms** dialog box appears.





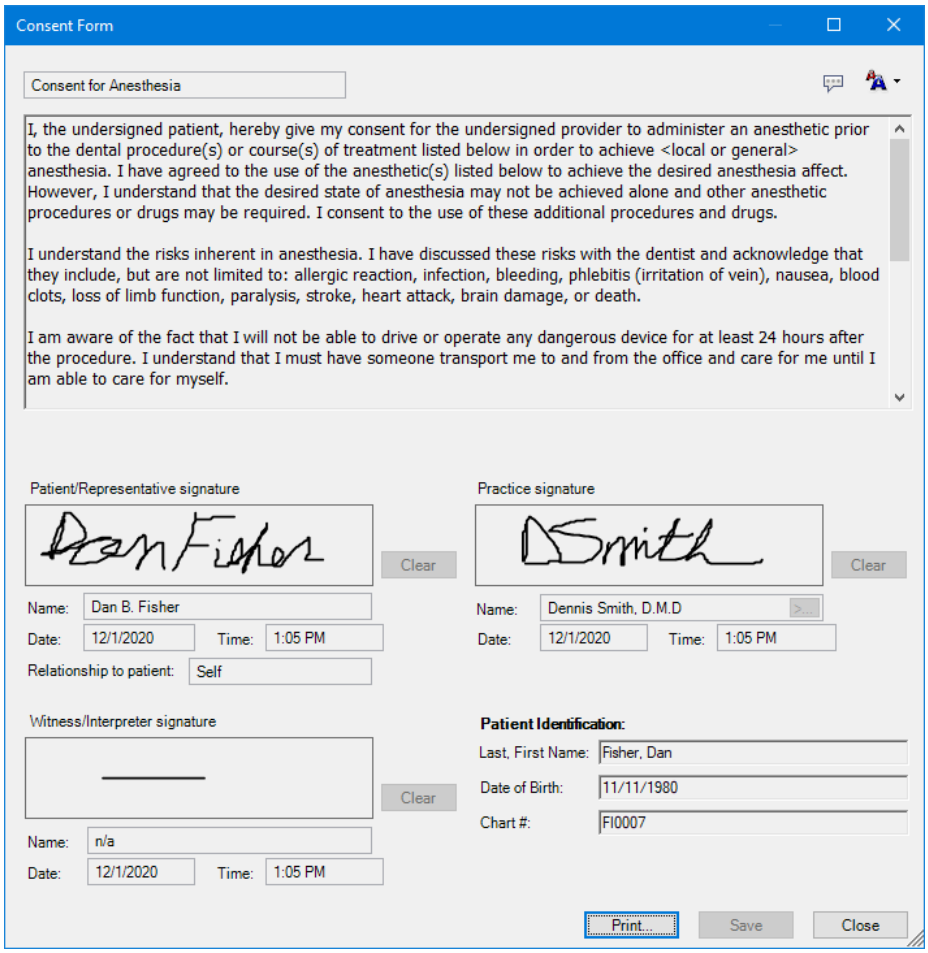
- Open the **Supporting Information** section on the Navigation panel, and then scroll down to **Informed Consent**. The consent forms that are attached to the case appear in the **Form** list.



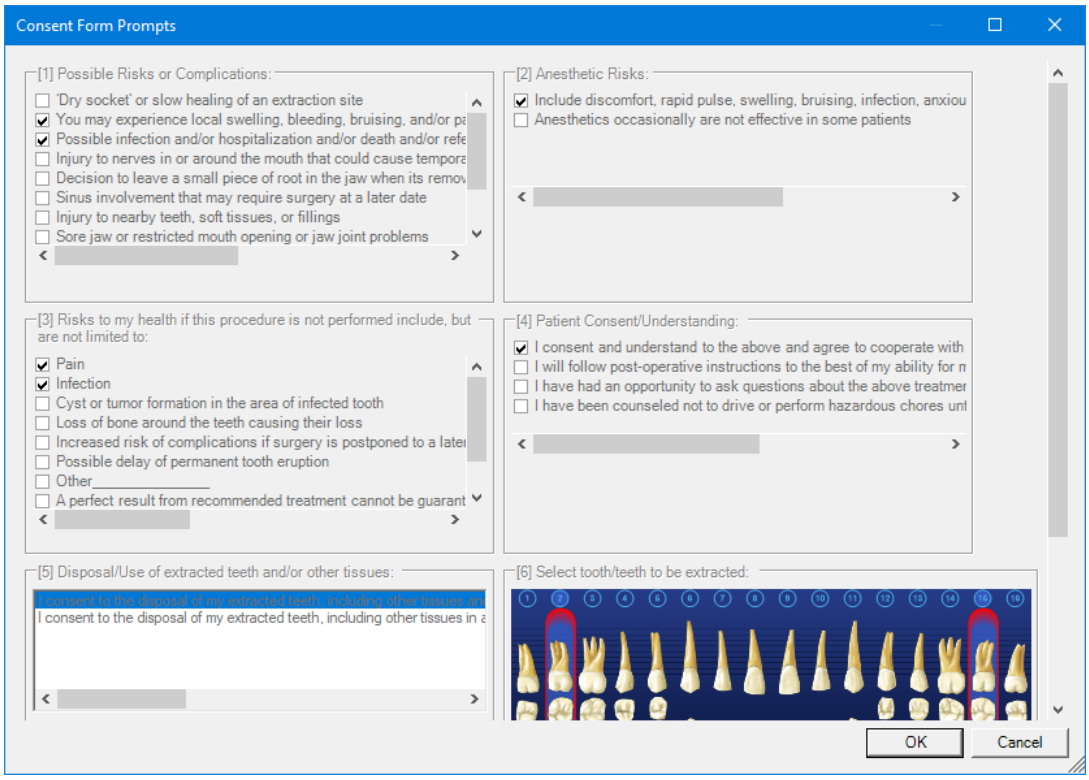
Note: For each attached consent form, the date when it was signed (if applicable), its name, and who signed (patient and/or provider, if applicable) appear for your reference.

3. Double-click the correct form.

   The **Consent Form** dialog box appears.



4. If any of the text of the consent form was entered using a template with prompts, to view the corresponding responses, click the **View Prompts** button .



You cannot edit any of the responses. When you are finished viewing the responses, click **OK**.

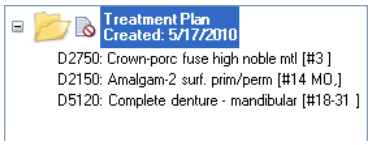
5. To print the consent form, click **Print**.
6. Click **Close**.

Editing and Deleting Procedures

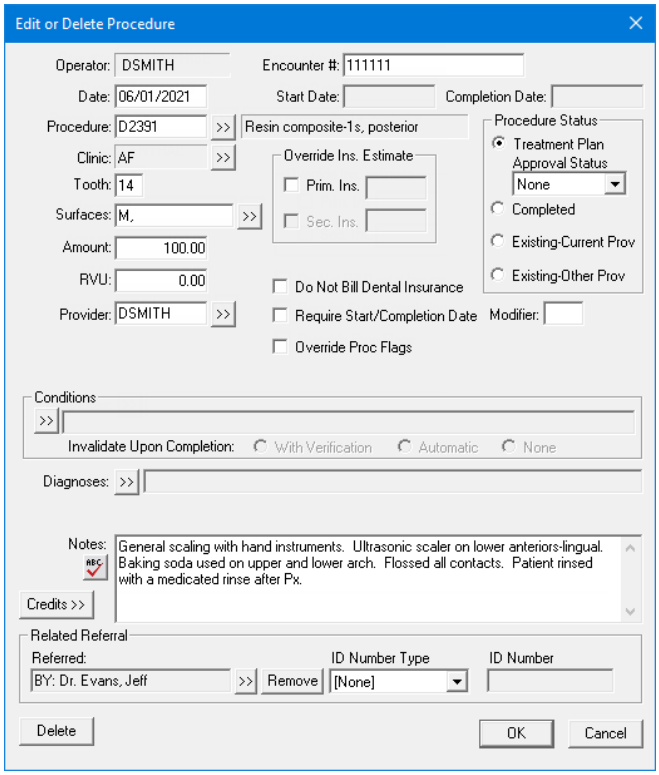
You can edit or delete existing treatment-planned procedures that are not in history.

To edit or delete a treatment-planned procedure

1. In Treatment Planner, on the Navigation 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. Do one of the following:
   - Make any necessary changes, and then click **OK**. For information about the options that are available for editing, see "Entering Treatment" in Chapter 4: Patient Chart.
   - Click **Delete** and then **OK** to delete the procedure. The treatment-planned procedure is removed from Treatment Planner, Chart, and Ledger-Treatment Plan.

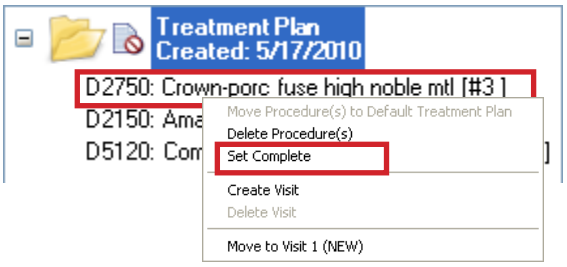
Tip: To delete multiple procedures at the same time, in the **Treatment Plan Case Setup** section, while pressing the Ctrl key, click the procedures you want to delete. Next, right-click one of the selected procedures, and then click **Delete Procedure(s)**. Then, on the confirmation message that appears,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

Posting Completed Procedures

After you complete procedures, you can post those procedures from Treatment Planner.

To post a completed procedure

In Treatment Planner, on the Navigation panel, from the **Treatment Plan Case Setup** section, expand the appropriate case by clicking the plus sign (+), right-click the procedure you want to complete, and then click **Set Complete**.



Tips:

- To complete multiple procedures at the same time, while pressing the Ctrl key, click the procedures that you want to complete. Next, right-click one of the selected procedures, and then click **Set Complete**.
- To set all the procedures in a selected case complete at the same time, click the **Update Case Status** button on the **Treatment Plan Case Setup** section's toolbar, and then click **Completed**.
- In the case details, a blue check mark appears next to any completed procedures.

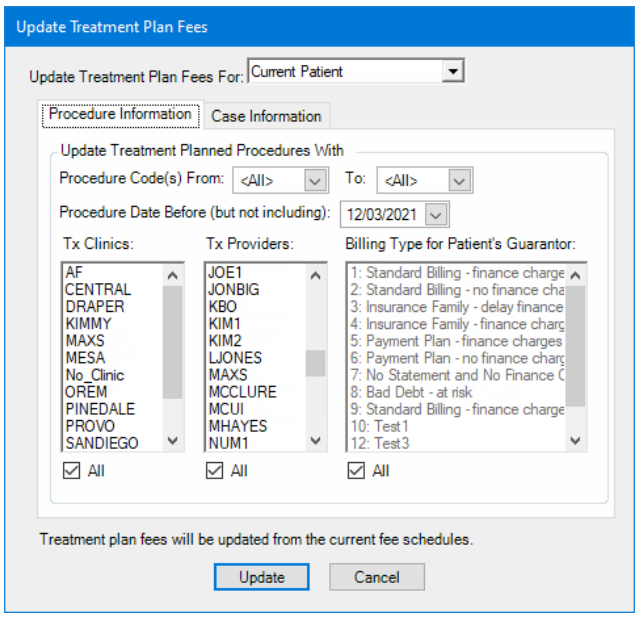
Updating Treatment Plan Fees

To maintain the integrity of treatment plan estimates, Dentrix Enterprise does not automatically update the fees for procedures assigned to a treatment plan. If your fees have changed since the time a treatment plan was given to a patient, that treatment plan can be manually updated for that patient from Treatment Planner to reflect any fee schedule changes if certain criteria you specify for the procedures are met. You can also update treatment plan fees for all patients with treatment-planned procedures matching the criteria you specify.

To update treatment plan fees

1. In Treatment Planner, from the **Edit** menu, click **Update Treatment Plan Fees**.

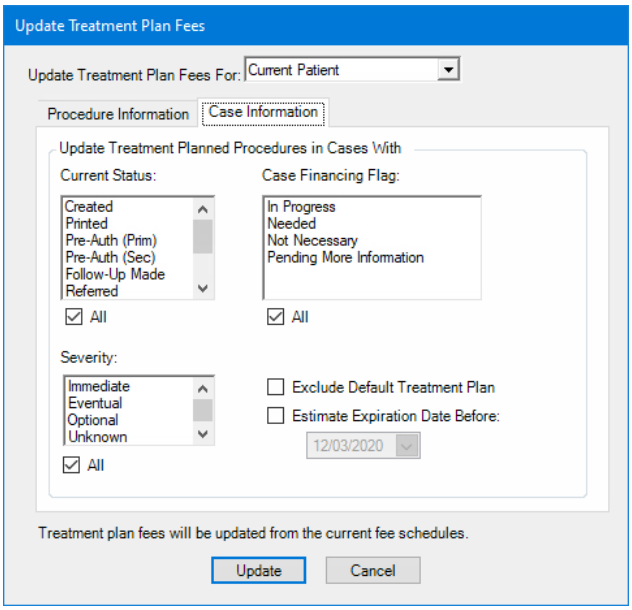
   The **Update Treatment Plan Fees** dialog box appears.



2. Set up the following options:

   - **Update Treatment Plan Fees For** – To update the fees for the currently selected patient only, select "Current Patient." To update the fees for all patients with treatment plans, select "All Patients."
   - **Procedure Information** – This tab provides the following options for updating treatment plan fees:
     - **Procedure Code(s)** – Select the procedure or range of the procedures to update for **From** and **To**. To update all procedures, leave **From** "<All>" **To** "<All>"selected.
     - **Procedure Date Before** – Select the cut-off date to use for updating fees for treatment-planned procedures. Only treatment-planned procedures dated on or before the selected date will be updated with the new fees.
     - **Tx Clinics** – To update treatment-planned procedures performed in specific clinics, select the desired clinics (to select multiple clinics, while pressing the Ctrl key, click each clinic), or leave **All** selected to update procedures for all clinics.
     - **Tx Provider** – To update treatment-planned procedures performed by a specific provider, select the providers (to select multiple providers, while pressing the Ctrl key, click each provider), or leave **All** selected to update procedures for all providers.
     - **Billing Type for Patient's Guarantor** – If you are updating treatment plan fees for all patients, to update treatment-planned procedures for patients with specific billing types, select the billing types (to select multiple billing types, while pressing the Ctrl key, click each billing type), or leave **All** selected to update procedures for patients with any billing type.

- **Case Information** – This tab provides the following options for updating treatment plan fees:



  - **Current Status** – To update treatment-planned procedures in cases with specific statuses, select the case statuses, or leave **All** selected to update treatment-planned procedures in cases with any status.
  - **Case Financing Flag** – To update treatment-planned procedures in cases with specific financing flags, select the financing types, or leave **All** selected to update treatment-planned procedures in cases with any financing flag.
  - **Severity** – To update treatment-planned procedures in cases with specific case severities, select the severity levels, or leave **All** selected to update treatment-planned procedures in cases with any severity.
  - **Exclude Default Treatment Plan** – To exclude all procedures added to a default treatment plan, select this option.
  - **Estimate Expiration Date Before** – To update fees for procedures in cases created prior to but not on the date specified, select this option, and then select a cut-off date.

3. Click **Update**.

Important: Depending upon which fee schedule is assigned to the patient, the fee for the patient's treatment-planned procedures might not have been updated or not updated with the fee you might have expected. For more information about fee schedule hierarchy, see the "Updating treatment plan fees" topic in the Dentrix Enterprise Help.

Generating Treatment Planner Reports

You can print the following Treatment Planner reports:

- Treatment Case Report
- Patient Treatment Case Report
- Patient Proposed Treatment Case Report
- Practice Treatment Case Report

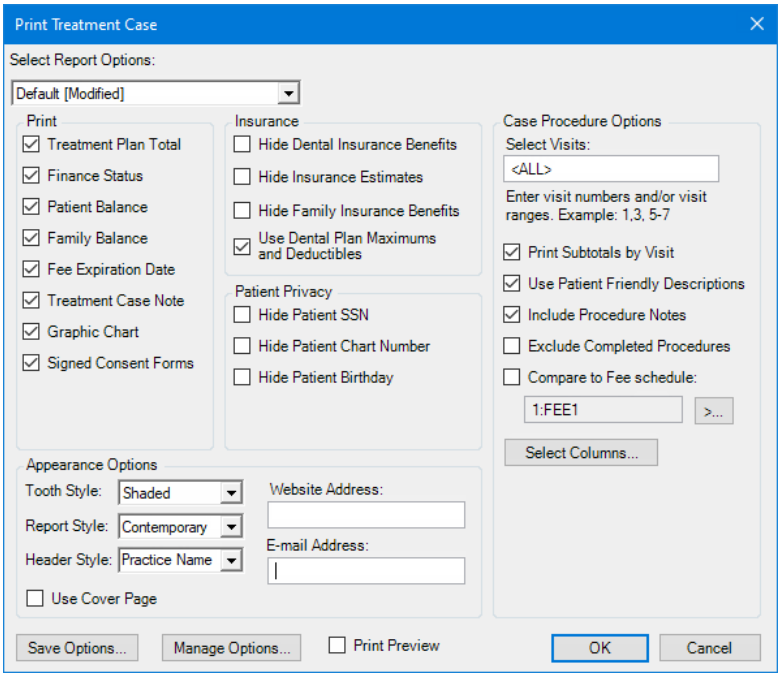
Treatment Case Report

You can print the Treatment Case Report to report on a specific case.

To generate the report

1. In Treatment Planner, on the Navigation panel, from the **Treatment Plan Case Setup** section, select a case.
2. From the **File** menu, point to **Print**, and then click **Treatment Case Report**.

   The **Print Treatment Case** dialog box appears.



3. Set up any of the following options:
   - **Print** – Select the information you want to include.
   - **Insurance** – Select the insurance information you want to exclude. To include the amount of any deductibles applied, select **Use Dental Plan Maximums and Deductibles**.
   - **Patient Privacy** – Select the patient information you want to exclude.

- **Case Procedure Options**
  - Enter a visit or range of visits (for example, 1, 3, 5-7) you want to include on the report in the **Select Visits** box, or leave "<ALL>" entered to include all visits.
  - Select the visit-specific 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.

Tips:

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

4. Click **OK**.

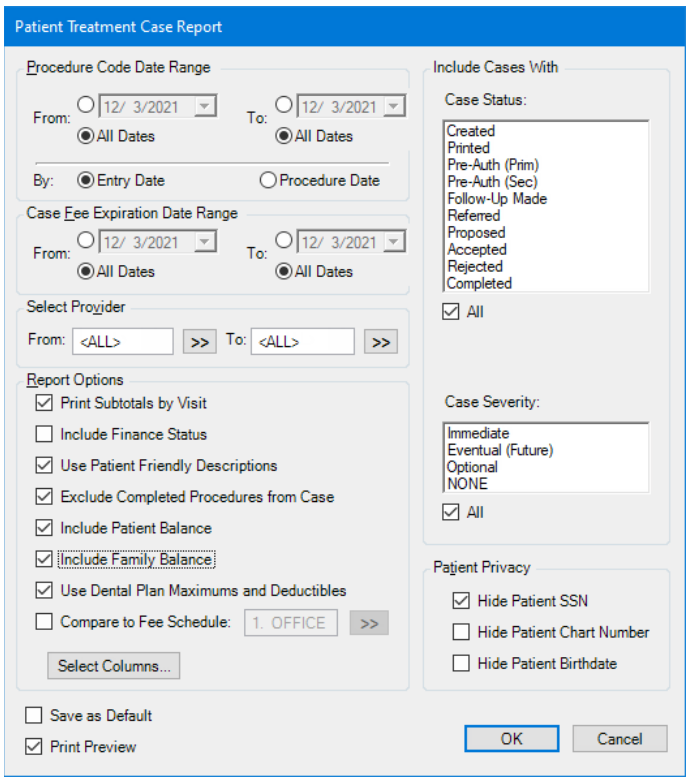
Patient Treatment Case Report

You can print the Patient Treatment Case Report to report on the current patient.

To generate the report

1. In Treatment Planner, on the Navigation panel, from the **Treatment Plan Case Setup** section, select a case.
2. From the **File** menu, point to **Print**, and then click **Patient Treatment Case Report**.

   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**.

Patient Proposed Treatment Case Report

You can print the Patient Proposed Treatment Case Report to report on the current patient's proposed cases.

To generate the report

1. In Treatment Planner, on the Navigation panel, from the **Treatment Plan Case Setup** section, select a case.
2. From the **File** menu, point to **Print**, and then click **Patient Proposed Treatment Case Report**.

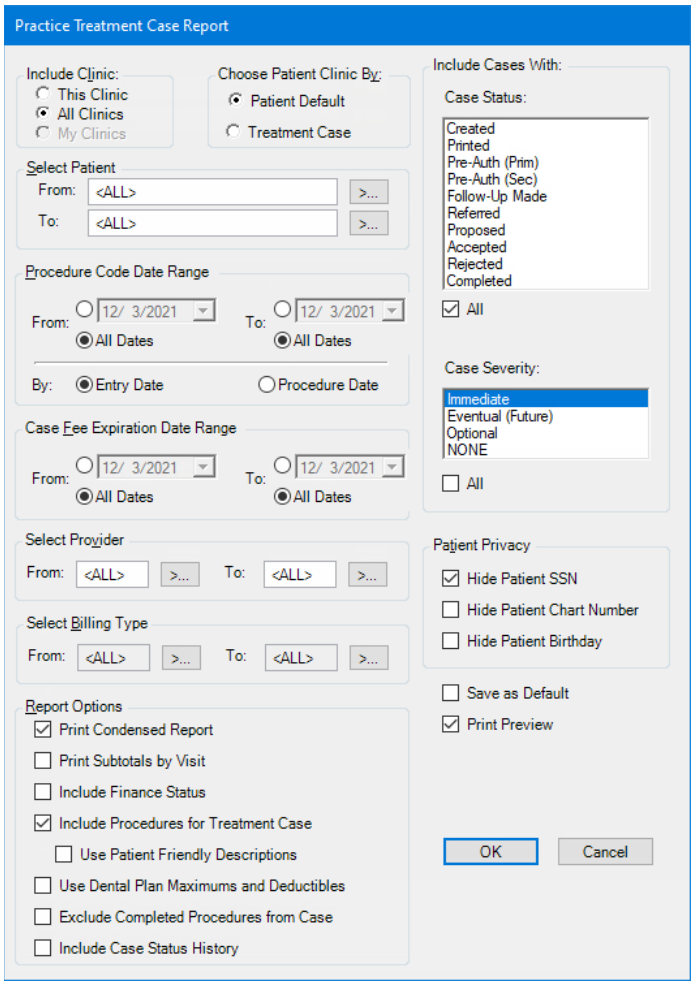
Practice Treatment Case Report

You can print the Practice Treatment Case Report to report on the whole practice.

To generate the report

1. In Treatment Planner, on the Navigation panel, from the **Treatment Plan Case Setup** section, select a case.
2. From the **File** menu, point to **Print**, and then click **Practice Treatment Case Report**.

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



3. Set up any of the following options:
   - **Select Patient** – To select a patient or range of patients with treatment-planned procedures within the range to include, click the **From** and **To** search buttons [>...], and select the patient(s). You can also enter names or partial last names (for example, **From** "a" **To** "c") in the boxes. To include all patients, leave **From** "<ALL>" **To** "<ALL>" entered.
   - **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**. Also, select whether you want to include procedures by **Entry Date** or **Procedure Date**.
   - **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 patients' treatment-planned procedures to include, click the **From** and **To** search buttons [>...], and select the provider(s). To include all providers, leave **From** "<ALL>" **To** "<ALL>" entered.
- **Select Billing Type** – To select a billing type or range of billing types of patients with treatment-planned procedures to include, click the **From** and **To** search buttons [>...], and select the billing type(s).
- **Report Options** – Select the information you want to include.
- **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 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 7: Ledger

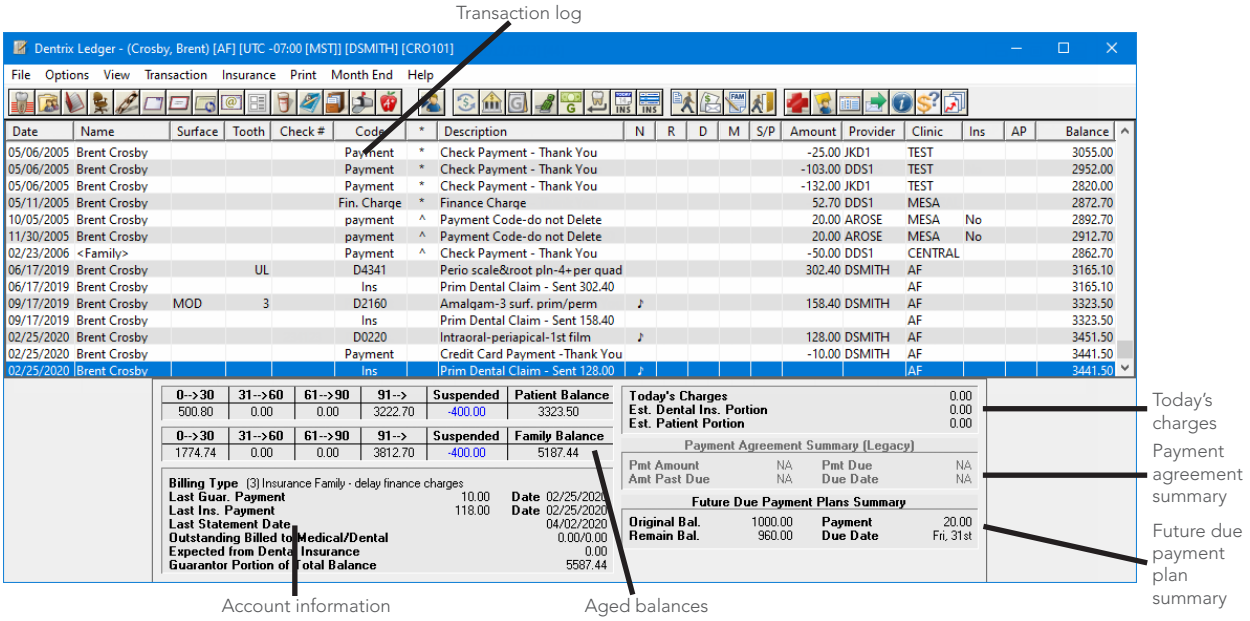
The Dentrix Enterprise Ledger displays a wealth of information in an easy-to-read format. Also, from Ledger, you can enter payments, file claims, print statements, and much more.

This chapter covers the following topics about using Ledger:

- The Ledger Window
- Selecting Ledger Views
- Changing an Account's Billing Type
- Entering Transactions
- Editing Current Transactions
- Deleting Current Transactions
- Invalidating Transactions in History
- Processing Dental Insurance Claims
- Processing Medical Insurance Claims
- Working with Treatment Plans
- Generating Ledger Reports
- Using Fast Checkout
- Posting Batch Guarantor Payments
- Posting Batch Insurance Payments
- Searching for Payments
- Working with Payment Plans
- Using the Suspended Credits Manager
- Working with Notes in Ledger
- Performing Month-end Routines

The Ledger Window

The **Ledger** window consists of the menu bar, toolbar, transaction log, and various sections containing financial information.



This section covers the following topics to help you understand how to use the **Ledger** window:

- The Ledger Toolbar
- The Transaction Log
- Viewing Aged Balances
- Viewing Account Information
- Viewing Today's Charges
- Viewing Payment Agreement Information
- Viewing Future Due Payment Plan Information
- Filtering the Transaction Log

The Ledger Toolbar

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



The function of the buttons specific to Ledger are explained in the following table.

	Click the **Patient Financing** button to go to the Citi website to sign up and manage patient financing options.
	Click the **Select Patient** button to select a patient whose record you want to view in the Ledger.
	Click the **Patient Finances** button to view and add payment plans and change account billing types.
	Click the **Guarantor Notes** button to enter notes for an account and/or that account's billing statements.
	Click the **Enter Payment** button to enter patient payments.
	Click the **Enter Procedure** button to post procedures to a patient's Ledger.
	Click the **Ins. Today's Proc** button to create and then display and/or batch (according to the setup options selected) an insurance claim for any procedures posted on the current system date.
	Click the **Ins. Selected Proc.** button to create and then display and/or batch (according to the setup options selected) an insurance claim for the selected procedures.
	Click the **Print Walkout** button to display and/or batch (according to the setup options selected) a family walkout statement.
	Click the **Print Statement** button to display and/or batch (according to the setup options selected) a billing statement.
	Click the **Print Family Ledger** button to display and/or batch (according to the setup options selected) a family ledger report.
	Click the **Fast Checkout** button to perform a fast checkout (according to the setup options selected).
	Click the **Patient Alerts** button to enter or manage the alerts for the patient currently being viewed in the Ledger.
	Click the **Clinical Notes** button to manage clinical notes regarding the treatments for the patient currently being viewed in the Ledger.

The Transaction Log

The transaction log is a written record of all transactions posted to a patient/family's account. For each transaction, the date, patient or guarantor name, tooth number and surface (when applicable), procedure code or type, a description, amount, provider, and clinic are shown and whether or not insurance has been billed is indicated.

Date	Name	Surface	Tooth	Check #	Code	*	Description	N	R	D	M	S	Amount	Provider	Clinic	Ins	AP	Balance
05/15/2014	Shirley Crosby	MO	4		D2150		Amalqam-2 surf. prim/perm						125.00	DESMITH	CENTRAL			125.00
05/15/2014	Shirley Crosby		8		D3221		Pulpal debridemnt-prim/perm ...	♪					0.00	DESMITH	CENTRAL	X		125.00
05/15/2014	Shirley Crosby		UL		D4220		Gingiv curettage,surgical /quad						190.00	DESMITH	CENTRAL	X		315.00
05/15/2014	Shirley Crosby				D1110		Prophylaxis-adult				△		65.00	DESMITH	CENTRAL	X		380.00
05/15/2014	Shirley Crosby				D0150		Comp oral eval-new/estab pat		R		△		85.00	DESMITH	CENTRAL	X		465.00
05/15/2014	<Family>			1234234	Payme...		Check Payment - Thank You					S	-1000.00	<Multipl...	CENTRAL			-535.00
05/15/2014	Shirley Crosby				Ins		Prim Dental Claim - Sent 125.00								CENTRAL			-535.00

Each column provides useful information about a financial transaction or procedure:

- **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 or postdated the transaction or procedure.
- **Name (Patient Name)** – The name of the patient associated with the transaction or procedure. For a financial transaction (payment, adjustment, and so forth), if it has been applied to the family, "<Family>" appears, or if it has been applied to the guarantor, the guarantor's name appears.
- **Surface (Tooth Surface(s))** – The surface associated with the procedure.
- **Tooth (Tooth Number)** – The tooth associated with the procedure.
- **Check #** – The check number associated with the payment.
- **Code (Procedure/Transaction Code)** – The associated procedure code, financial transaction type (payment, adjustment, or so forth), or "Ins" for claims.
- * **(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.
- **Description** – The description of the transaction or procedure.
- **N (Has Note)** – A musical note in this column indicates that there is a note attached to the procedure.
- **R (Has Referral by)** – A letter R in this column indicates that a referral is attached to the procedure.
- **D (Has Diagnosis)** – A letter D in this column indicates that the procedure has been cross coded with a dental diagnostic code.
- **M (Has Medical Cross Coding)** – A triangle (appearance varies) in this column indicates that a certain stage of medical cross coding has been done for the procedure.
- **S (Payment Contains Suspended amount)** – A letter S in this column indicates that the payment has a suspended amount.
- **Amount** – The amount of the transaction.
- **Provider** – The provider associated with the transaction.
- **Clinic** – The clinic associated with the transaction.

- **Ins (Insurance Claim Created)** – Any of the following may appear:

  X – An **X** in the **Ins** column indicates that the procedure is flagged as "Do Not Bill To Insurance."

  No – A **No** in the **Ins** column indicates that the procedure is not attached to a claim.

- **AP (Approval)** – If you are viewing the Ledger-Treatment Plan view, an approval status associated with the treatment-planned procedure may appear.
- **Balance (Running Balance)** – The patient's or family's running balance (depending on the Ledger view). This column only shows amounts if the transaction log is being sorted chronologically (in ascending order) by the **Date** column.

Viewing Aged Balances

The aged balances and the total balances for the current patient and family are displayed. Any suspended amounts are also shown.

0-->30	31-->60	61-->90	91-->	Suspended	Patient Balance
480.00	350.00	1280.00	3071.00	0.00	5181.00

0-->30	31-->60	61-->90	91-->	Suspended	Family Balance
985.00	350.00	1280.00	3161.00	-449.00	5327.00

Viewing Account Information

The account information displayed includes the billing type, amount and date of the last guarantor payment, amount and date of last insurance payment, date of the last statement, total amount of all outstanding claims, estimated amount insurance will pay, and estimated amount of the patient portion.

Billing Type	(13) Managed Care Account		
Last Guar. Payment	20.00	**Date**	04/07/2015
Last Ins. Payment	140.00	**Date**	03/24/2015
Last Statement Date			07/15/2015
Outstanding Billed to Medical/Dental			165.00/0.00
Expected from Dental Insurance			0.00
Guarantor Portion of Total Balance			5776.00

Viewing Today's Charges

For the current system date, the total of all transactions, the estimated amount that dental insurance will pay according to the coverage setup in the Family File, and the estimated amount the patient owes according to the coverage setup in the Family File are displayed.

Today's Charges	125.00
Est. Dental Ins. Portion	125.00
Est. Patient Portion	0.00

Viewing Payment Agreement Information

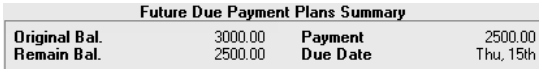
If a legacy payment agreement exists for the account, the current status of the agreement appears. For information about setting up payment plans, see "Creating Payment Plans" in this chapter.

Payment Agreement Summary (Legacy)			
Pmt Amount	448.17	**Pmt Due**	448.17
Amt Past Due	0.00	**Due Date**	12/20/2008

Note: Any existing payment agreements from versions of Dentrix Enterprise prior to 11.0.4 Update 4 are converted to payment plans during the upgrade of Dentrix Enterprise to the current version.

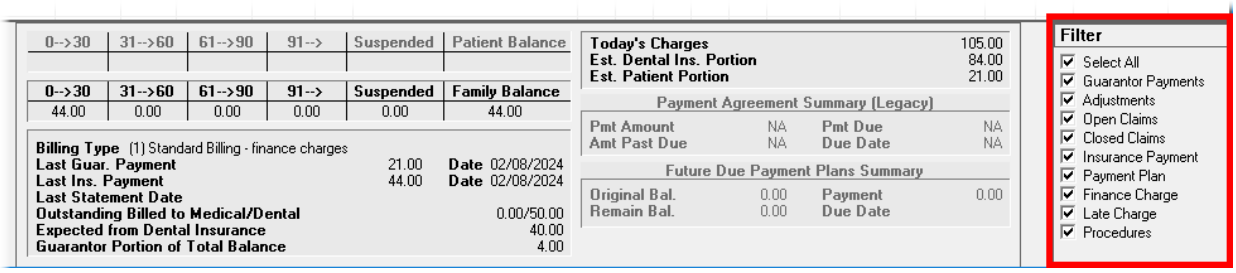
Viewing Future Due Payment Plan Information

If a future due payment plan exists for the account, the current status of the payment plan is shown. For information about setting up future due payment plans, see “Creating Future Due Payment Plans” in this chapter.



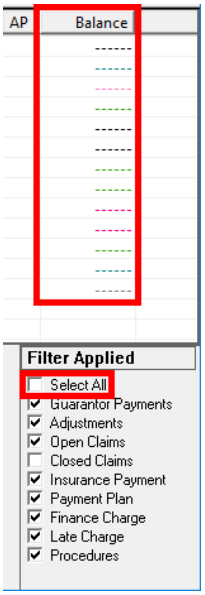
Filtering the Transaction Log

You can filter the transaction log in Ledger to show only certain transaction types and claims. Under **Filter** (in the lower-right corner), clear any checkboxes to hide those items; or clear the **Select All** checkbox to quickly hide all items, and then select the checkboxes of only the items you want to view.



Notes:

- If not all transaction types and claims are being viewed, the filter options header **Filter** changes to **Filter Applied**, and the **Balance** column of the transaction list does not show any amounts.



- Ledger reverts back to showing all transaction types and claims once you select a different patient or close the window.

Selecting Ledger Views

While in the Ledger, you can choose to display account information in several different ways.

To switch between the Ledger views

- **Options** – In the Ledger, with a patient selected, from the **Options** menu, select a view option. The option with a check mark is the view currently being used. The Ledger title bar also indicates the current view.
  - **Ledger** – When first opened, the Ledger displays all transactions posted during the current month for the selected patient.
  - **Ledger + History** – You can see all transactions for the selected patient, including history transactions.
  - **Treatment Plan** – You can view and work with a patient's treatment plan.
- **View** – In the Ledger, with a patient selected, from the **View** menu, select a view option. The checked option is the view currently being used.
  - **Show Transaction Links** – When the transaction for which you want to find links is selected, you can see all of the procedures that are linked to an insurance claim and all of the payments and adjustments that are linked to a procedure.
  - **All With Running Balance** – You can view transactions for the entire family. In addition, a column is added to the right side of the transaction log that displays a running balance for the account.
  - **Family Members** – You can quickly switch to any family member's ledger by selecting that family member.

Changing an Account's Billing Type

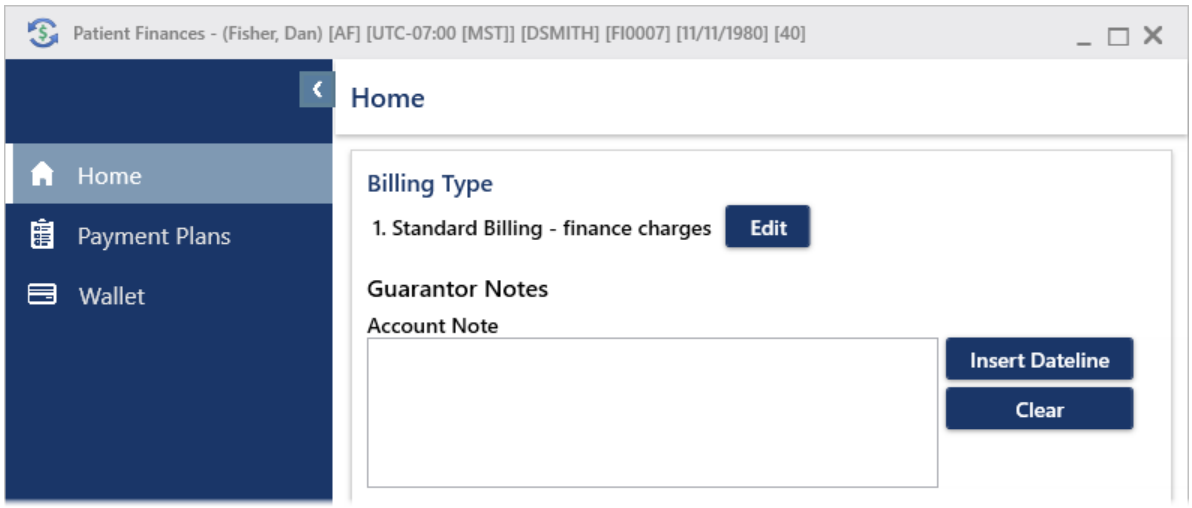
You can use billing types to group accounts into categories for billing and reporting purposes. For example, if you do not want to bill certain families, or if you need to indicate that you sent an account to collections, you can assign them a distinct billing type to keep them separate from other patients when you run reports or print statements. You can easily change an account's billing type as needed (for instance, when the account has been sent to collections).

You assign billing types per account. When you assign a billing type to a patient, Dentrix Enterprise assigns everyone in that patient's family in the Family File that billing type.

To change an account's billing type

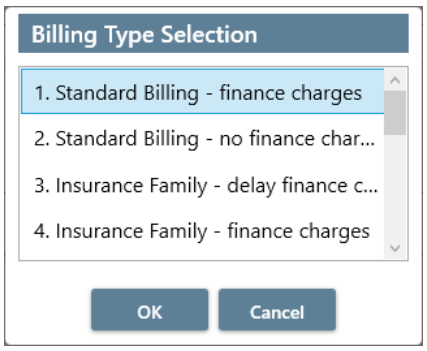
1. In the Ledger, with a patient selected, click the **Patient Finances** button .

   The **Patient Finances** window opens.



2. Under **Billing Type**, click **Edit**.

   The **Billing Type Selection** dialog box appears.



3. Select a billing type.
4. Click **OK**.

Tip: To add a note about the change in the billing type, enter an **Account Note**.

Entering Transactions

This sections covers the following topics about posting transactions in the Ledger:

- Posting Procedures
- Posting Payments
- Posting Payments to Payment Plans
- Applying Suspended Credits
- Posting Adjustments
- Posting Finance and Late Charges

Posting Procedures

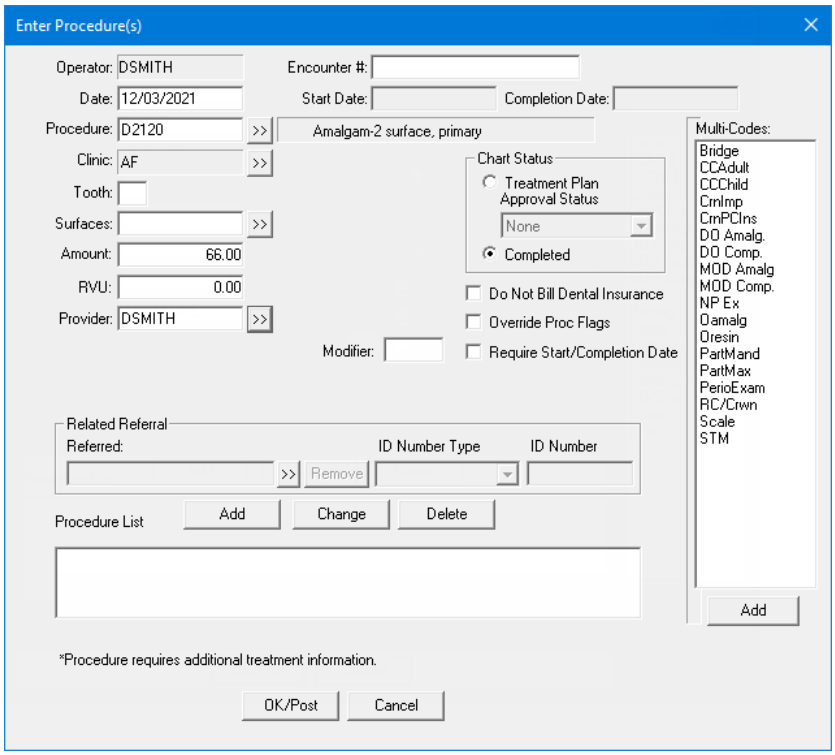
All charges listed on an account are posted through the use of a procedure code. Typically, the procedure code used is one of the ADA codes that come pre-loaded with Dentrix Enterprise. However, dental offices often perform procedures or assess charges that don't have a standard procedure code (sometimes referred to as "administrative codes"). You need to add these charges and assign them to a procedure code. Most of the time, you post treatment in the Patient Chart; and then, when the procedures are completed, they are automatically posted to Ledger. In some cases, however, you may need to post a procedure (such as an administrative code) directly in Ledger.

Note: According to your organization's policies and standards, you may be required to enter and edit only administrative codes (such as those for missed or broken appointments) from Ledger. That being the case, you would have to enter and edit procedure codes related to patient treatment from the Patient Chart.

To post a procedure

1. In Ledger, with a patient selected, click the **Enter Procedure** button  . This option is available only if a patient is selected, the selected patient is not archived, and you are not viewing the running balance for all family members.

   The **Enter Procedure(s)** dialog box appears.



2. Enter the procedure information:
   a. By default, the procedure's **Date** is today's date, but you can change it.
   b. Click the **Procedure** search button >>. The **Procedure Codes** dialog box appears. Select a procedure code **Category** to see a list of the corresponding procedure codes. Select the desired procedure code, and then click **OK**.

c. Other boxes will appear if the selected code requires additional treatment information. If required for the procedure code, enter additional treatment information:

- **Tooth** – Enter the appropriate **Tooth** number or letter. You can also enter a supernumerary tooth number or letter.
- **Range of Teeth** – Enter the first tooth number or letter in the range, a dash, and then the last tooth number or letter in the range.
- **Surfaces** – Click the **Surfaces** search button ». The **Surfaces Selection** dialog box appears. Select the applicable treatment areas, and then click **OK**. If multiple teeth have been entered, the treatment areas you specify will be applied to all those teeth.
- **Quadrants** – Select the appropriate quadrant.
- **Sextants** – Select the appropriate sextant.
- **Arch** – Select the appropriate arch.

d. Dentrix Enterprise automatically enters the **Amount** for the **Procedure** being posted. But, you can change the amount as needed.

e. Set up any of the following options:

- **Clinic** – To change the clinic for the procedure, click the search button » to select the correct clinic.
- **Provider** – To change the provider attached to the procedure, click the search button » to select the correct provider.

f. Click **Add** to add the procedure to the **Procedure List**.

Note: Repeat these steps for any other procedures that you want to post.

3. Click **OK/Post**. The procedures posted in Ledger automatically appear in the Patient Chart as well.

Posting Payments

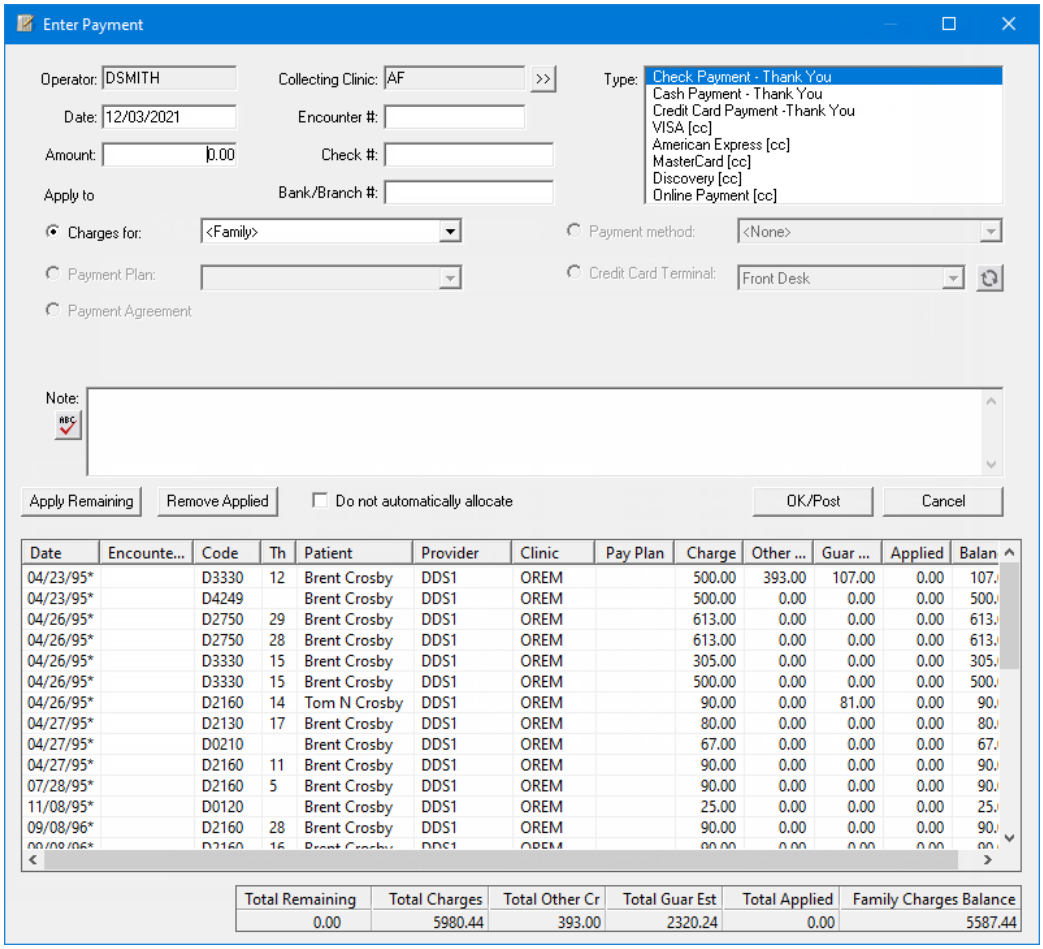
Dentrix Enterprise uses line-item accounting to calculate account balances. You can view balances for the entire family and for individual patients within the family. When a patient makes a payment, you can credit the payment to individual patient charges or to the entire family balance (oldest balance first). Dentrix Enterprise allows the posting of pre-payments and suspended payments that are not immediately allocated to a charge. Also, Dentrix Enterprise has a feature that allows you to quickly view linked charges and credits.

All payments made by patients are classified as guarantor payments and will be listed under the guarantor's name. Keep in mind that, even though you may have selected a family member other than the guarantor, guarantor payments are always displayed in the Ledger view, so you can easily see when the last time a payment was made to the account.

To post a payment

1. In Ledger, with a patient selected, click the **Enter Payment** button .

   The **Enter Payment** dialog box appears.



2. Set up the following options:
   - **Collecting Clinic** – Click the search button >> to select a clinic.
   - **Date** – Payments are automatically assigned the current system date, but you can change the date as needed.
   - **Type** – Select the correct payment type. For information about how to set up payment types, see the "Customizing Payment Types" topic in the Dentrix Enterprise Help.

- **Amount** – Enter the dollar amount of the payment.
- **Check #** – If the patient is paying with a check, enter the **Check #** and **Bank/Branch #** of the check.
- **Apply to Charges for** – Select "<Family>" to list charges for the entire family with the amount owed to each provider; or, to list only a specific patient's charges, select that patient. For information about how to set up the **Apply to Charges for** list default selection, see "Setting Up Program Preferences" in Chapter 1: Introduction and Initial Setup.
- **Note** – Document any unusual circumstances surrounding the payment.

3. When you enter an amount, Dentrix Enterprise will automatically allocate the payment to the oldest provider balances, according to the charges listed. The amount applied appears in the **Applied** column. You can apply any remaining amount or edit the applied amounts as needed:
   - To apply a remaining amount, select the desired charges (to select multiple charges, while holding down the Ctrl key, click each charge), and then click **Apply Remaining**. The amount in the **Total Remaining** box is applied to the selected charges.

     Note: If the amount exceeds the guarantor estimate, a dialog box will appear. Select either **Do not apply the remaining amount** (to only apply an amount equal to the guarantor estimate) or **Apply the remaining amount to the balances** (to apply the remaining amount but not exceed the total charge, which can be paid by insurance and will result in overpayment), and then click **OK**.
   - To remove applied amounts, select the desired charges, and then click **Remove Applied**.
   - To edit an applied amount, double-click the desired charge to enable the applied amount to be edited, enter the correct amount to be applied, and then click the check mark  .
   - If a credit results from how you have applied or unapplied amounts, to have the credit not be applied to any listed charge when anyone attempts to apply suspended credits to the account, select **Do Not Automatically Allocate**.
4. Click **OK/Post**.

   If all or a portion of the payment has not been applied to any charges, a message appears and ask if you want to suspend the amount. Click **Yes**. The unapplied amount will be suspended but can be applied at a later time as explained in "Applying Suspended Credits" in this chapter.

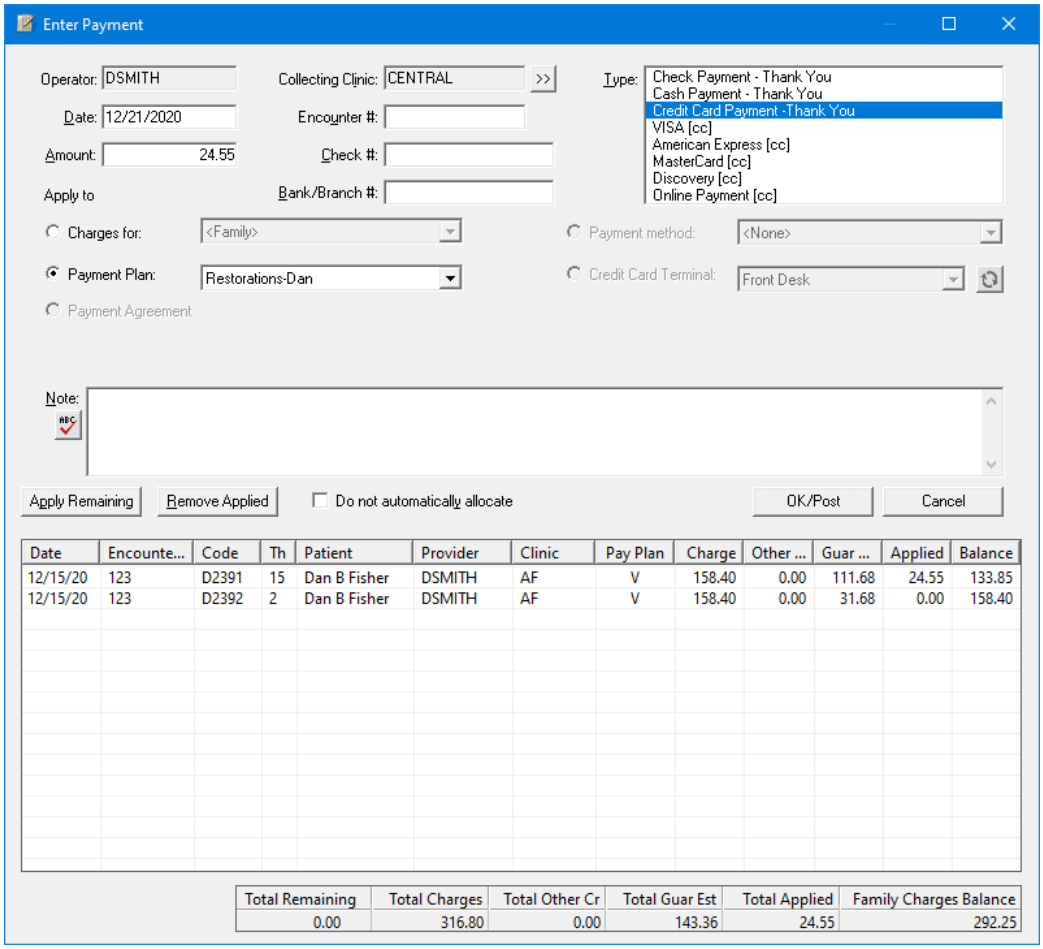
Posting Payments to Payment Plans

You can credit a payment toward a payment plan balance.

To post a payment to a payment plan

1. In Ledger, with a patient selected, click the **Enter Payment** button  .

   The **Enter Payment** dialog box appears.



2. Enter the payment information. For details on posting payments, see "Posting Payments" in this chapter.
3. Under **Apply to**, select **Payment Plan**, and then select the payment plan to which you want to apply the payment.
4. Click **OK/Post**.

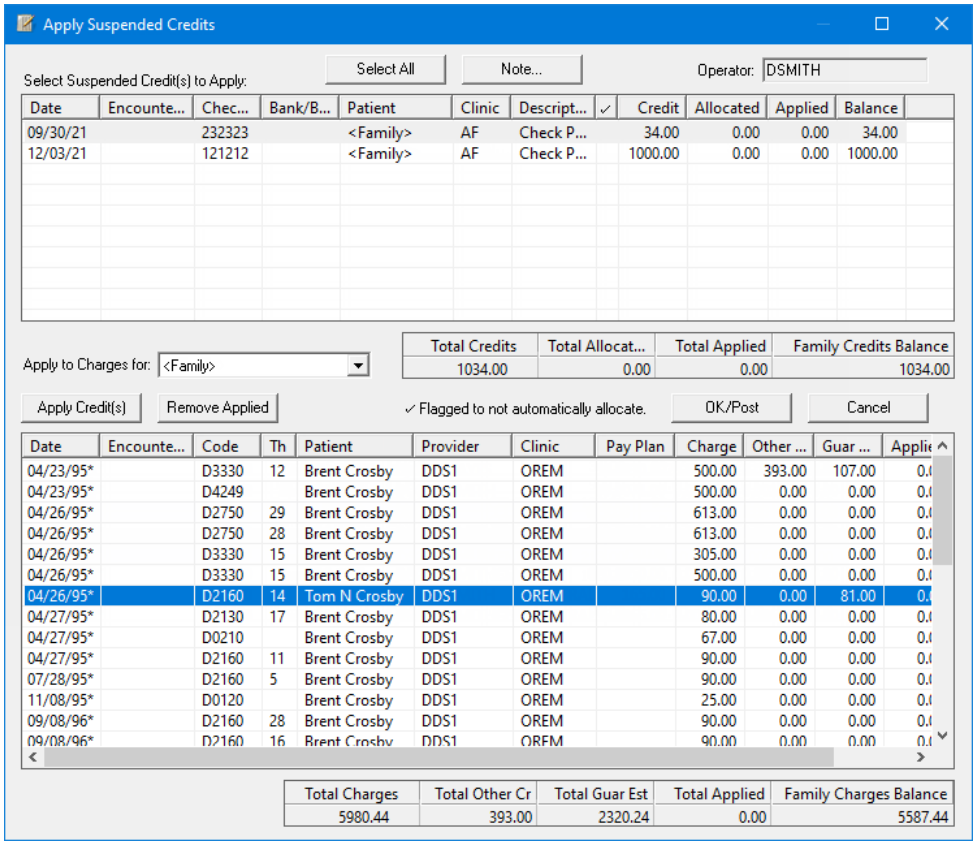
Applying Suspended Credits

Since Dentrix Enterprise uses line-item accounting, payments and adjustments should be applied to posted procedures. However, for times when it is necessary to suspend a payment or credit (such as for a pre-payment or an overpayment), you may do so. Then, once charges are posted, you can apply the suspended amount toward those charges.

To apply a suspended credit

1. In Ledger, with a guarantor or patient selected, from the **Transaction** menu, click **Apply Suspended Credits**.

   The **Apply Suspended Credits** dialog box appears.



2. Select the credits to be applied, or click **Select All** to select all suspended credits.

   Tip: To view or update the payment note for a selected credit, click **Note**.

3. From the **Apply to Charges for** list, select "<Family>" to list charges for the entire family with the amount owed to each provider; or, to list only a specific patient's charges, select that patient. For information about how to set up the **Apply to Charges for** list default selection, see "Setting Up Program Preferences" in Chapter 1: Introduction and Initial Setup..
4. Click **Apply Credit(s)**.
5. Click **OK/Post**.

   Tip: To see which charges and credits are linked, select a transaction in Ledger, and then, from the **View** menu, click **Show Transaction Links**. All linked transactions will be selected.

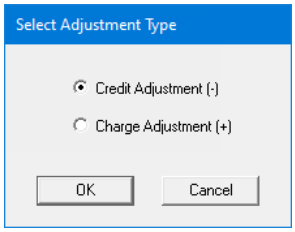
Posting Adjustments

Dentrix Enterprise aligns itself with generally accepted accounting principles (GAAP), which recommends that you enter adjustments to correct posting errors, record refunds, and offer discounts. Posting adjustments instead of just editing procedure amounts will allow you to accurately track how those adjustments (like friends and family discounts) affect revenue. In Dentrix Enterprise, you can enter the two types of adjustments: a credit adjustment, which lowers an account balance; and a charge/debit adjustment, which raises an account balance. Additionally, since Dentrix Enterprise uses line-item accounting, you allocate a credit adjustment to one or more procedures (line items). For information about setting up adjustment types, see the "Customizing Adjustment Types" topic in the Dentrix Enterprise Help.

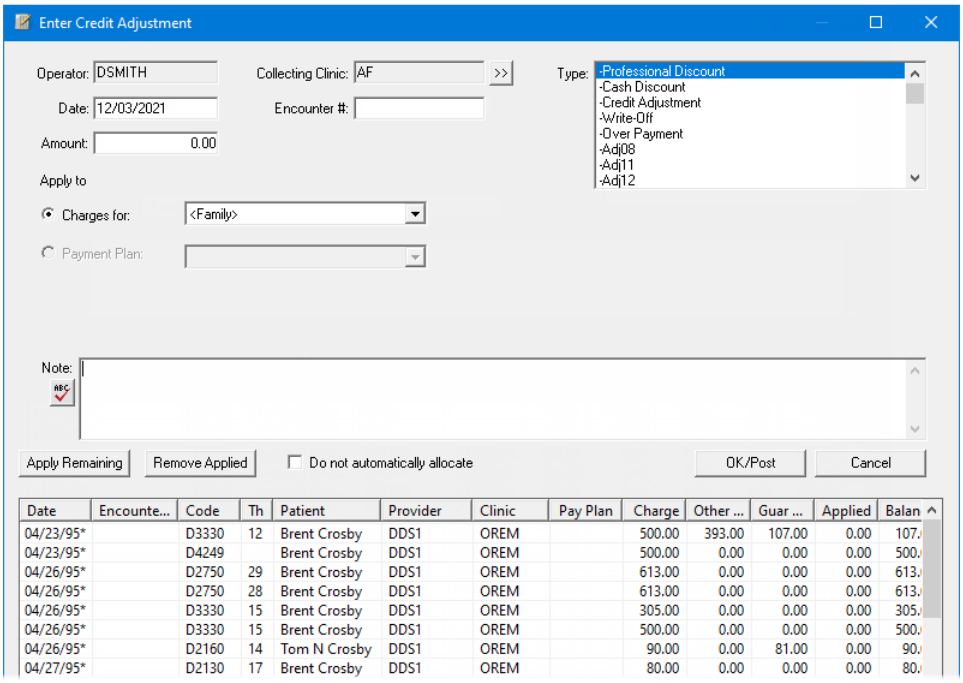
To post an adjustment

1. In Ledger, with a guarantor or patient selected, from the **Transaction** menu, click **Enter Adjustment**.

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



2. Select either **Credit Adjustment (-)** (if the adjustment reduces the account balance) or **Charge Adjustment (+)** (if the adjustment increases the account balance).
3. Click **OK**.
4. Post the adjustment according to the specified type:
   - For a credit adjustment, the **Enter Credit Adjustment** dialog box appears.



   Do the following:

   a. Set up the following options:
      - **Collecting Clinic** – Click the search button >> to select a clinic.

- **Date** – By default, the adjustment's date is today's date, but you can change it.
- **Type** – Select the correct adjustment type.
- **Amount** – Enter the dollar amount of the adjustment.
- **Apply to Charges for** – Either select **<Family>** to list charges for the entire family with the amount owed to each provider, or select a specific patient to list charges for only that patient. For information about how to set up the **Apply to Charges for** list default selection, see "Setting Up Program Preferences" in Chapter 1: Introduction and Initial Setup.
- **Note** – Enter the reason for the adjustment.

b. When you enter an amount, Dentrix Enterprise automatically allocates the adjustment to the oldest provider balances, according to the charges listed. The amount applied appears in the **Applied** column. You can apply any remaining amount or edit the applied amounts as needed:

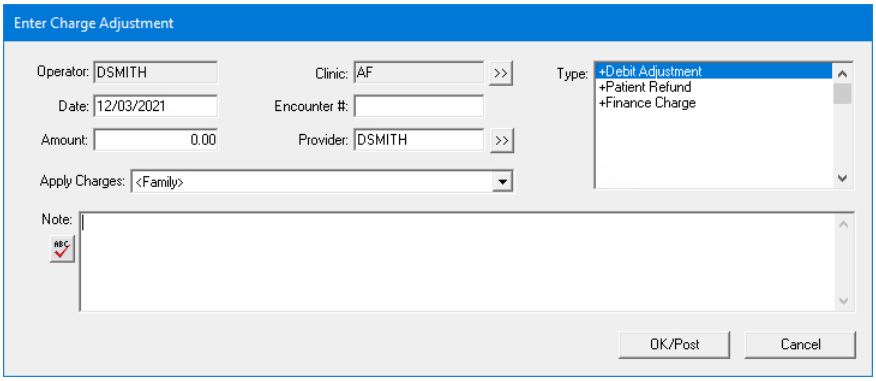
- To apply a remaining amount, select the desired charges (to select multiple charges, while holding down the Ctrl key, click each charge), and then click **Apply Remaining**. The amount in the **Total Remaining** box is applied to the selected charges.

  Note: If the amount exceeds the guarantor estimate, a dialog box will appear. Select either **Do not apply the remaining amount** (to only apply an amount equal to the guarantor estimate) or **Apply the remaining amount to the balances** (to apply the remaining amount but not exceed the total charge, which can be paid by insurance and will result in overpayment), and then click **OK**.

- To remove applied amounts, select the desired charges, and then click **Remove Applied**.
- To edit an applied amount, double-click the desired charge to enable the applied amount to be edited, enter the correct amount to be applied, and then click the check mark  .
- If a credit results from how you have applied or unapplied amounts, to have the credit not be applied to any listed charge when anyone attempts to apply suspended credits to the account, select **Do Not Automatically Allocate**.

c. Click **OK/Post**.

- For a charge adjustment, the **Enter Charge Adjustment** dialog box appears.



Do the following:

a. Set up the following options:

- **Clinic** – Click the search button >> to select a clinic.
- **Date** – By default, the adjustment's date is today's date, but you can change it.
- **Type** – Select the correct adjustment type.

- **Amount** – Enter the dollar amount of the adjustment.
- **Provider** – Click the search button [>>] to select the appropriate provider for the adjustment.
- **Apply to Charges for** – Select "<Family>" to apply the charge to the entire family's balance; or, to apply the charge to only a specific patient's balance, select that patient. For information about how to set up the **Apply to Charges for** list default selection, see "Setting Up Program Preferences" in Chapter 1: Introduction and Initial Setup.
- **Note** – Enter the reason for the adjustment

b. Click **OK/Post**.

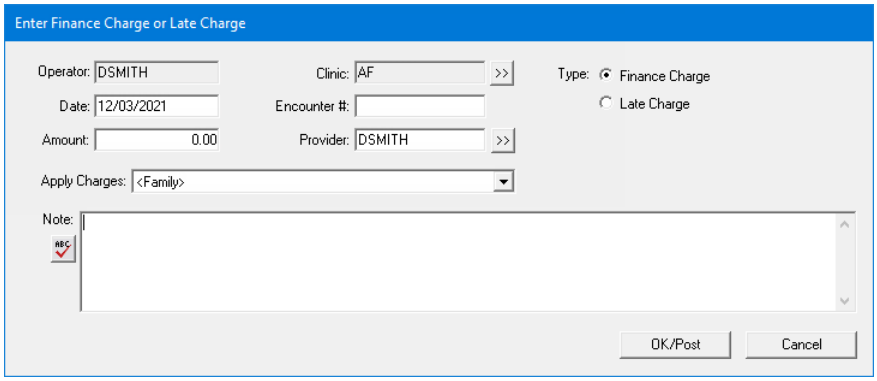
Posting Finance and Late Charges

Dentrix Enterprise aligns itself with generally accepted accounting principles (GAAP), which recommends that you enter late charges and finance charges instead of editing a procedure amount. This will allow you to accurately track how those late charges and finance charges affect revenue.

To post a finance or late charge

1. In Ledger, with a guarantor or patient selected, from the **Transaction** menu, click **Enter Finance Charge or Late Charge**.

   The **Enter Finance Charge or Late Charge** dialog box appears.



2. Set up the following options:
   - **Clinic** – Click the search button [>>] to select the correct clinic.
   - **Date** – By default, the adjustment's date is today's date, but you can change it.
   - **Amount** – Enter the dollar amount of the charge.
   - **Provider** – Click the search button [>>] to select the appropriate provider for the charge.
   - **Type** – Select the correct type of charge: **Finance Charge** or **Late Charge**.
   - **Apply to Charges for** – Select "<Family>" to apply the charge to the entire family's balance; or, to apply the charge to only a specific patient's balance, select that patient. For information about how to set up the **Apply to Charges for** list default selection, see "Setting Up Program Preferences" in Chapter 1: Introduction and Initial Setup.
   - **Note** – Enter an explanation for a finance or late charge.
3. Click **OK/Post**.

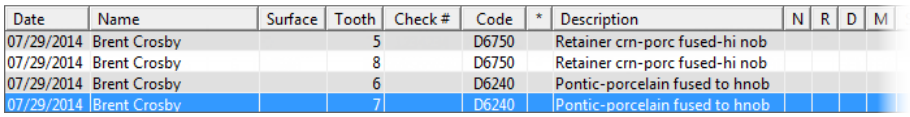
Editing Current Transactions

From time to time, a posting mistake will be made, and you will need to correct it. You can edit and delete procedures, payments, and adjustments that have not been moved to history (when closing a month).

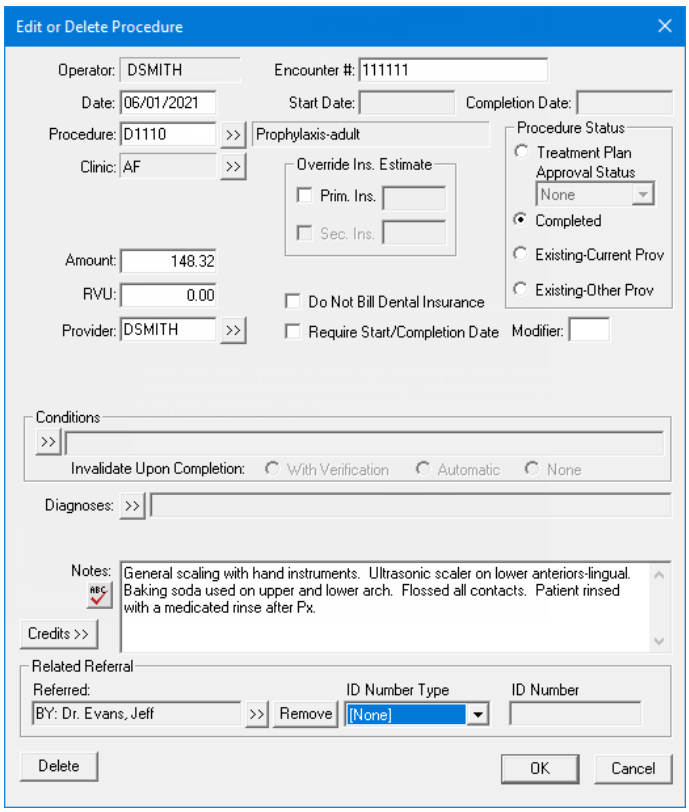
Procedures attached to an insurance claim cannot be edited until the claim has been deleted. For information about how to delete a claim, see "Deleting Dental Insurance Claims" in this chapter.

To edit a current transaction

1. In Ledger, with a patient selected, double-click a transaction.



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



2. Make any necessary changes to the transaction. For an explanation of the options available for editing transactions, see "Editing Treatment" in Chapter 4: Patient Chart.
3. Click **OK**.

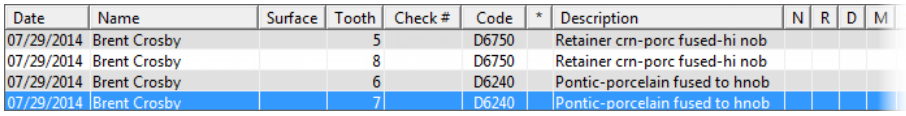
Deleting Current Transactions

You can delete a transaction that has been posted in Ledger or Chart and has not been moved to history (when closing a month).

Before you can edit or delete a procedure, you must delete any claims linked to that procedure.

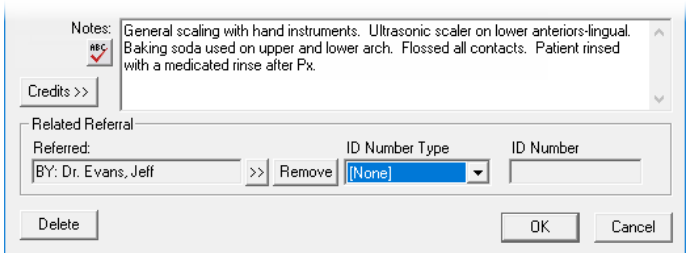
To delete a current transaction

1. In Ledger, with a patient selected, double-click a transaction.



Date	Name	Surface	Tooth	Check #	Code	*	Description	N	R	D	M
07/29/2014	Brent Crosby		5		D6750		Retainer crn-porc fused-hi nob				
07/29/2014	Brent Crosby		8		D6750		Retainer crn-porc fused-hi nob				
07/29/2014	Brent Crosby		6		D6240		Pontic-porcelain fused to hnob				
07/29/2014	Brent Crosby		7		D6240		Pontic-porcelain fused to hnob				

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



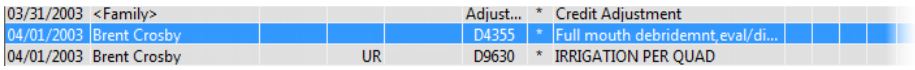
2. Click **Delete** in the lower-left corner of the dialog box.
3. On the confirmation message that appears, click **OK**.

Invalidating Transactions in History

Dentrix Enterprise saves your office from repetitive data entry by posting procedures to both 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 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 Ledger.

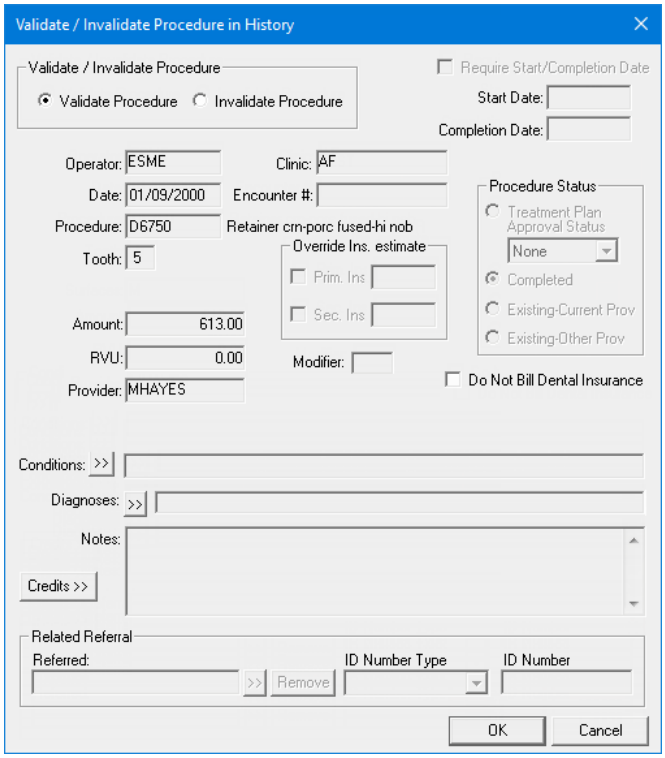
To invalidate a history transaction

1. In Ledger, with a patient selected, double-click a procedure in history.



Note: If to the left of the procedure description, there is an asterisk (*), the transaction is 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 Chart but left in Ledger as a history transaction. In 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.

Processing Dental Insurance Claims

For most offices, handling insurance claims is a big part of the practice management routine. Therefore, Dentrix Enterprise includes many features to help you generate claims for insured patients when they receive treatment. You can print claims or send them electronically. Also, you can post payments for claims submitted to insurance carriers.

Additionally, billing dental insurance can be a complicated operation because of the inconsistent way different insurance carriers handle claims. Fortunately, Dentrix Enterprise has the tools to handle most insurance situations.

This section covers the following topics about processing dental insurance claims:

- Understanding Insurance in Ledger
- Creating Primary Dental Insurance Claims
- Changing Dental Claim Information
- Including Attachments with Dental Insurance Claims
- Reprinting Dental Insurance Claims
- Deleting Dental Insurance Claims
- Posting Dental Insurance Payments
- Creating Secondary Dental Insurance Claims
- Editing or Deleting Dental Insurance Payments
- Indicating Dental Insurance Benefits Used and Deductibles Met

Understanding Insurance in Ledger

The Ledger module provides much insurance information at a glance:

- **Insurance coverage** – You can easily tell if a patient has insurance coverage by looking at the Ledger menu bar. The **Insurance** option is available if a patient has been assigned insurance in the Family File. If the **Insurance** option is unavailable but the selected patient has insurance, on the **View** menu, make sure that **All (with running balance)** does not have a check mark.
- **Procedure or claim status** – From the transaction log, you can quickly see the status of a procedure or claim. The **Ins** column indicates whether or not a procedure has been billed to insurance: if the column is empty, the listed procedure has been attached to an insurance claim; if the column displays "No," an insurance claim has not been created for the procedure.
- **Claim amounts** – Once a dental insurance claim has been created, the **Outstanding Billed to Insurance**, **Expected from Dental Insurance**, and **Guarantor Portion of Total Balance** amounts will change to reflect the amount of the procedures on the claim and the insurance coverage percentages.

  Note: The insurance estimates in Ledger and on billing statements only include procedures that have been billed to dental insurance. The entire procedure cost is allocated to the **Guarantor Portion of Total Balance** until a dental claim is created for the procedure.

- **Submission status** – An insurance claim will have "Not Sent," "Sent," or "Received" as part of its description in the transaction log. A claim is considered "not sent" until it is sent to the Batch Processor or printed. A claim is considered "sent" once it has been sent to the Batch Processor or printed. A claim is considered "received" when a payment is entered.

Creating Primary Dental Insurance Claims

You will create an insurance claim each time an insured patient receives treatment. You can create a claim immediately after a patient checks out, or you can create a batch of insurance claims at the end of the day. In Dentrix Enterprise, creating and sending a claim can be as simple as clicking one button. Determine which of the following methods for creating claims you want to use in your office.

To create a claim

1. In Ledger, with a patient selected, do one of the following:
   - Create a claim for today's procedures. This option is the simplest way to create a claim. Use this method for creating a dental insurance claim immediately after procedures have been posted. From the **Insurance** menu, click **Today's Procedures**, **Today's Procedures - Direct Print**, or **Today's Procedures - Batch**. Or, you can click the **Ins. Today's Proc.** button on the toolbar.

     Dentrix Enterprise creates a dental claim that includes all procedures posted on the current system date.
   - Create a claim for specific procedures. Use this method for creating a dental insurance claim for a specific procedures or procedures that were posted on another date.
     a. Select the procedures for which you want to create a dental claim (to select multiple procedures, while holding down the Ctrl key, click the desired procedures).
     b. From the **Insurance** menu, click **Selected Procedures**, **Selected Procedures - Direct Print**, or **Selected Procedures - Batch**. Or, you can click the **Ins. Selected Proc.** button on the toolbar.

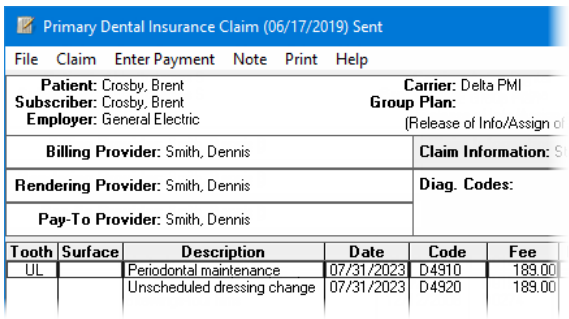
     Dentrix Enterprise creates a dental claim that includes all selected procedures.

   Note: For information about how to set the printing default for the **Ins. Today's Proc.** button and **Ins. Selected Proc.** button, see "Setting Up Direct Print Options" in Chapter:1 Introduction and Initial Setup.

   One of the following occurs:
   - If, from the **Insurance** menu, you select **Today's Procedures** or **Selected Procedures** to create a dental claim, before the claim is sent, the **Primary Dental Insurance Claim** window appears, allowing you to edit the claim information.

     Note: You only need to edit a claim when it requires special handling, such as the addition of a narrative or to indicate that you are attaching X-rays.
   - Dentrix Enterprise sends the claim to the Batch Processor or prints it immediately. Ignore the steps that follow.

2. Make any necessary changes to the dental claim as explained in "Changing Dental Claim Information" in this chapter.



3. To batch, send, or print the dental claim, on the menu bar, click **Print**.

The **Insurance Claim Print** dialog box appears.



4. Under **Include**, **Claim** is selected by default and unavailable if there are no attachments. If there are attachments, **Claim** and **Attachment(s)** are both selected by default. You can clear **Attachment(s)** if you are not including any attachments.
5. Do one of the following:
   - Click **Send to Batch** to send the claim to the Batch Processor.
   - Click **Send Electronically** to send the claim through electronic filing.
   - Click **Print** to print the claim now.

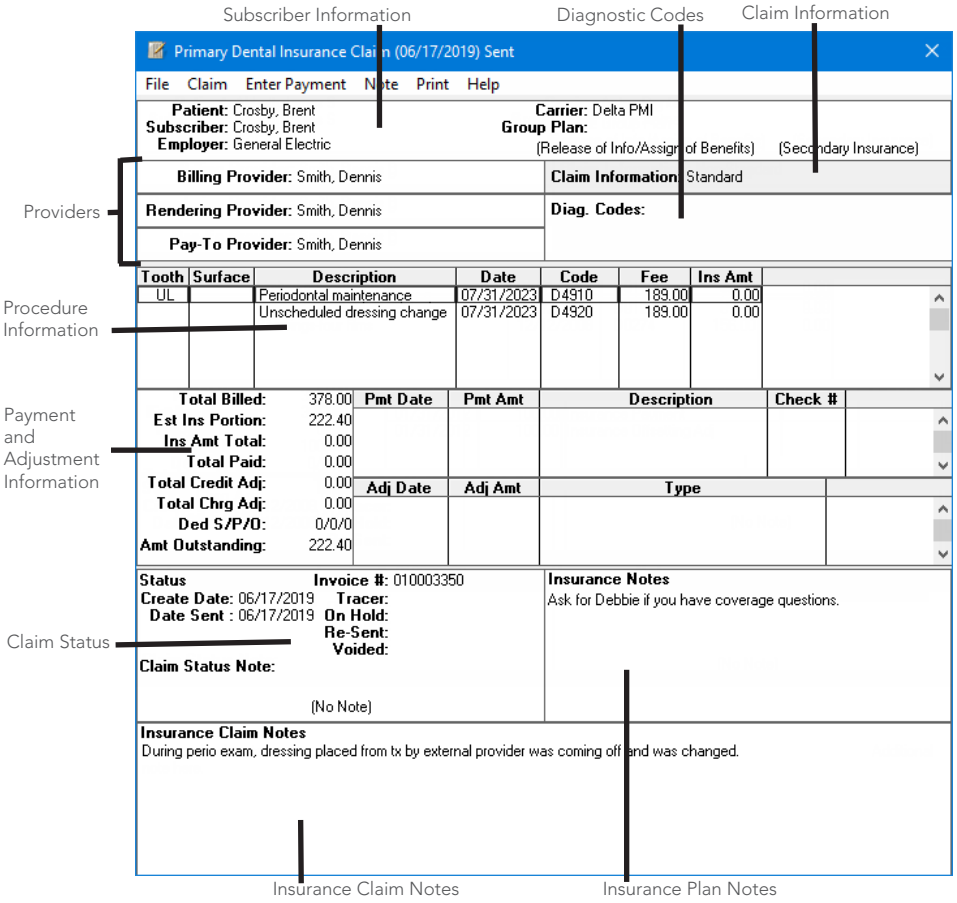
   Note: If you click **Cancel**, the claim status will be "Not Sent." (This is not recommended.)

Changing Dental Claim Information

When a dental insurance claim is created, a standard set of information is used to fill out the claim. If you need to add non-standard information to a dental claim, you can edit the claim information from the insurance claim window. You can access the insurance claim window from Ledger using one of the following methods:

- Double-click an existing claim in the Ledger transaction log.
- If you have not yet created a dental claim for procedures posted today, from the **Insurance** menu, click **Today's Procedures**.
- If you have not yet created a dental claim for procedures posted on a day other than the current system date, select the procedures, and then, from the **Insurance** menu, click **Selected Procedures**.

The Insurance Claim window is made up of the following boxes called "blocks": **Subscriber Information**, **Billing Provider**, **Rendering Provider**, **Pay-To Provider**, **Claim Information**, **Diagnostic Codes**, **Procedure Information**, **Payment Information**, **Claim Status**, and **Insurance Plan Notes**, and **Insurance Claim Notes**.



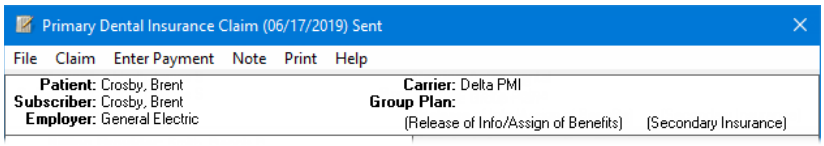
To edit the information in any of these blocks, double-click the desired block.

Editing Patient and Subscriber Information

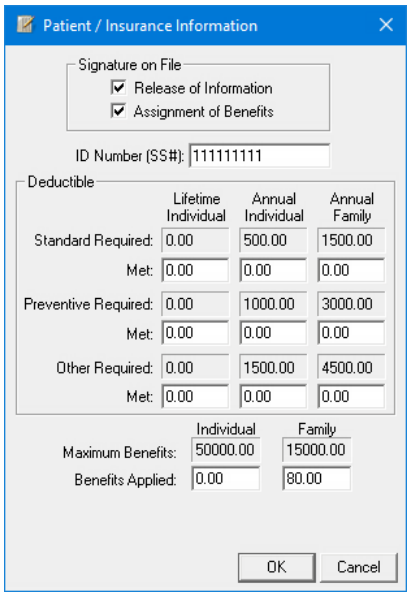
The **Subscriber Information** block displays the patient name, subscriber name, employer, insurance carrier name, and group plan name. If **Release of Information** and/or the **Assignment of Benefits** were selected in the Family File when assigning insurance, "Release of Info" and/or "Assign of Benefits" are listed in parentheses.

To edit subscriber information for the claim

1. Double-click the **Subscriber Information** block.



The **Patient/Insurance Information** dialog box appears.



2. Edit the following information:

- **Signature on File** – Whatever options are selected in the patient's Family File are the defaults for all insurance claims created for the patient. Changes made to the **Signature on File** options in the **Patient/Insurance Information** dialog box affect the corresponding dental claim only. Select or clear the options as needed.
  - **Release of Information** – Select this option to indicate to the insurance carrier that the patient has signed release forms authorizing the office to submit information on the patient's behalf.
  - **Assignment of Benefits** – Select this option to indicate to the insurance carrier that the patient has signed release forms authorizing the insurance carrier to send reimbursement to the office rather than the patient.
- **ID Number (SS#)** – The subscriber's ID number from the Family File is automatically put into the dental claim. You can change the subscriber ID that appears on this claim.

- **Deductible and Benefits** – In the Family File, you can indicate a subscriber's maximum benefits and deductible(s). With this information, Dentrix Enterprise can provide you with accurate insurance estimates, which take the plan maximums and deductibles into account. The **Patient/Insurance Information** dialog box displays both the entered maximum benefits and deductibles for the carrier, as well as the benefits used and deductible met amounts. If necessary, you can edit deductibles met and benefits applied in the appropriateboxes. Once the information has been posted, Dentrix Enterprise will use the updatedinformation for calculating all future insurance estimates for the patient or family.
- **Update Secondary** – If the secondary (or tertiary or quaternary) dental insurance information was entered after the primary dental claim was created, the dialog box has an **Update Secondary Insurance** (or Tertiary or Quaternary Insurance) check box. Dentrix Enterprise will not use the new secondary (or tertiary or quaternary) dental insurance information until this check box has been selected.

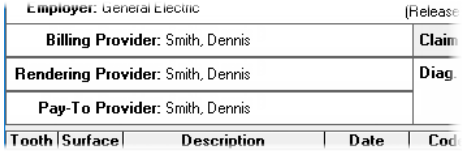
3. Click **OK**.

Changing Providers

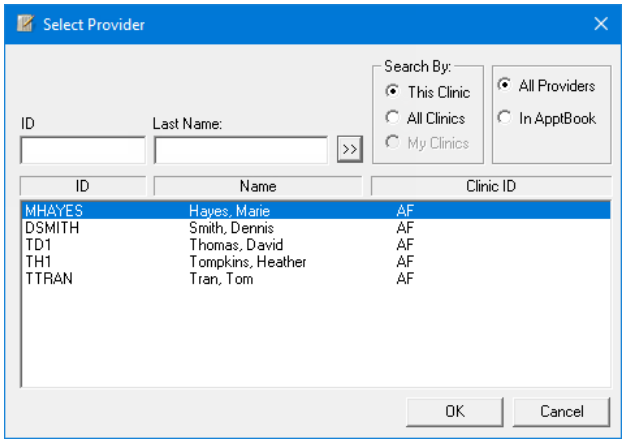
You can change the billing provider, rendering provider, and/or pay-to provider for the dental claim. For information about setting up the default providers for these blocks, see "Setting Up Practice Defaults" in Chapter 1: Introduction and Initial Setup.

To change a provider for the claim

1. Double-click the **Billing Provider**, **Rendering Provider**, or **Pay-To Provider** block.



The **Select Provider** dialog box appears.



2. Search for and select the appropriate provider.
3. Click **OK**.

Editing Claim Information

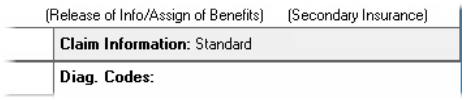
The **Claim Information** block displays information that is specific to a patient and a dental insurance claim. Those items are found on a standard ADA insurance claim form. The standard information prints on the dental claim unless it has been edited.

The block displays "Standard" unless the information has been changed, in which case, "Non-Standard" is displayed.

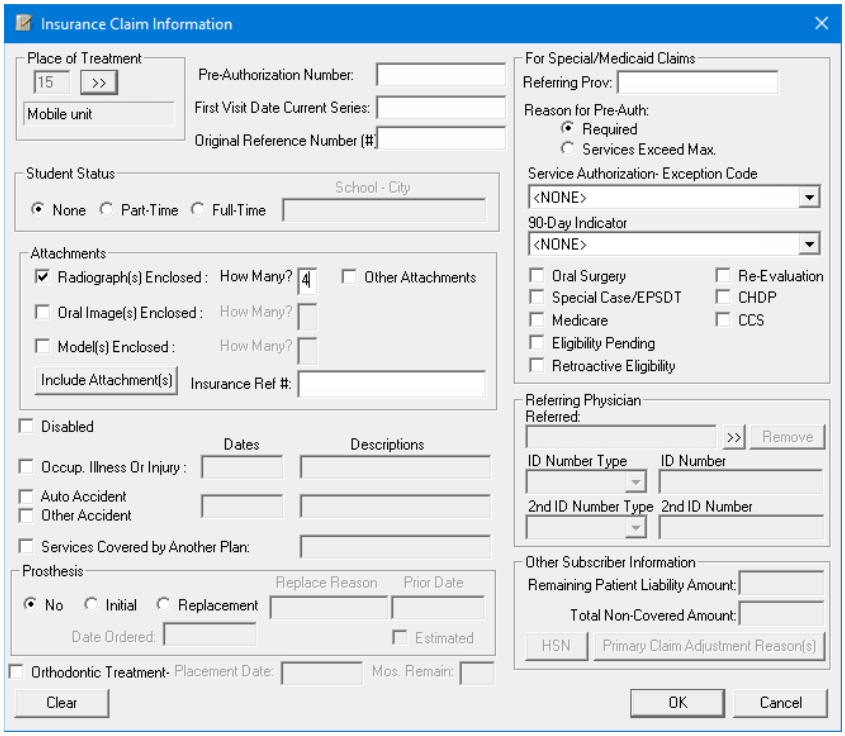
Note: When dental claim information is entered or cleared from the insurance claim window, the changes apply only to the claim currently being displayed and the associated primary, secondary, tertiary, quaternary, or medical claim. When a new dental claim is created, Dentrix Enterprise uses the default claim information that was defined for the patient from their appointment. For information about how to set up claim defaults, see the "Scheduling appointments for existing patients" topic in the Dentrix Enterprise Help.

To change claim information for this claim

1. Double-click the **Claim Information** block.

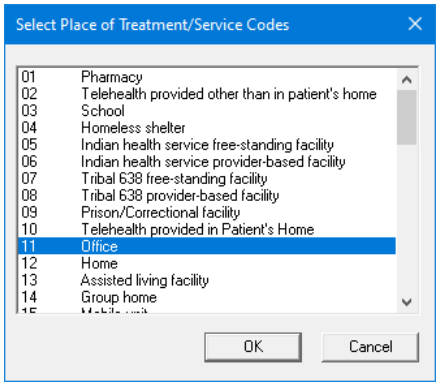


The **Insurance Claim Information** dialog box appears.



2. Edit the following information:
   - **Place of Treatment** – Where the treatment for this claim was performed. To change the place of treatment for this claim, do the following:
     a. Click the **Default** search button >>.

        The **Select Place of Treatment/Service Codes** dialog box appears.



c. Select a place of treatment.

d. Click **OK**.

- **Pre-Authorization Number** – If a treatment pre-authorization was approved for this claim, enter the appropriate pre-authorization number.
- **First Visit Date Current Series** – If this claim is for treatment that is part of a multi-visit treatment, enter the first date of service for this series of treatments.
- **Original Reference Number (#)** – For a voided or resubmitted Medicaid claim, enter the original reference number.
- **Attachments** – To add, edit, or remove claim attachments, select or clear the appropriate option. For more information about claim attachments, see "Including Attachments with Dental Insurance Claims" in this chapter.

3. Click **OK**.

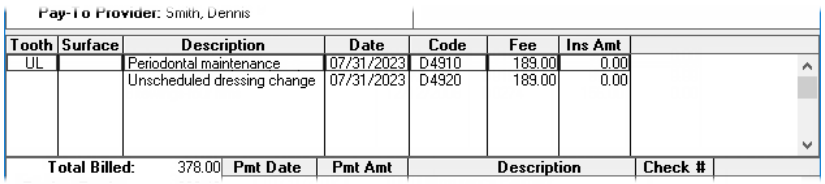
For comprehensive details about all the options available for changing claim information, see the "Editing claim information" topic under "Dental" in the Dentrix Enterprise Help.

Editing Procedure Information

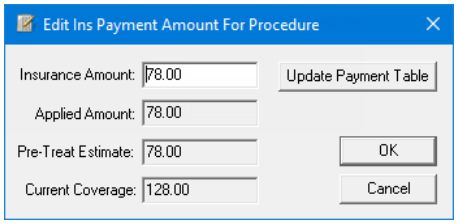
The **Procedure Information** block lists all of the procedures attached to the dental claim and shows the tooth, surface, description, date, procedure code, fee, and amount insurance has paid or pre-authorized for each procedure. The **Date** column shows the date of completion for the dental insurance claim (or the date recommended for the pre-treatment estimate—the recommended date does not print on a pre-treatment estimate). The block can only show up to six procedures at one time, but you can use the scroll bar to view any additional procedures.

To edit a procedure amount

1. To edit the amount the insurance plan will pay for a procedure on this claim, double-click the desired procedure.



The **Edit Insurance Payment Amount For Procedure** dialog box appears.



2. Enter the **Insurance Amount** (from an EOB, the amount that the insurance carrier is paying). For information about the applied amount, see the "Posting dental insurance payments" topic in the Dentrix Enterprise Help.
3. Update the payment table, if applicable.

   Important: It is important that you only the payment table only when the payment amount applies to all patients covered by a given plan. For example, if the estimated insurance portion is different from the payment amount because money is being withheld toward a deductible, do not update the payment table. Similarly, if a patient has exceeded his or her maximum benefit, do not update the payment table.
4. Click **OK**.

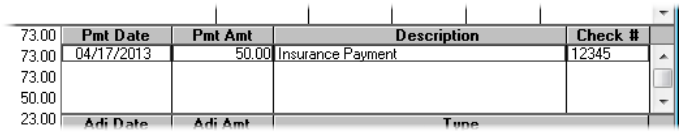
Editing Payment and Estimate Information

The **Payment/Estimate Information** block displays the following information:

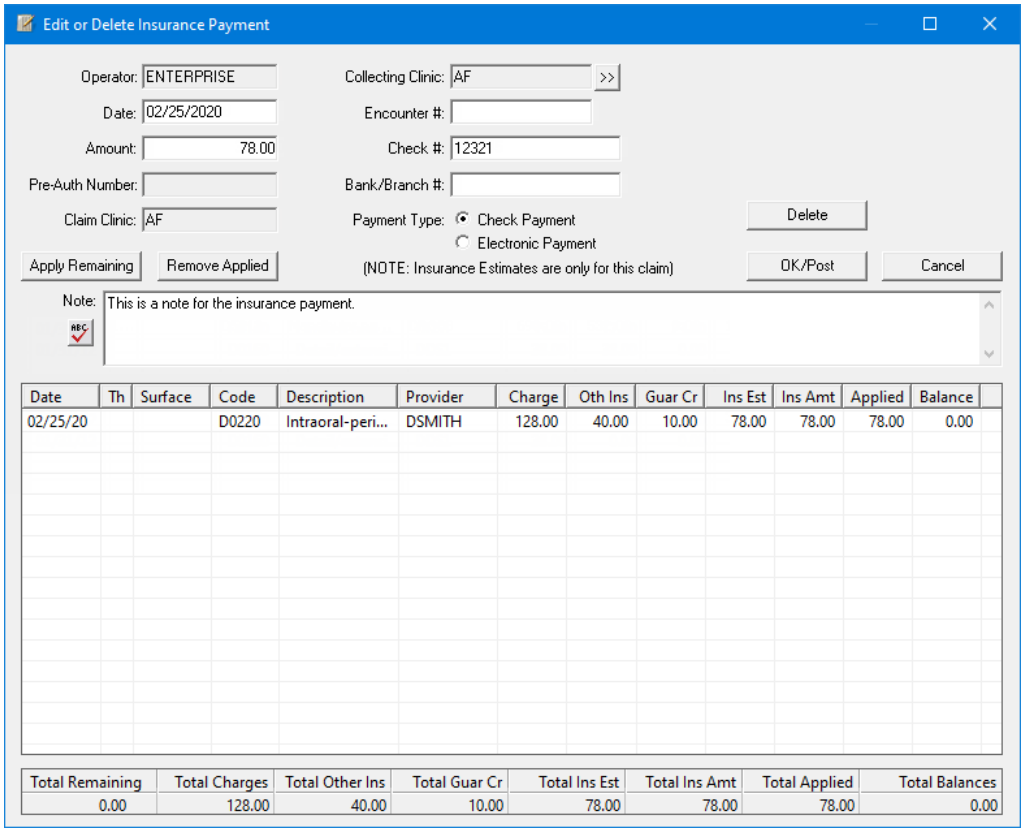
- The dates payments were received
- The check numbers and the amount applied to the deductible
- The total of the itemized payments/estimates
- The total charges for procedures on the claim
- The estimated insurance portion
- The total payment or authorized amount

To edit or delete a payment or pre-authorization

1. Double-click a payment or pre-authorization.



   The **Edit or Delete Insurance Payment** dialog box appears.



2. Make any necessary changes, and then click **OK/Post** to apply the changes. For information about the options available for insurance payments, see "Posting Dental Insurance Payments" in this chapter.

   Note: To delete the payment or pre-authorization, click **Delete** and then **OK** on the confirmation message that appears.

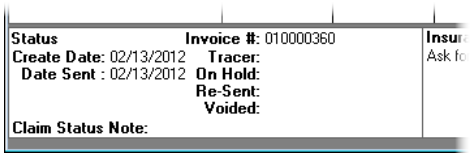
Updating Claim Statuses

The **Claim Status** block displays the dates the dental claim was created, sent, traced, placed on hold, re-sent and/or voided. When a dental claim is created, the **Create Date** defaults to the current date. When a dental claim is sent, the status is automatically flagged as "Sent," and the **Sent Date** defaults to the current system date.

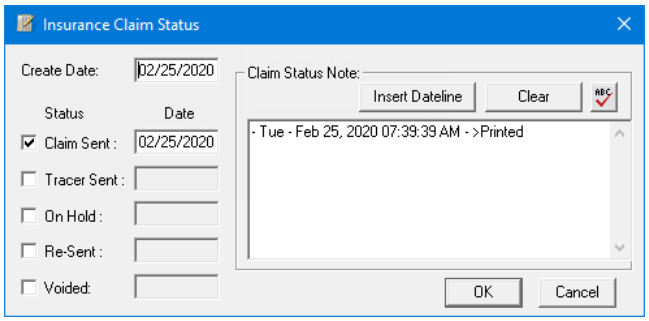
Note: When a payment or pre-authorization amount is entered for a dental claim, the status is automatically flagged as "Received."

To manually change the status and date for the claim

1. Double-click the **Claim Status** block.



   The **Insurance Claim Status** dialog box appears.



2. Select a **Status**: **Claim Sent**, **Tracer Sent**, **On Hold**, **Re-Sent**, or **Voided**; and then enter or change the **Date**. You can also change the **Create Date**.

   Note: When the claim is listed in Ledger, the status of "Not Sent," or "Sent" and the associated date are displayed according to what is set in the Insurance Claim Status dialog box. The "Received" status and date depend on the payment or estimate entered in the **Insurance Claim Status** dialog box for this claim.

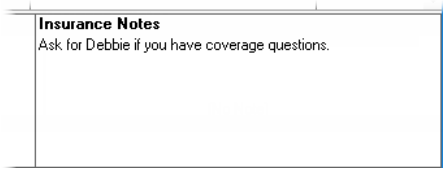
3. To enter an internal note regarding the claim status to help track claim activity, position your text cursor in the **Claim Status Note** box, click **Insert Dateline** if you want to insert the current date and time, and then enter the desired note.
4. Click **OK**.

Editing Dental Insurance Plan Notes

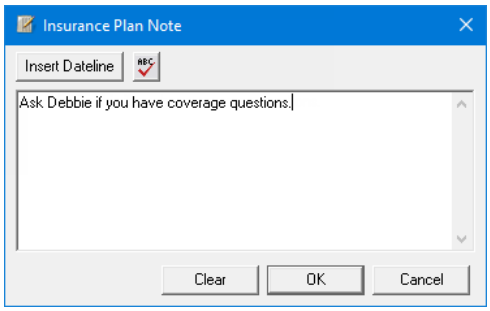
The Insurance Plan Note block displays any notes that have been entered for an insurance plan from the Family File (for any patient with the same insurance plan). The insurance plan note does not print on the insurance claim. For information about how to include a note on the claim, see "Adding Dental Insurance Claim Notes" in this chapter.

To edit an insurance plan note

1. Double-click the **Insurance Plan Note** block.



   The **Insurance Plan Note** dialog box appears.



2. Enter or edit the notes for the insurance plan.
3. Click **OK**.

Modifying Dental Insurance Claim Notes

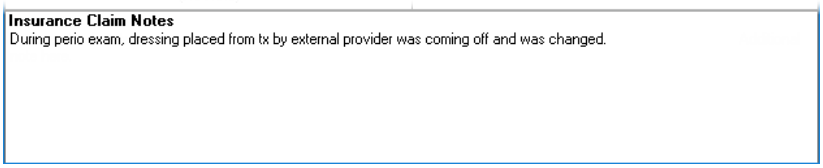
The Insurance Claim Notes block displays any narratives that have been added to the claim to document and/or explain treatment, such as remarks for unusual services. From the claim window, you can add, remove, or reorder entries for the insurance claim note. You can also insert a dateline, spell check entries, or clear all entries. Also, from the claim window, you can manually copy a procedure note to an insurance claim note.

Notes:

- You can set up a procedure note to be copied automatically to an insurance claim note.
- An insurance claim note will be printed on a claim or will be sent with an electronic claim.
- Only the first 125 characters of an insurance claim note can be transmitted with an electronic claim.

To modify insurance claim notes

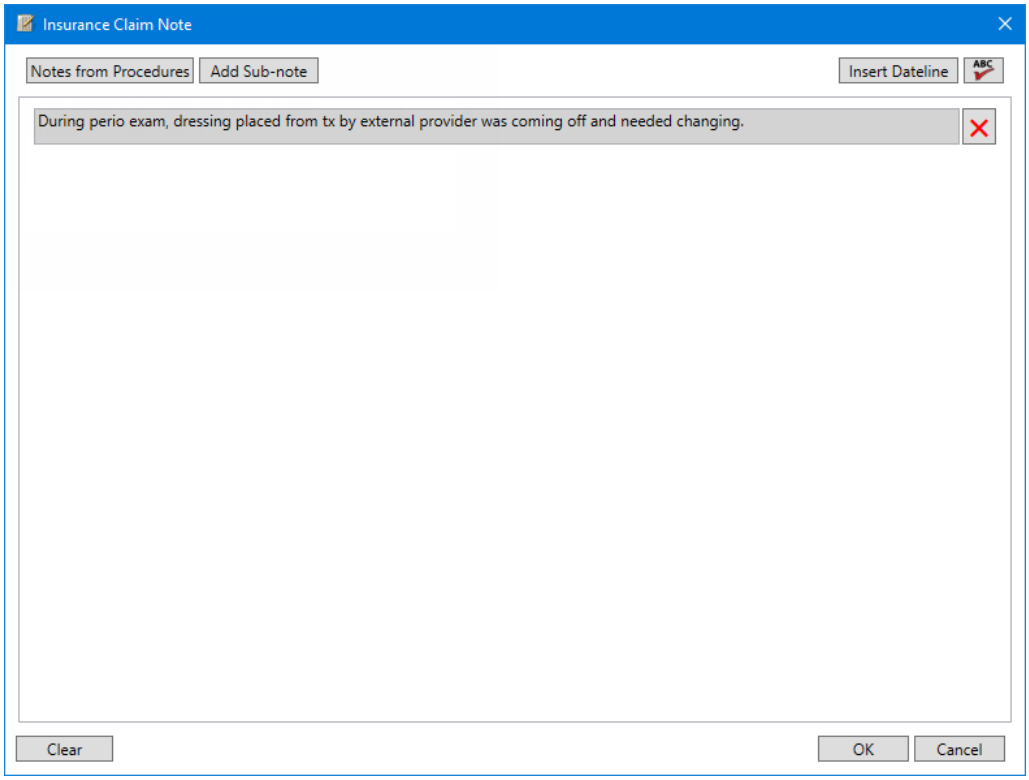
1. Do one of the following:
   - Double-click the **Insurance Claim Notes** block.



   - On the insurance claim window's menu bar, click **Note**.



   The **Insurance Claim Note** dialog box appears.

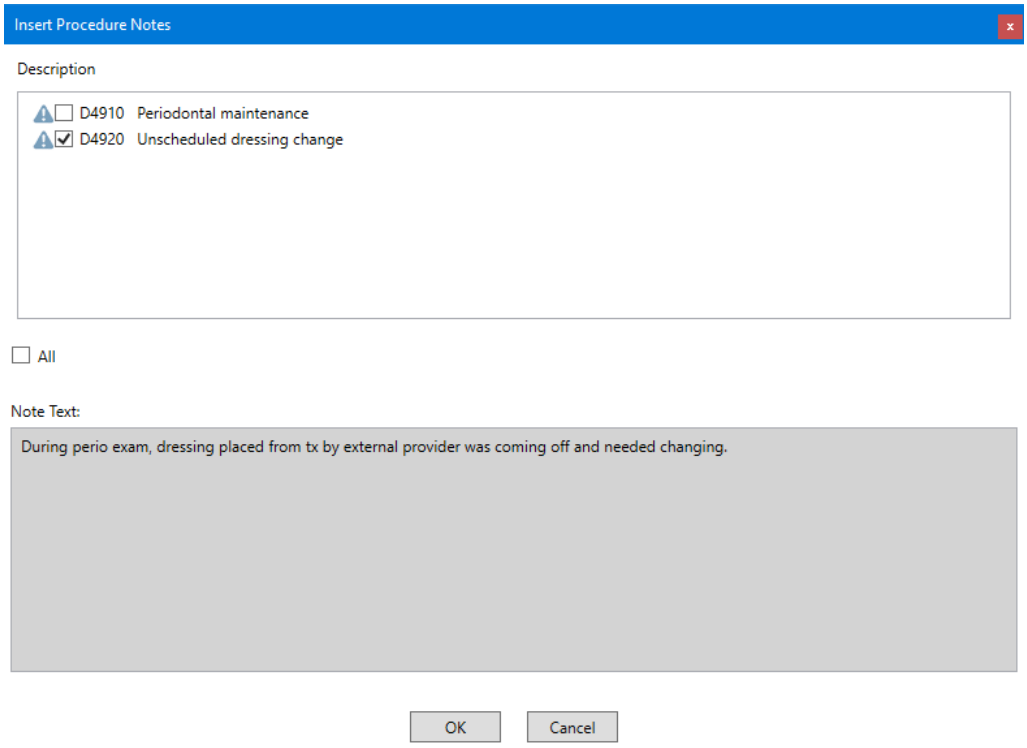


2. Do any of the following as needed:

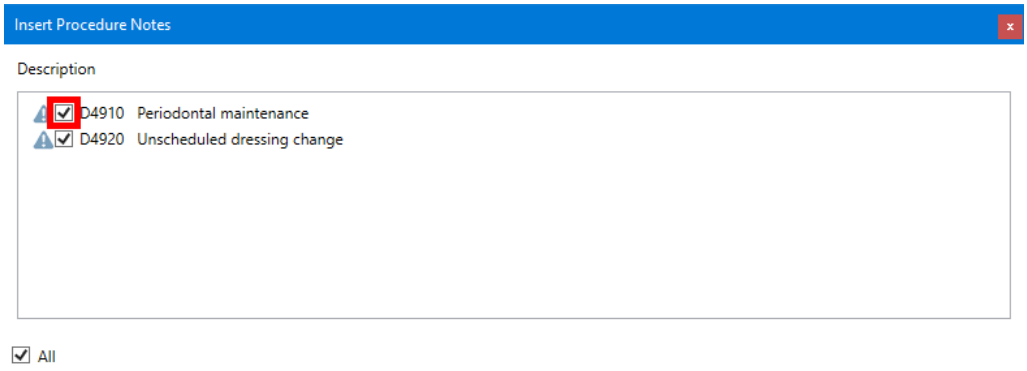
- Include a procedure note as a claim note entry – Do the following:

a. Click **Notes from Procedures**.

The **Insert Procedure Notes** dialog box appears.



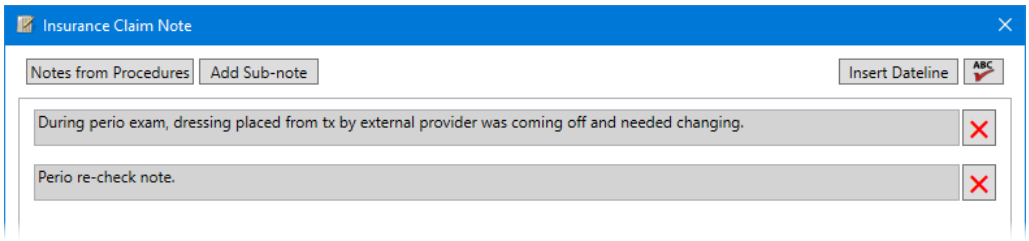
b. Select the checkbox of a procedure in the **Description** list, or select the **All** check box to add the notes from all the procedures listed.



Note: Of the procedures on the claim, only those with notes (entered automatically or manually) appear in the list.

c. Click **OK**.

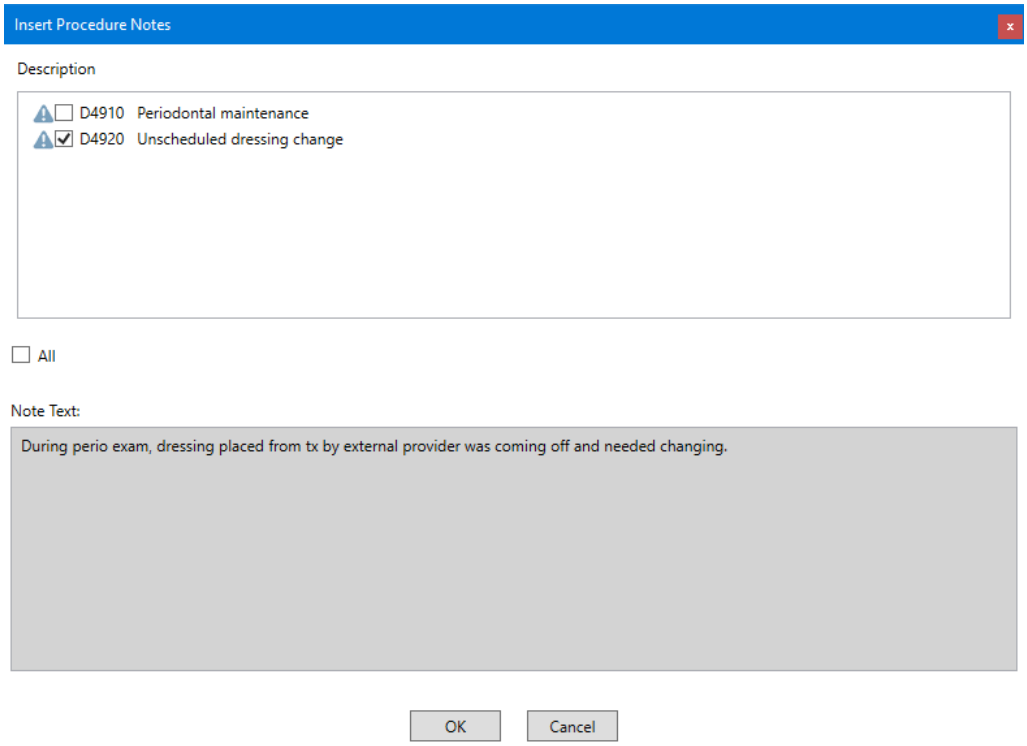
A new claim note entry appears in the **Insurance Claim Note** dialog box.



- Exclude a procedure note from being a claim note entry – Do the following:

  a. Click **Notes from Procedures**.

  The **Insert Procedure Notes** dialog box appears.

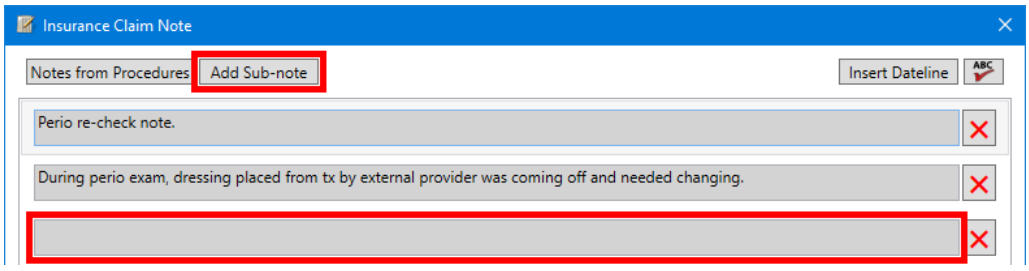


  b. Clear the checkbox of a procedure in the **Description** list, or clear the **All** check box to exclude the notes from all the procedures listed.

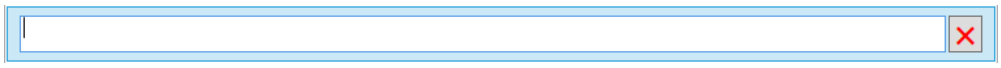
  c. Click **OK**.

- Add a free-text claim note entry – Do the following:

  a. Click **Add Sub-note**, and then double-click the new entry that appears at the bottom of the list.

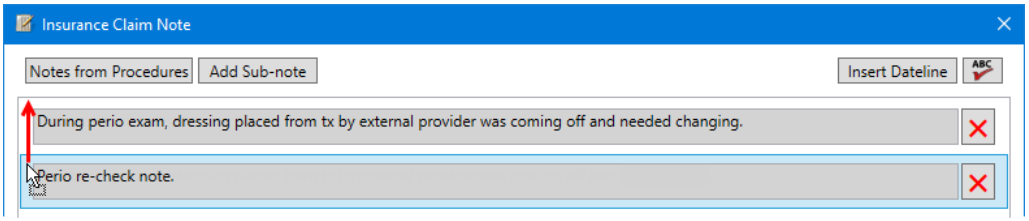


  The entry becomes an editable box.



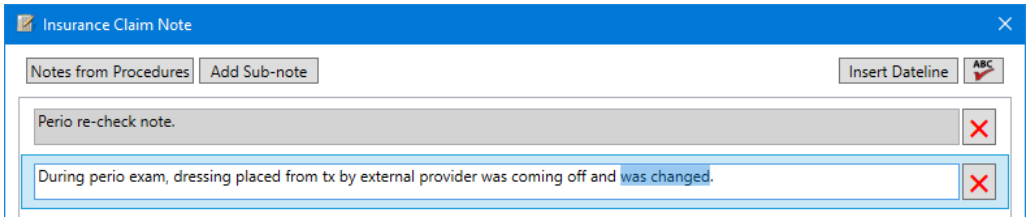
b. Enter text, and then press Tab.

- Reorder a claim note entry – Drag an entry in the list to a position above or below another entry.



- Edit a claim note entry – Do the following:

a. Double-click an entry in the list.



b. Change the text, and then press Tab.

Note: Changing the text of a note entry that was added from a procedure note does not change the procedure note attached to the posted procedure.

- Remove a claim note entry – Click an entry's **Remove** button .
- Insert a dateline as a claim note entry – Click **Insert Dateline**.
- Spell check the claim note entries – Click the **Check Spelling** button .
- Remove all the claim note entries – Click **Clear**.

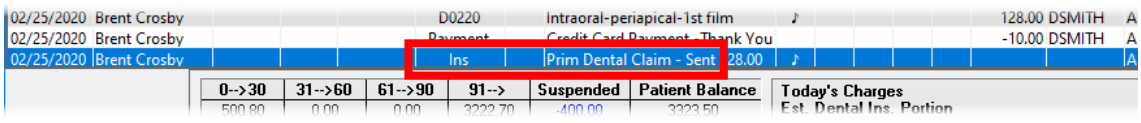
3. Click **OK**.

Including Attachments with Dental Insurance Claims

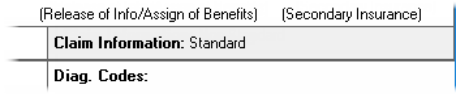
You can attach radiographs, images, models, documents, and perio charts to dental insurance claims.

To include attachments with a claim

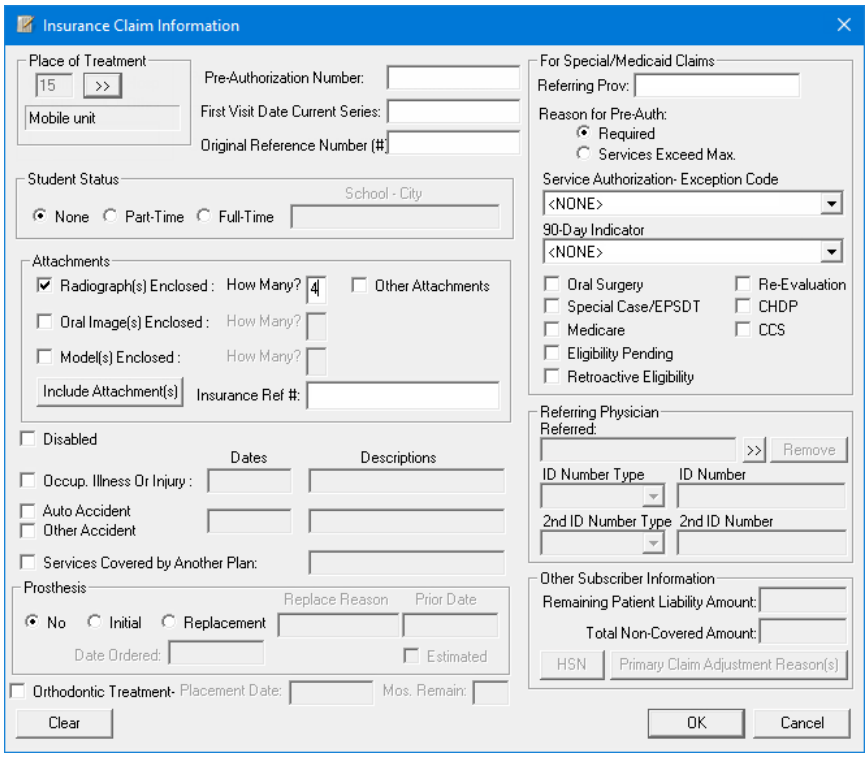
1. If you are not already viewing the insurance claim window, double-clicking an existing dental claim in the Ledger transaction log.



2. In the insurance claim window, double-click the **Claim Information** block.

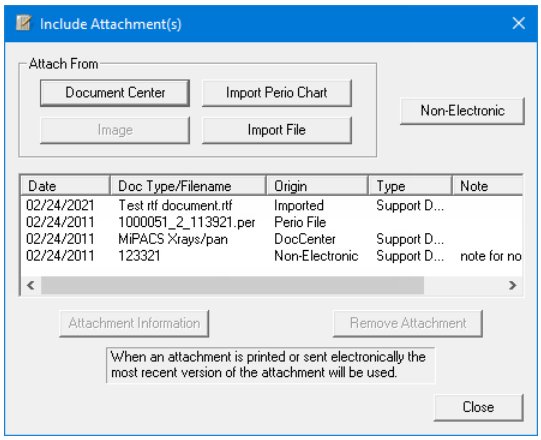


The **Insurance Claim Information** dialog box appears.



3. Select whether you are attaching radiographs, oral images, models, and/or other, and then enter the number of items being attached in the corresponding **How Many?** boxes.
4. Click **Include Attachment(s)**.

   The **Include Attachments** dialog box appears.



5. Under **Attach From**, do any of the following:
   - Click **Document Center** to attach any images (such as .pngs and .jpgs) in the patient's Document Center.
   - Click **Import Perio Chart** to attach any saved periodontal examination.
   - Click **Import File** to attach any file with an .rtf or .txt extension.
6. If you will be including an attachment of another type with a printed claim, click **Non-Electronic**. In the **Attachment Information** dialog box that appears, enter an **Attachment Note**, select an **Attachment Type** and **Transmission Code**, enter a **Control Number**, and then click **OK**.

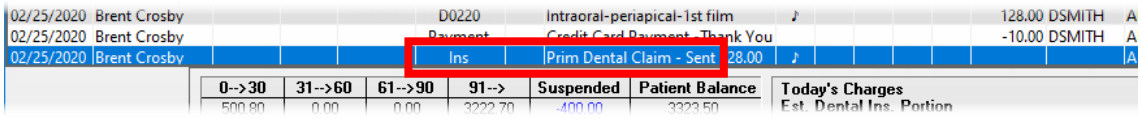
7. If you want to view or add attachment information for an attachment, select the desired attachment in the list, click **Attachment Information**. In the **Attachment Information** dialog box that appears, enter an **Attachment Note**, select an **Attachment Type**, and then click **OK**.
8. Click **Close** to return to the **Insurance Claim Information** dialog box.
9. Click **OK**.

Reprinting Dental Insurance Claims

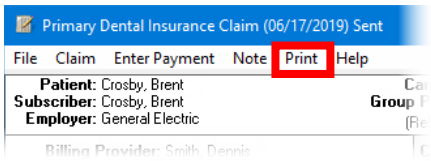
If you have edited an insurance claim, you can reprint it.

To reprint a claim

1. In Ledger, with a patient selected, double-click an existing claim in the transaction log.

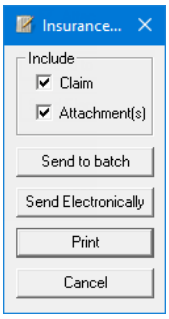


The insurance claim window appears.



2. On the menu bar, click **Print**.

   The **Insurance Claim Print** dialog box appears.



3. If you are not including any attachments, clear the **Attachment(s)** check box.
4. Click **Send to Batch** (to send the claim to the Batch Processor), **Send Electronically** (to send the claim through electronic filing), or **Print** (to print the claim now).

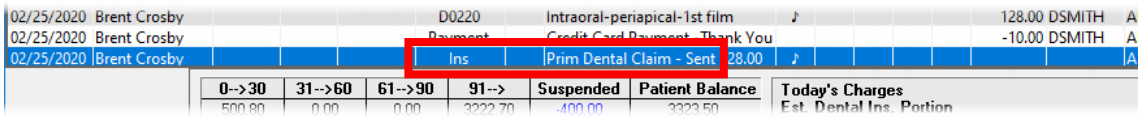
Deleting Dental Insurance Claims

You can delete a dental claim after it has been created. If a secondary dental claim has been created, you must delete the secondary claim before you can delete the corresponding primary dental claim. If a dental claim has been paid and is in history, you cannot delete it.

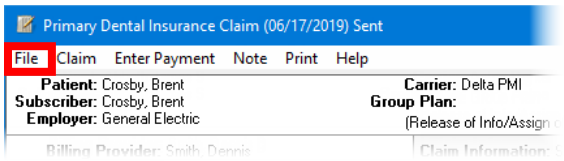
For information about how to delete a payment for a claim without deleting the claim, see "Editing or Deleting Dental Insurance Payments" in this chapter.

To delete an insurance claim

1. In Ledger, with a patient selected, double-click an existing claim in the transaction log.



The insurance claim window appears.



2. From the **File** menu, click **Delete**.
3. On the confirmation message that appears and cautions you that deleting the claim will also delete any attached payments and adjustments, click **OK**.

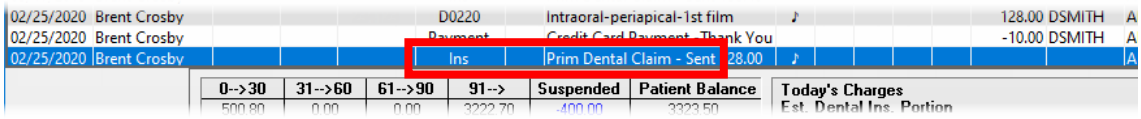
Posting Dental Insurance Payments

For Dentrix Enterprise to accurately track insurance deductibles and benefits used, you must link insurance payments to their corresponding dental claims. To help you make sure insurance payments are linked correctly, when you post an insurance payment, Dentrix Enterprise will automatically itemize the payment for each procedure according to the estimated insurance portion, but you can easily edit or remove the applied amount as needed. Deductibles will be applied according to the dental insurance plan's coverage table automatically, but you can change or remove any amounts as needed. Also, you can write off an amount (make an adjustment) while posting the payment.

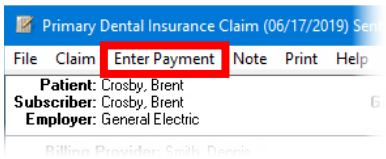
Tip: For new offices, if the claim for which you are posting payments was not created using Dentrix Enterprise, post the insurance payment as a guarantor payment. For information about how to add a payment type, such as "Insurance Payment," to distinguish these payments from patient payments, see the "Customizing Payment Types" topic in the Dentrix Enterprise Help.

To post an insurance payment

1. In Ledger, with a patient selected, double-click an existing claim in the transaction log.

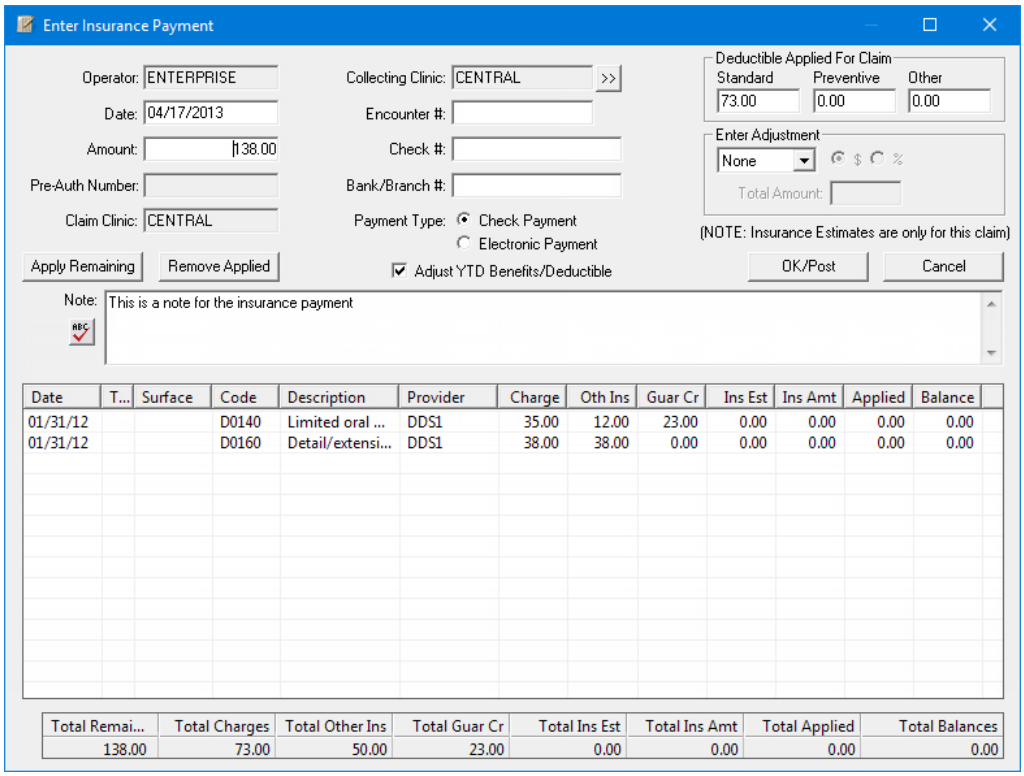


The **Insurance Claim** window appears.



2. On the menu bar, click **Enter Payment**.

   The **Enter Insurance Payment** dialog box appears.



3. Set up the following options:
   - **Collecting Clinic** – Click the search button >> to select the clinic that is collecting the payment. The **Claim Clinic** (the clinic where the claim was created) appears for your reference.
   - **Date** – By default, the payment's date is today's date, but you can change it.
   - **Amount** – Dentrix Enterprise automatically inserts the estimated insurance portion in this box, but you can change amount of the payment if the paid amount on the insurance check is different.
   - **Payment Type** – Select **Check Payment** or **Electronic Payment** (EFT). If the carrier is making payment to the office with a check, enter the **Check #** and **Bank/Branch #** of the check.
   - **Adjust YTD Benefits/Deductible** – Leave this check box selected if you want Dentrix Enterprise to adjust the patient's year-to-date benefits and any applied deductible accordingly.
   - **Deductible Applied For Claim** – If money has been withheld toward a deductible, enter the withheld amount in the appropriate boxes: **Standard**, **Preventative**, and/or **Other**.
   - **Note** – To document information regarding the insurance payment, enter a note.
4. In cases where your practice does not bill the patient, such as with some preferred provider (PPO) plans, you can quickly create an adjustment to offset any remaining balance. Also, for instances where a negative payment (refund) is entered for a claim, you can enter an adjustment for that claim. Do the following:
   a. Under **Enter Adjustment**, from the list, select **Write-Off(-)** or **Refund(+)**.
   b. Click **$** to adjust off a dollar amount or **%** to adjust off a percentage of the claim's remaining balance.
   c. If you selected **$**, the unpaid balance for the claim appears in the **Total Amount** box, but you can change the adjustment amount. If you selected **%**, the unpaid balance for the claim appears in the of box. Enter the percentage to be adjusted in the **%** box, and Dentrix Enterprise will calculate the adjustment amount and populate the = box.

5. When you enter a payment amount, Dentrix Enterprise will automatically allocate the payment to the oldest provider balances, according to the charges listed. The amount applied appears in the **Applied** column. You can apply any remaining amount or edit the applied amounts as needed:

   - To apply a remaining amount, select the desired charges (to select multiple charges, while holding down the Ctrl key, click each charge), and then click **Apply Remaining**. The amount in the **Total Remaining** box is applied to the selected charges.

     If the amount exceeds the guarantor estimate, a dialog box will appear. Do one of the following:

     - Select **Do not apply the remaining amount** to only apply an amount equal to the insurance estimate, and then click **OK**.
     - Select **Apply the remaining amount to** and **Exceed insurance estimates** to apply the remaining amount but not exceed the total charge (which will result in an overpayment), and then click **OK**.
     - If at least one of the selected procedures has a non-insurance credit amount (**Guar Cr** column) that can be suspended or re-allocated and one or more non-insurance credits have not been placed in history, select **Apply the remaining amount to** and **Change guarantor credit allocations** to suspend the non-insurance credit amount but apply the insurance payment, and then click **OK**.

       Tip: You can use the **Change guarantor credit allocations** option in cases where you have a primary claim with a pending secondary claim and paying the balance might result in a remaining balance that is less than what will be paid by the secondary insurance carrier. However, it is more practical to deal with that possibility when the secondary claim is paid rather than with the payment for the primary claim.

   - To remove applied amounts, select the desired charges, and then click **Remove Applied**.
   - To edit an applied amount, double-click the desired charge to enable the applied amount to be edited, enter the correct amount to be applied, and then click the check mark  .
   - To save the paid amount as a reference for future estimates, double-click the procedure (or right-click the procedure, and click **Edit Ins Payment Amount**). In the **Edit Insurance Payment Amount for Procedure** dialog box, enter the insurance amount from the insurance EOB, and then, if appropriate, you can update the payment table. If the applied amount exceeds the amount of the procedure, a message appears and asks if you want to automatically adjust the applied amount to the amount of the procedure or return to edit the applied amount.

     The next time any patient with this insurance plan has the same procedure recommended or completed, Dentrix Enterprise will use the payment amount as the insurance estimate.

     Important: It is important that you update the payment table only when the payment amount applies to all patients covered by that plan. For example, if the estimated insurance portion is different from the payment amount because money is being withheld toward a deductible, do not update the payment table. Similarly, if a patient has exceeded his or her maximum benefit, do not update the payment table.

6. Click **OK/Post**.

   If the payment amount exceeds the allocated amount and/or the estimated insurance portion exceeds the allocated amount, a dialog box (or message) appears. Choose how you want to handle the insurance overpayment. For information about how to handle insurance overpayments, see the "Handling insurance overpayments" topic in the Dentrix Enterprise Help.

   If **Write-Off** was selected, the **Enter Credit Adjustment for Insurance Claim** dialog box appears. Make any necessary changes to the adjustment type, provider, and amount, and then click **OK** to post the insurance payment and corresponding adjustment.

If the patient has secondary insurance or medical coverage, a message appears and reminds you to create a secondary or medical claim. Click **OK**, and then click **Create Secondary** or **Create Medical** on the Insurance Claim window's menu bar.

Note: At times, an insurance carrier will send partial payment for an insurance claim while waiting for more information on certain procedures. In this situation, Dentrix Enterprise provides the following methods for posting two separate payments to the claim:

- Splitting an existing dental claim into two separate claims
- Posting multiple payments to one dental claim

For information about how to perform these tasks, see the "Posting partial dental insurance payments" topic in the Dentrix Enterprise Help.

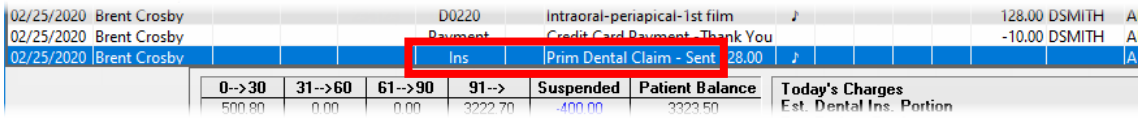
Creating Secondary Dental Insurance Claims

For patients with additional dental insurance coverage, when you enter an insurance payment for their primary dental insurance claim, Dentrix Enterprise asks if you want to create a secondary dental insurance claim. However, if you choose to not create a secondary dental claim after entering an insurance payment for the primary dental claim, or if you add the patient's secondary dental insurance plan after the entering an insurance payment for the primary dental claim, Dentrix Enterprise allows you to manually create a secondary dental insurance claim.

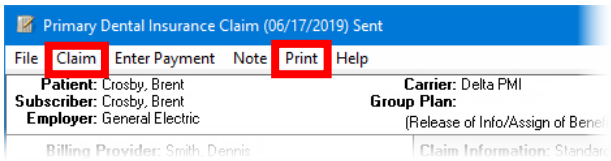
With Dentrix Enterprise, you can also create tertiary and quaternary dental claims.

To create a secondary claim

1. In Ledger, with a patient selected, double-click a primary dental claim.



The insurance claim window appears.



2. If you added secondary insurance information after you created the primary claim, you must update the secondary insurance information on the primary claim before you can create the secondary claim. In the claim window, double-click the **Patient/Subscriber Information** block, select **Update Secondary Insurance**, and then click **OK**.
3. From the **Claim** menu, click **Create Secondary**.

   Dentrix Enterprise creates the additional claim, and the insurance claim window displays that secondary claim.

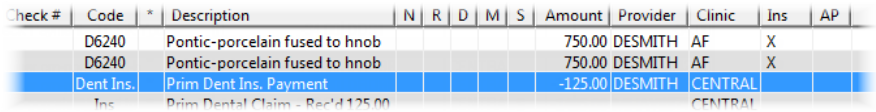
   Tip: To switch back to the primary insurance claim, from the **Claims** menu, click **View Primary Dental**.
4. While viewing the secondary claim, on the menu bar, click **Print**. In the dialog box that appears, click **Print** (to print the claim immediately) or **Send to Batch** (to send the claim to the Batch Processor in the Office Manager).

Editing or Deleting Dental Insurance Payments

You can correct a mistake that was made when posting an insurance payment. You can also delete an insurance payment that was entered in error. However, you cannot edit or delete an insurance payment that has been moved to history (when closing a month).

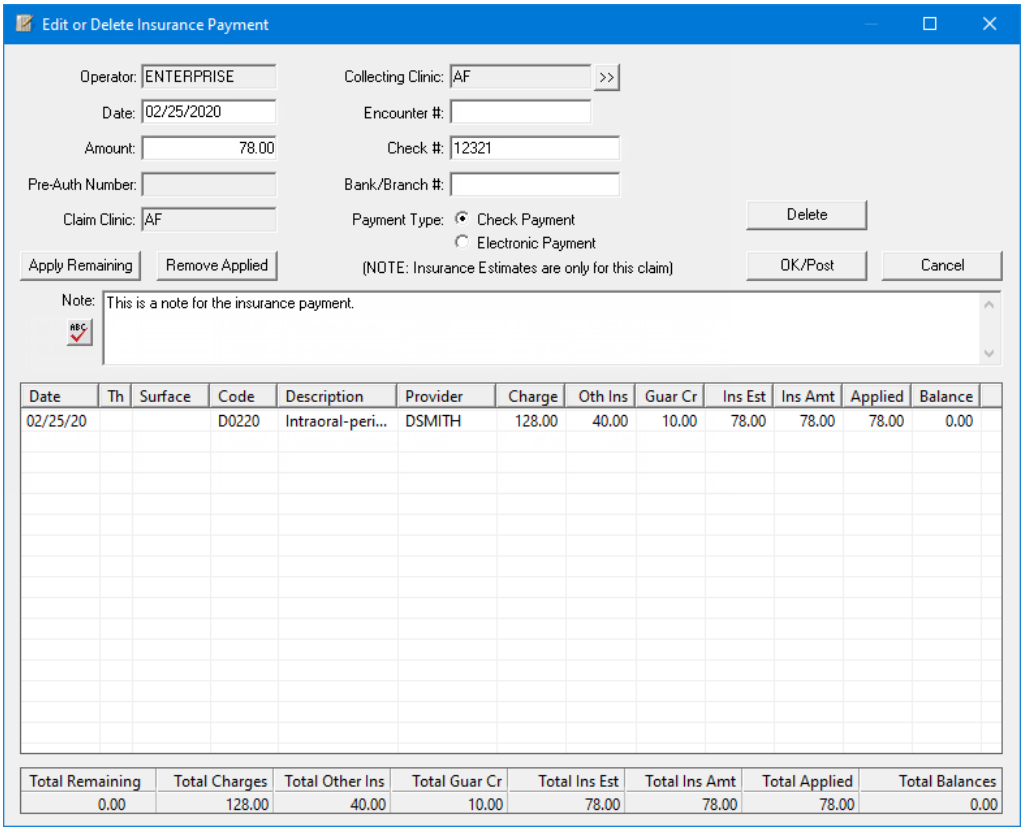
To edit or delete an insurance payment

1. In Ledger, with a patient selected, double-click an insurance payment in the transaction log.



Check #	Code	*	Description	N	R	D	M	S	Amount	Provider	Clinic	Ins	AP
	D6240		Pontic-porcelain fused to hnob						750.00	DESMITH	AF	X	
	D6240		Pontic-porcelain fused to hnob						750.00	DESMITH	AF	X	
	Dent Ins.		Prim Dent Ins. Payment						-125.00	DESMITH	CENTRAL		
	Ins		Prim Dental Claim - Rec'd 125.00								CENTRAL		

The **Edit or Delete Insurance Payment** dialog box appears.



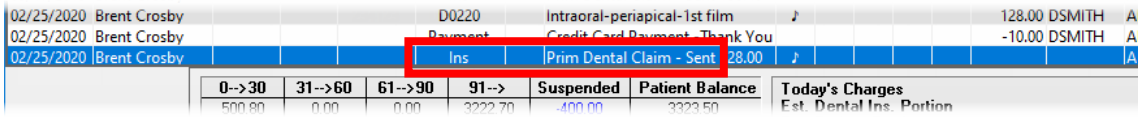
2. Do one of the following:
   - Edit the payment amount or applied amounts as necessary, and then click **OK/Post.**
   - To delete the payment, click **Delete**. When a confirmation message appears, click **OK** to continue with the deletion. You are taken to the insurance claim window, where you can re-post the payment correctly.

Indicating Dental Insurance Benefits Used and Deductibles Met

Typically, you will indicate deductibles met when posting an insurance payment, and Dentrix Enterprise will automatically track benefits used and deductibles met for patients. However, on occasion, you can have patients who come to your practice mid-year. These patients might have met part or all of their deductibles for the year or used part or all of the maximum benefits.

To enter benefits used and deductibles met

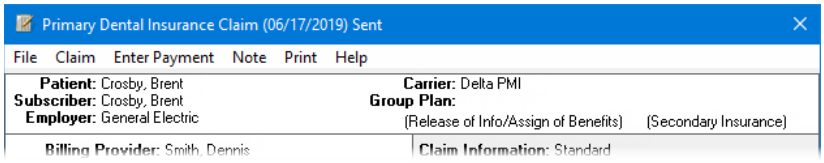
1. In Ledger, with a patient selected, double-click a sent (pending) dental claim in the transaction log.



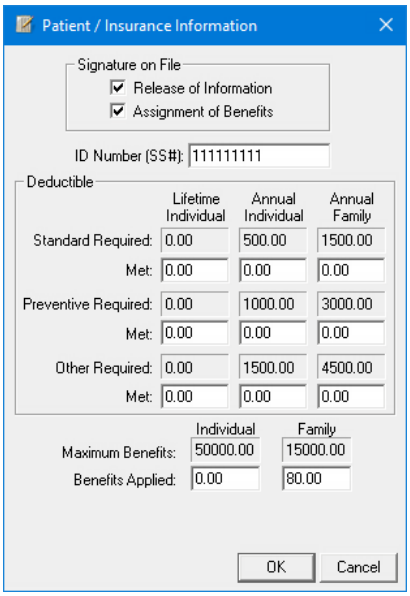
The insurance claim window appears.

Tip: If an insurance claim for this patient has not yet been created, you can post "dummy" procedures and create a "fake" claim and then delete them once the deductible information has been entered.

2. Double-click the **Subscriber Information** block.



The **Patient/Insurance Information** dialog box appears.



Notes:

- In the Family File, you can indicate a subscriber's maximum benefits and deductible(s). With this information, Dentrix Enterprise can provide you with accurate insurance estimates, which take the plan maximums and deductibles into account.
- The **Patient/Insurance Information** dialog box displays both the entered maximum benefits and deductibles for the carrier, as well as the benefits used and deductible met amounts.

3. If necessary, edit deductibles met and benefits applied in the appropriate boxes. Once the information has been posted, Dentrix Enterprise will use the updated information for calculating all future insurance estimates for the patient or family.
4. Click **OK**.

Processing Medical Insurance Claims

For hospitals and skilled nursing facilities, if you submit dental insurance claims using eClaims (also known as eTrans), which is the electronic claims service that is provided by Henry Schein One, you can use it to submit medical insurance claims electronically as 837i files.

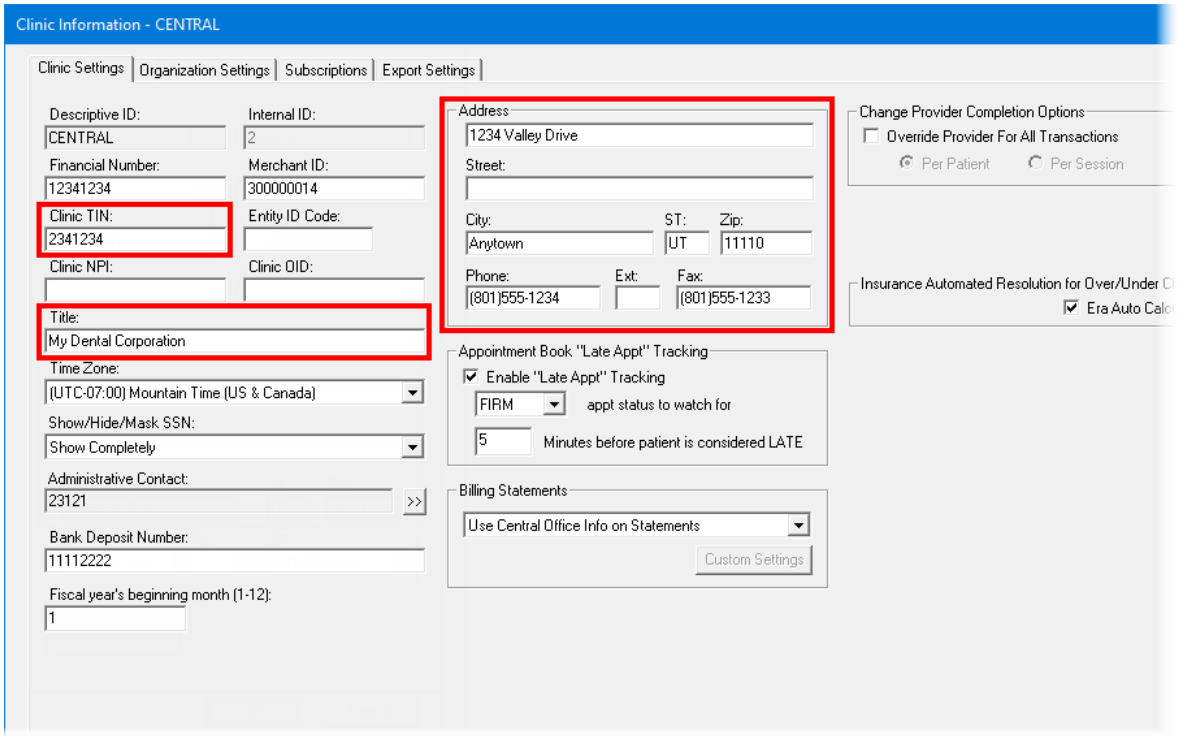
Important: The submission of 837i files is supported. The submission of 837p files is not supported.

- The 837i is the electronic version of the paper form UB-04. 837i files are used to transmit institutional claims. Institutional claims are those submitted by hospitals and skilled nursing facilities.
- The 837p is the electronic version of the paper form CMS-1500. 837p files are used to transmit professional claims. Professional claims are those submitted by physicians, suppliers, and other non-institutional providers for either inpatient or outpatient services.

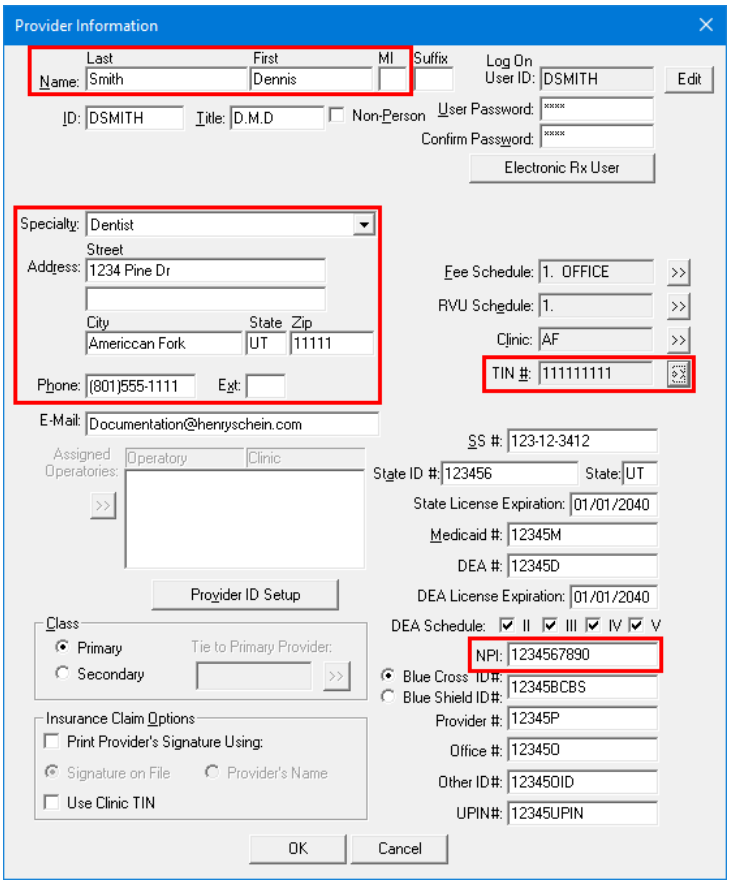
Requirements

For the successful transmission of medical insurance claims, make sure that the required information is set up in the following areas of Dentrix Enterprise:

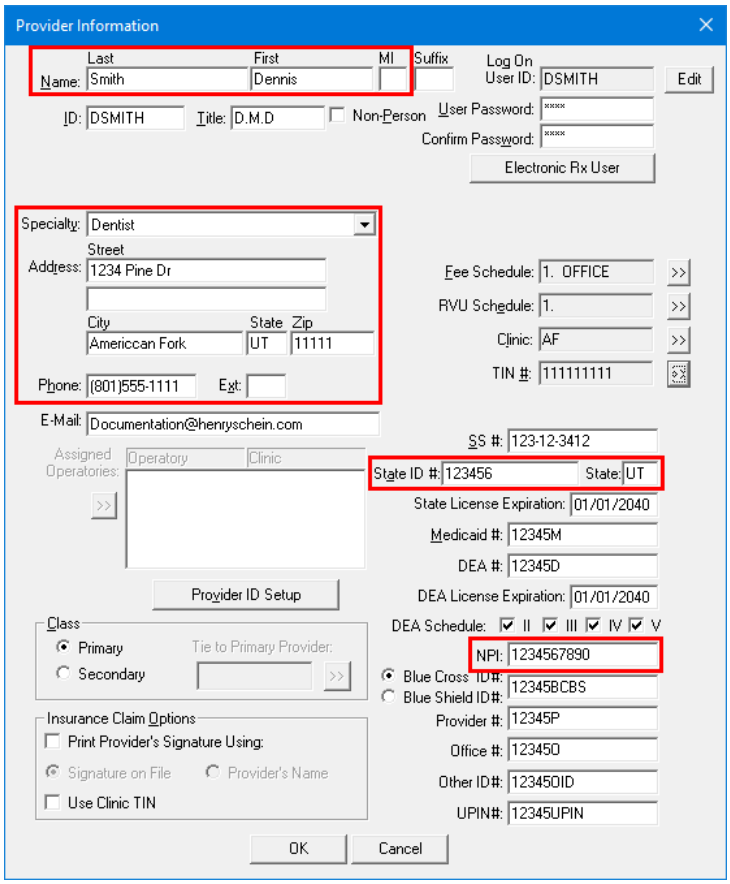
- **Clinic Information** – Verify the clinic information for each clinic where services are rendered. While logged in to a clinic, in the Office Manager, on the **Maintenance** menu, point to **Practice Setup**, and then click **Clinic Resources Setup**. In the **Clinic Resource Setup** dialog box, under **Clinic Information**, click **Edit**. In the **Clinic Information** dialog box, the following information is required:
  - **Clinic TIN**.
  - **Title**.
  - **Address** – Street, **City**, **ST**, and **Zip**.



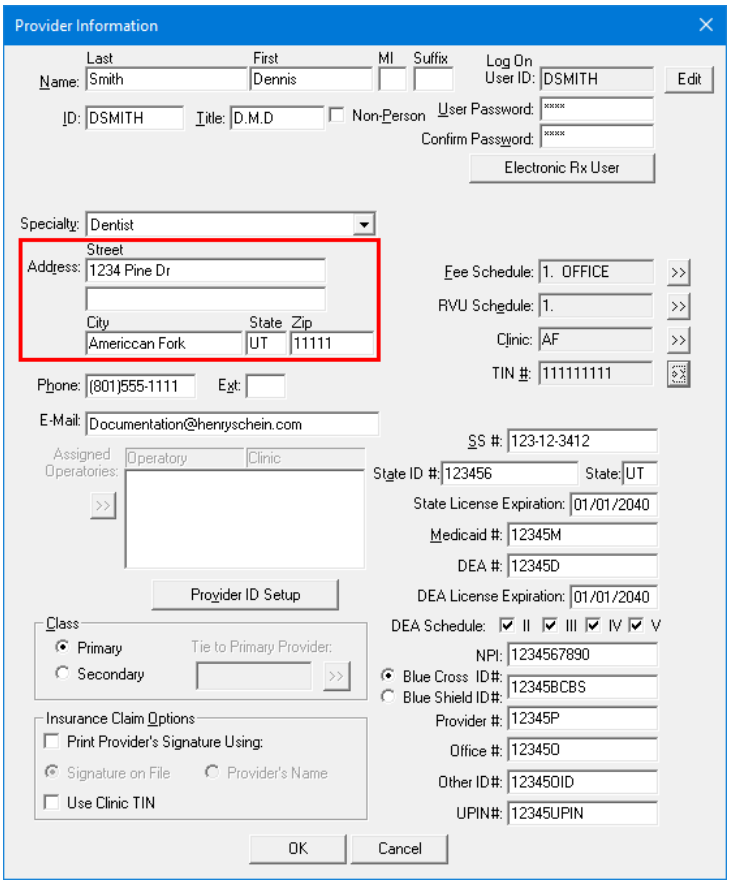
- **Billing Provider Information** – Verify the provider information for each billing provider. In the Office Manager, on the **Maintenance** menu, point to **Practice Setup**, and then click **Clinic Resources Setup**. In the **Clinic Resource Setup** dialog box, under **Provider(s)**, double-click a provider. In the **Provider Information** dialog box, the following information is required:
  - **Name**.
  - **Specialty**.
  - **Address** – **Street**, **City**, **ST**, and **Zip**.
  - **Phone**.
  - **TIN #**.
  - **NPI**.



- **Rendering Provider Information** – Verify the provider information for each provider who renders services. In the Office Manager, on the **Maintenance** menu, point to **Practice Setup**, and then click **Clinic Resources Setup**. In the **Clinic Resource Setup** dialog box, under **Provider(s)**, double-click a provider. In the **Provider Information** dialog box, the following information is required:
  - **Name**.
  - **Specialty**.
  - **Address** – **Street**, **City**, **ST**, and **Zip**.
  - **Phone**.
  - **State ID**.
  - **NPI**.

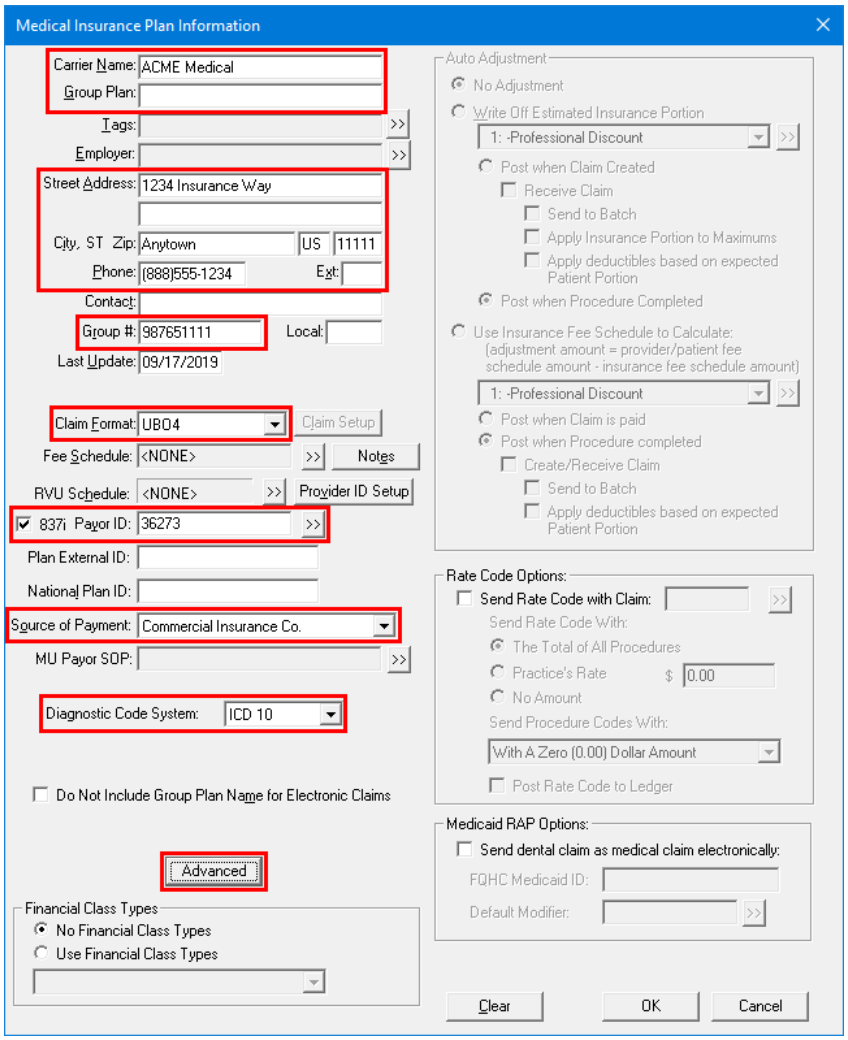


- **Pay-To Provider Information** – Verify the provider information for each pay-to provider. In the Office Manager, on the **Maintenance** menu, point to **Practice Setup**, and then click **Clinic Resources Setup**. In the **Clinic Resource Setup** dialog box, under **Provider(s)**, double-click a provider. In the **Provider Information** dialog box, the following information is required:
  - **Address** – **Street**, **City**, **ST**, and **Zip**.

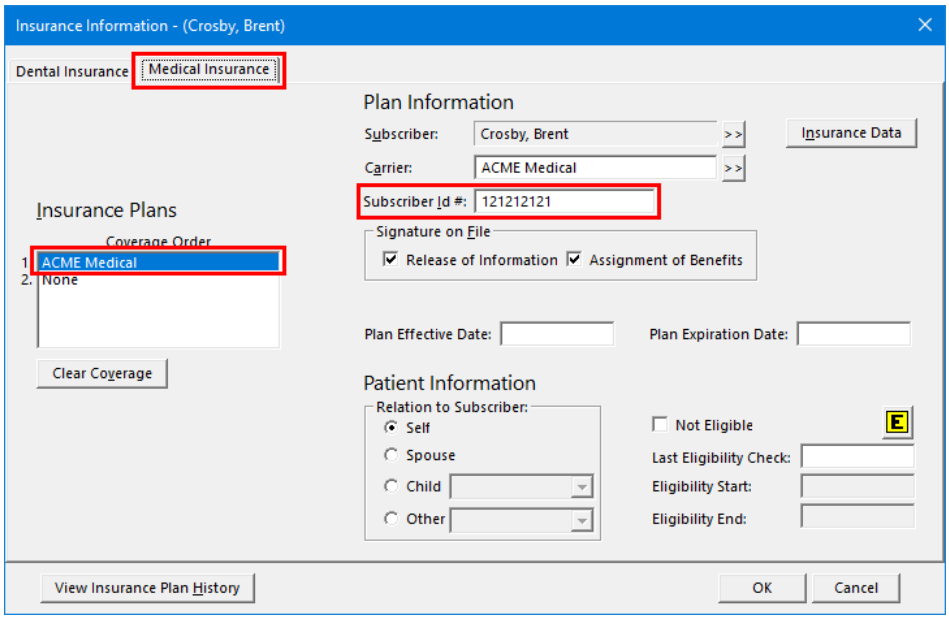


- **Medical Insurance Plan Information** – Verify the information for each medical insurance plan that is attached to a patient. With a patient selected in the Family File, double-click the Insurance Information block. In the **Insurance Information** dialog box, select the **Medical Insurance** tab, select a plan in the **Coverage Order** list, and then click **Insurance Data**. In the **Medical Insurance Plan Information** dialog box the following information is required:
  - **Carrier Name**.
  - **Group Plan** – Optional if **Group #** is present.
  - **Address** – **Street Address**, and **City, ST Zip**.
  - **Group #**.
  - **Claim Format** – **UBO4** must be selected.
  - **837i** – Check box must be selected.
  - **Payor ID** – Optional if **Group Plan** is present.

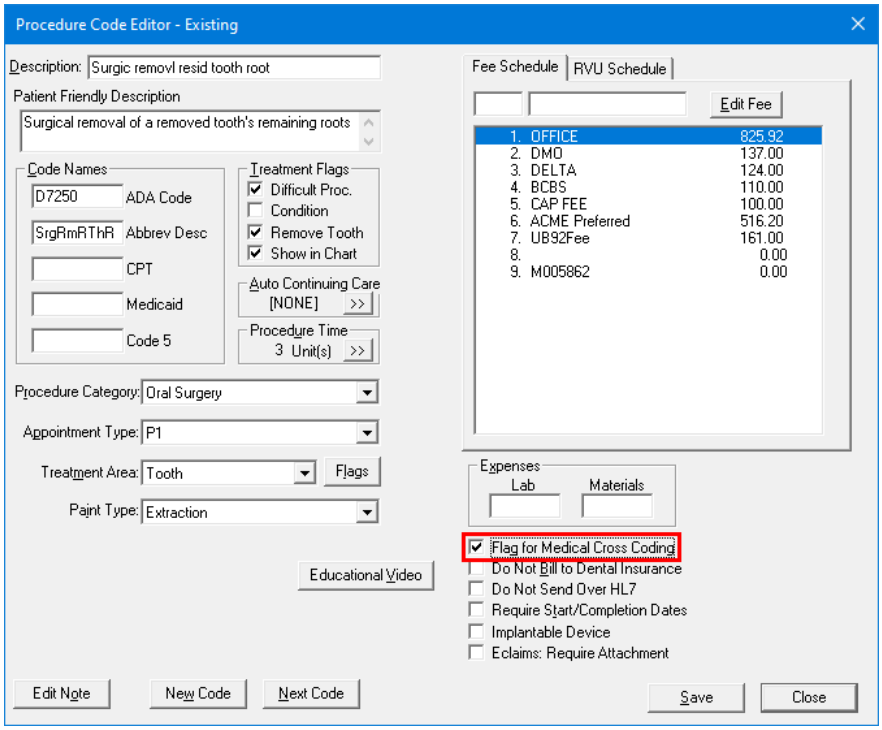
    Note: If blank, the default Provider ID will be populated on the claim form.
  - **Source of payment** – Cannot be **[None]**.
  - **Diagnostic Code System** – **ICD 9** or **ICD 10**.
  - **Advanced** – Optional claim settings.



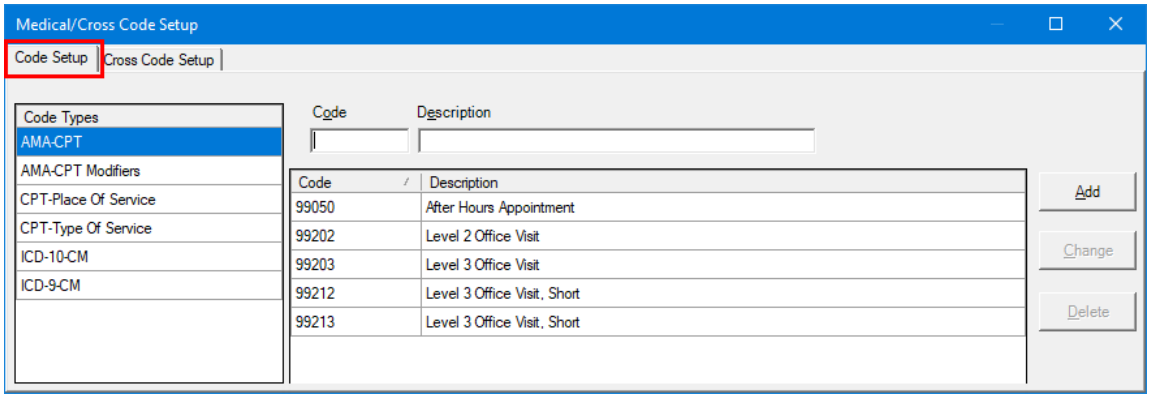
- **Patient** – Verify the subscriber information for each medical insurance plan that is attached to a patient. With a patient selected in the Family File, double-click the Insurance Information block. In the **Insurance Information** dialog box, select the **Medical Insurance** tab, and then select a plan in the **Coverage Order** list. The following information is required
  - **Medical Insurance Plan**.
  - **Subscriber Id #**.



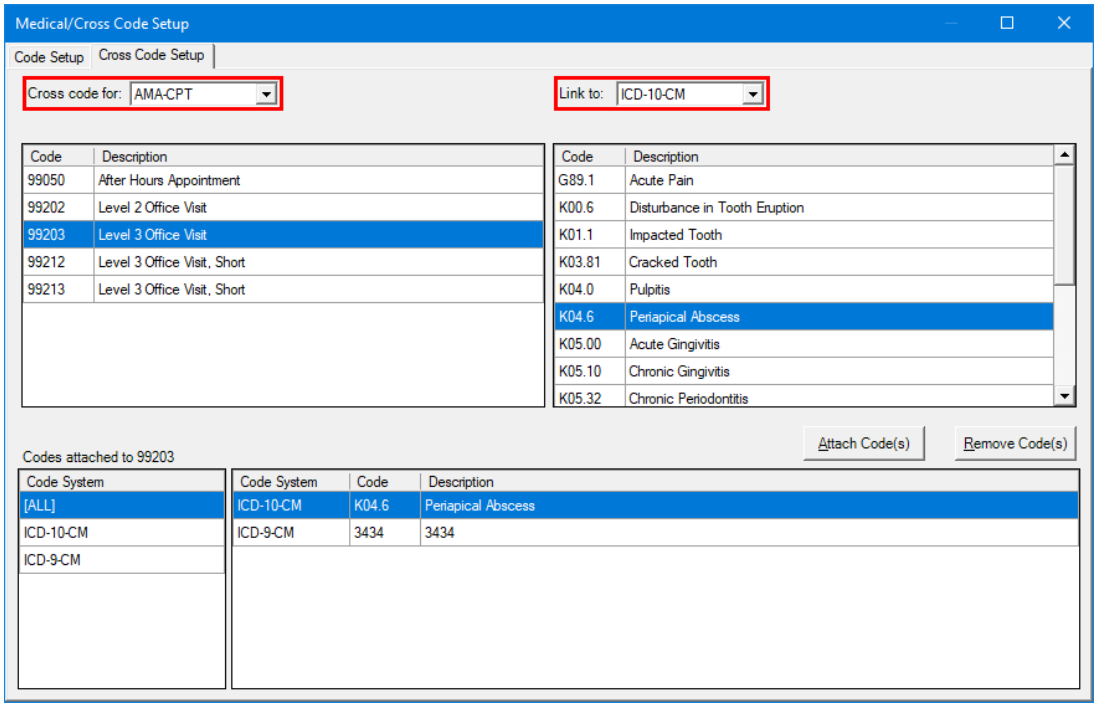
- **Procedure code** – Verify each ADA procedure code that will be billed to medical insurance can be cross coded. While logged in to the Central clinic, in the Office Manager, on the **Maintenance** menu, point to **Practice Setup**, and then click **Procedure Code Setup**. In the **Procedure Code Setup** dialog box, select a category in the **Procedure Code Category** list, and then double-click a procedure in the list on the right. In the **Procedure Code Editor - Existing** dialog box, the following information is required:
  - **Flag for Medical Cross Coding** – This must be selected.



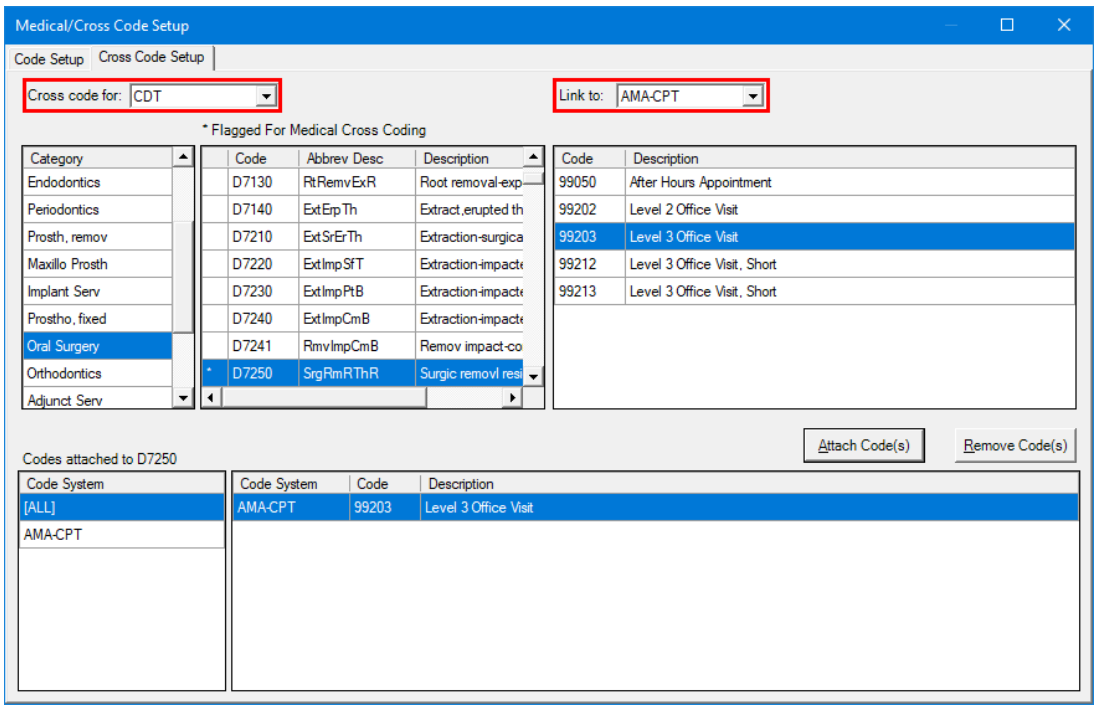
- **Medical cross coding**: Verify the necessary medical codes are entered and cross coding is complete. In the Office Manager, on the **Maintenance** menu, point to **Practice Setup**, and then click **Cross-Coding and Medical Code Setup**. In the **Medical/Cross Code Setup** dialog box, perform cross coding on the following tabs:
  - **Code Setup** – Verify applicable codes exist for the following types: **AMA-CPT**, **AMA-CPT Modifiers**, **CPT-Place of Service**, **CPT-Type of Service**, and **ICD-10-CM** or **ICD-9-CM** (depending on medical insurance plan).



- **Cross Code Setup** – Verify applicable medical and dental codes are cross coded:
  - **AMA-CPT** to **ICD-9-CM** and/or **ICD-10-CM**.



  - **CDT** to **AMA-CPT**.

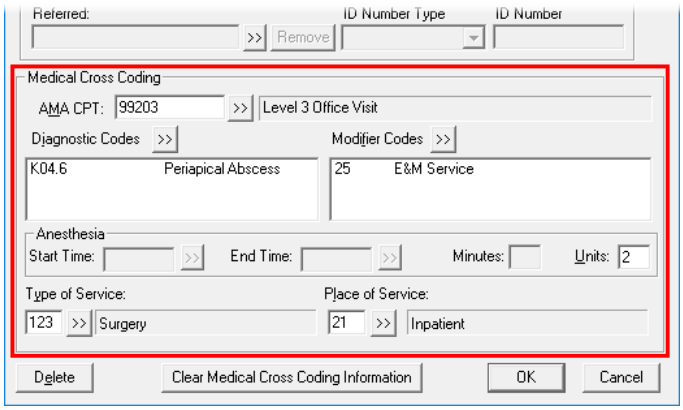


Posting Procedures and Submitting Claims

With all applicable setup complete, you can post procedures, cross code them, and submit medical claims for them.

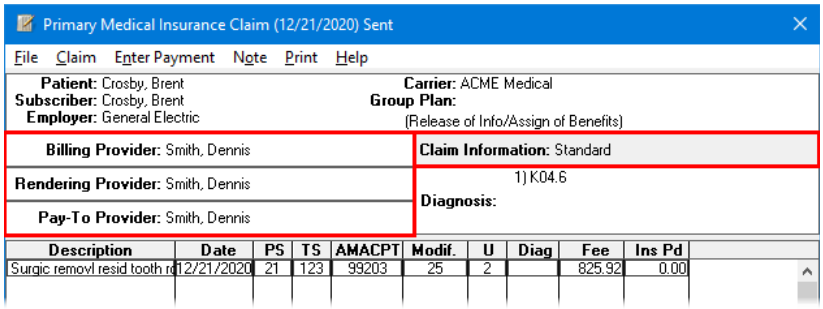
To post a procedure and submit a claim

1. Post a procedure that is cross coded for medical billing:



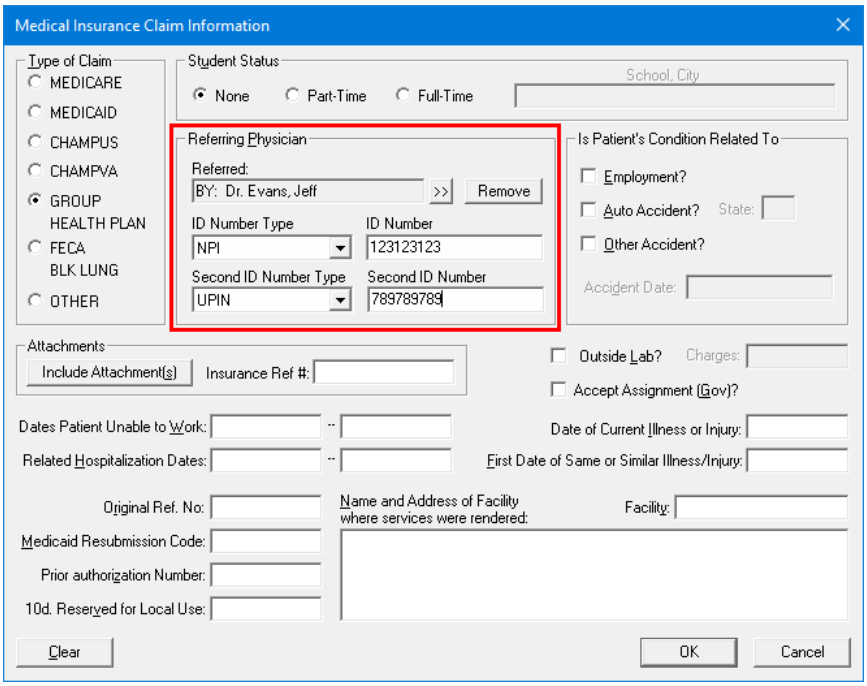
   - **AMA CPT** – ICD-9 or ICD-10 code (depending on the medical insurance plan).
   - **Diagnostic Codes**.
   - **Modifier Codes**.
   - **Type of Service**.
   - **Place of Service**.

2. Create a primary medical claim with the following information:



   - **Providers**:
     - **Billing Provider**.
     - **Rendering Provider**.
     - **Pay-To Provider**.

- **Claim Information** (if applicable):



  - **Referring Physician**:
    - **Referred**.
    - **ID Number** – Only one ID is required: **NPI** or **UPIN**. But if you use both types, the first one must be **NPI**.
    - **Second ID Number** – If you use two types, the second type must be **UPIN**.
  - Any additional details, such as **Auto- Accident?** or **Prior authorization Number**.

3. Send the claim.

   The **eClaims Pre-Submission Summary** dialog box appears.

4. Correct any errors that the validation tool may find.
5. Resend the claim.

Note: You can create a secondary claim only after you receive the adjudication on the primary claim.

Working with Treatment Plans

Treatment Plans play an important part in generating and sustaining revenue for most dental offices. This section covers the following topics about the Ledger features that can help you manage patient treatment plans:

- Posting Treatment-planned Procedures
- Creating Dental Pre-treatment Estimates
- Entering Pre-treatment Estimate Authorizations
- Completing Treatment-Planned Procedures

Posting Treatment-planned Procedures

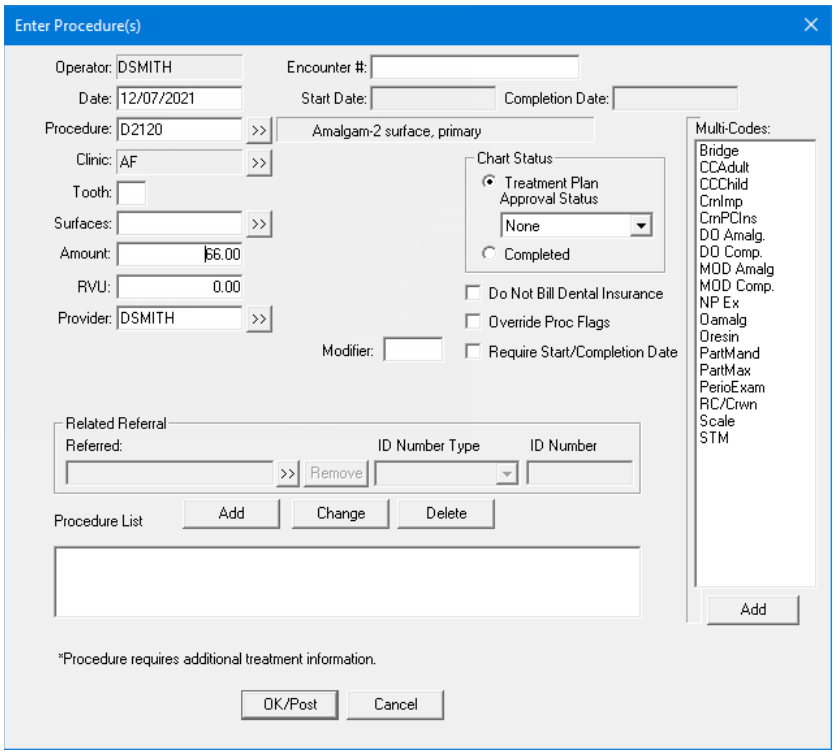
Most of the time, you post treatment-planned procedures in the Patient Chart; and then, when the procedures are completed, they are automatically posted to Ledger. In some cases, however, you may need to post a treatment-planned procedure directly in Ledger-Treatment Plan.

Note: According to your organization's policies and standards, you may be required to enter and edit procedure codes related to patient treatment from the Patient Chart.

To add a procedure to a patient's treatment plan

1. In Ledger, with a patient selected, from the **Options** menu, click **Treatment Plan** to switch to the Ledger-Treatment Plan view.
2. From the **Transaction** menu, click **Enter Procedure**.

   The **Enter Procedure(s)** dialog box appears.



3. Under **Chart Status,** leave **Treatment Plan** selected, and then select an **Approval Status**. Enter the other procedure information as explained in "Posting Procedures" in this chapter.

Notes:

- For information about how to set up approval statuses, see the "Customizing Approval Status" topic in the Dentrix Enterprise Help.
- When a procedure is completed, the last approval status selected before the procedure was set complete appears next to the procedure in the **AP** column of Ledger, Ledger-Treatment Plan, and Patient Chart.

4. **OK/Post**.

Creating Dental Pre-treatment Estimates

Dentrix Enterprise includes many features to help you generate dental pre-treatment estimates and print them or send them electronically. The process is similar to creating dental insurance claims. Create a pre-treatment estimate when a pre-authorization for treatment is required or when an insured patient requests a pre-determination of benefits for recommended treatment.

To create a pre-treatment estimate

1. In Ledger, with a patient selected, from the **Options** menu, click **Treatment Plan** to switch to the Ledger-Treatment Plan view.
2. Do one of the following:
   - Create a pre-treatment estimate for today's procedures. This option is the simplest way to create a pre-treatment estimate. Use this method for creating a dental pre-treatment estimate immediately after treatment-procedures have been posted. From the **Insurance** menu, click **Today's Procedures**, **Today's Procedures - Direct Print**, or **Today's Procedures - Batch**. Or, you can click the **Ins. Today's Proc.** button on the toolbar.

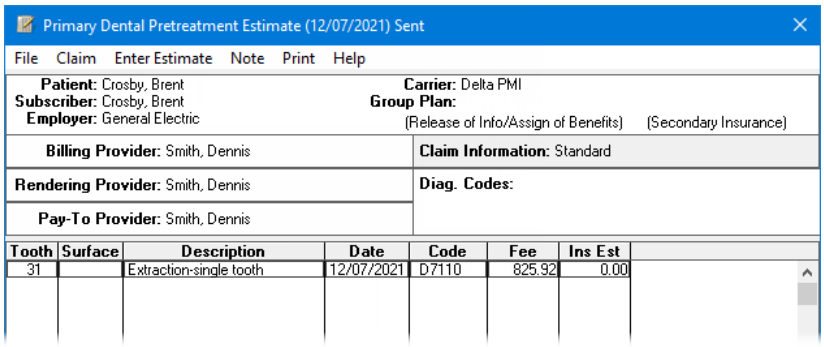
     Dentrix Enterprise creates a dental pre-treatment estimate that includes all procedures posted on the current system date.
   - Create a pre-treatment estimate for specific procedures. Use this method for creating a dental pre-treatment estimate for treatment-planned procedures that were posted on another date.
     a. Select the procedures for which you want to create a dental pre-treatment estimate (to select multiple procedures, while holding down the Ctrl key, click the desired procedures).
     b. From the **Insurance** menu, click **Selected Procedures**, **Selected Procedures - Direct Print**, or **Selected Procedures - Batch**. Or, you can click the **Ins. Selected Proc.** button on the toolbar (for details about how to set the printing default for this button, see the topic about setting up direct print options).

     Dentrix Enterprise creates a dental pre-treatment estimate that includes all selected procedures.

   One of the following occurs:
   - If, from the **Insurance** menu, you select **Today's Procedures** or **Selected Procedures** to create a dental pre-treatment estimate, before the pre-treatment estimate is sent, the **Primary Dental Pretreatment Estimate** window appears, allowing you to edit the claim information.

     Note: You only need to edit a pre-treatment estimate when it requires special handling, such as the addition of a narrative or to indicate that you are attaching X-rays.
   - Dentrix Enterprise sends the claim to the Batch Processor or prints it immediately. Ignore the steps that follow.

3. Make any necessary changes to the dental pre-treatment estimate as explained in "Changing Dental Claim Information" in this chapter. You can also add attachments to the pre-treatment estimate.



4. To batch, send, or print the dental pre-treatment estimate, on the menu bar, click **Print**.

   The **Pre-Estimate Print** dialog box appears.



5. If you are not including any attachments, clear the **Attachment(s)** check box.
6. Do one of the following:
   - Click **Send to Batch** to send the pre-treatment estimate to the Batch Processor.
   - Click **Send Electronically** to send the pre-treatment estimate through electronic filing.
   - Click **Print** to print the pre-treatment estimate now.

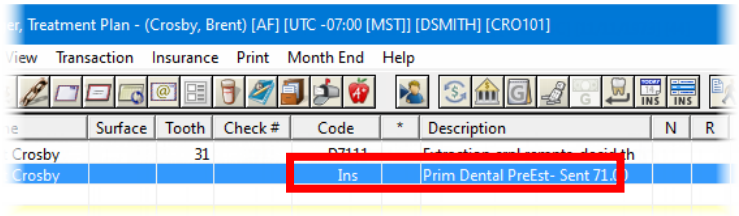
   Note: If you click **Cancel**, the pre-treatment estimate status will be "Not Sent." (This is not recommended.)

Entering Pre-treatment Estimate Authorizations

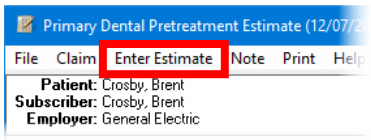
When an authorization for a pre-treatment estimate has been received back from an insurance carrier, you can enter the pre-authorization in Dentrix Enterprise.

To enter a pre-treatment estimate authorization

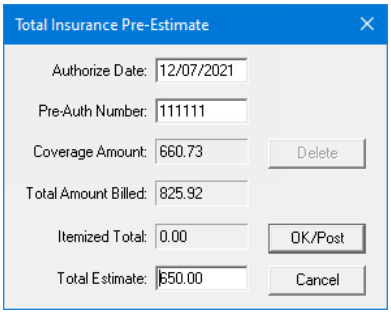
1. In Ledger, with a patient selected, from the **Options** menu, click **Treatment Plan** to switch to the Ledger-Treatment Plan view.
2. Double-click a pre-treatment estimate.



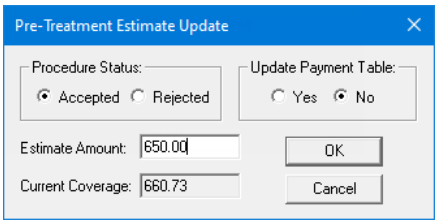
The pre-treatment estimate window appears.



3. From the **Enter Estimate** menu, click one of the following options:
   - **Total Estimate Only** – To open the **Total Insurance Pre-Estimate** dialog box. (Skip step 4.)



   - **Itemize by Procedure** – To open the **Pre-Treatment Estimate Update** dialog box. (Proceed to step 4.)



4. Do one of the following:
   - Dentrix Enterprise automatically inserts the estimated insurance portion in the **Estimate Amount** box. If the amount is correct, click **OK**.
   - If the procedure was rejected, under **Procedure Status**, select **Rejected**, and then click **OK**.

- If the actual estimate amount is different from what appears, enter the correct amount in the **Estimate Amount** box. To save the estimate amount as a reference for future estimates, under **Update Payment Table**, click **Yes**. The next time a patient with this plan has the same procedure recommended or completed, Dentrix Enterprise will use the new estimate amount. Then, click **OK**.

  Important: It is important that you update the payment table only when the payment amount applies to all patients covered by that plan. For example, if the estimated insurance portion is different from the payment amount because money is being withheld toward a deductible, do not update the payment table. Similarly, if a patient has exceeded their maximum benefit, do not update the payment table.

Repeat this step for all the other procedures attached to the estimate. Once all procedures have been entered, the **Total Insurance Estimate** dialog box appears.

5. Enter the **Pre-Auth Number**.
6. If you did not itemize payments, enter the authorized amount in the **Total Estimate** box.
7. Click **OK/Post**.

Completing Treatment-Planned Procedures

When a recommended treatment has been finished, you will need to set the procedure complete in Ledger-Treatment Plan. Setting a procedure complete removes it from Ledger-Treatment Plan and posts it in Ledger with the appropriate charge and insurance coverage information (including any pre-authorizations received).

To set a treatment-planned procedure complete

1. In Ledger, with a patient selected, from the **Options** menu, click **Treatment Plan** to switch to the Ledger-Treatment Plan view.
2. Select the procedures you want to complete. To select multiple procedures, while pressing the Ctrl key, click each procedure.
3. From the **Transaction** menu, click **Set Procedures Complete**.

   The selected procedures are transferred to Ledger.
5. To return to Ledger, from the **Options** menu, click **Ledger**.

Generating Ledger Reports

You can print the following reports from Ledger:

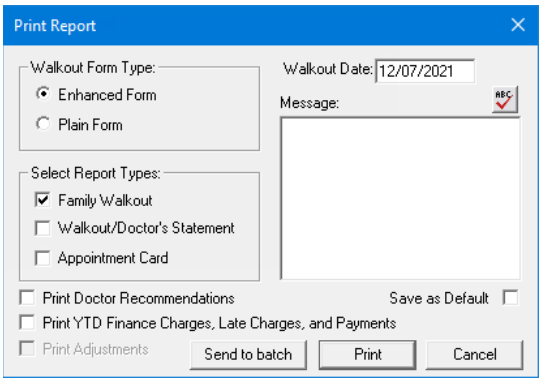
- Walkout Statement
- Single Billing Statement
- Family Ledger Report
- Patient Ledger Report

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. Dentrix Enterprise provides you with several options when printing a walkout statement.

To print a walkout statement

1. In 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. Set up the following options:
   - **Select Report Types** – Select the report types that you want to print:
     - **Family Walkout** – TThe family walkout statement shows all completed procedures, guarantor payments, and adjustments posted to the account on the date of the walkout. The walkout then totals all charges and credits for the day to indicate a total balance, estimated insurance portion, and a "Please Pay" amount. In addition, as a reminder, Dentrix Enterprise prints the next future appointment at the bottom of the statement.
     - **Walkout/Doctor's Statement** – If your office does not handle insurance for patients, the doctor's statement can be printed for the patient to use in place of an insurance claim. The doctor's statement shows all procedures for the selected patient but does not include payments. A signature line is printed at the bottom of the statement for the doctor's signature. Adjustments can be included on the statement by selecting **Print Adjustments**.
     - **Appointment Card** – You can generate a 4" x 6" reminder card that lists the next appointment for the patient.

- **Print Doctor Recommendations** – If you have added recommendation notes to your procedure codes, these notes will be printed on the family walkout statement if **Print Doctor Recommendations** is selected. For information about adding recommendation notes, see "Editing Procedure Codes" in Chapter 1: Introduction and Initial Setup.
- **Print YTD Finance Charges, Late Charges, and Payments** – If you want to add a row to the family walkout statement that shows the year-to-date account totals for finance charges, late charges, insurance payments, and guarantor payments, select this option.
- **Print Adjustments** – Normally, when you print a walkout/doctor's statement, only procedures are printed on the report. If you want adjustments to show on the statement, select **Print Adjustments**.
- **Message** – If you have a standard message that you want to print on all walkout statements by default, enter the note.

3. 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**.
4. Click **Send to Batch** or **Print**.

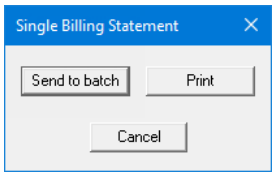
Single Billing Statement

You can generate a single billing statement for a selected account from Ledger. Also, you can generate billing statements for a range of accounts from the Office Manager.

To print a single billing statement

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

   The **Single Billing Statement** dialog box appears.



2. Click **Send to batch** or **Print**.

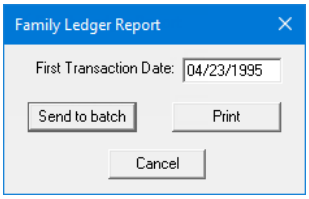
   The statement is generated, according to the options you have selected from the billing statement options set up in the Office Manager. The Balance Forward date on the statement is automatically set to one month prior to the current date. To change the statement print options you must change the statement default settings in the Office Manager. For details about the billing statement options, see "Generating Billing Statements" in Chapter 8: Office Manager.

Family Ledger Report

The Family Ledger Report shows an account history that includes all procedures, payments, adjustments, and service charges posted to Ledger. You can also generate this report for a range of accounts from the Office Manager.

To print the Family Ledger Report for the family being viewed in Ledger

1. In Ledger, with a patient selected, do one of the following:
   - If you only want current transactions (transactions posted since the month was closed out) on the report, click the **Print Family Ledger** button on the toolbar. (Ignore the steps that follow.)
   - If you want to include more transactions than the current transactions on the report, from the **Print** menu, click **Family Ledger**. The **Family Ledger Report** dialog box appears. (Proceed to step 2.)



2. Set up the following options:
   - **Balance Forward** – You can change the date to include more transactions.
   - **First Transaction Date** – Enter the date from which you want to print all transactions posted.
3. Click **Send to batch** or **Print**.

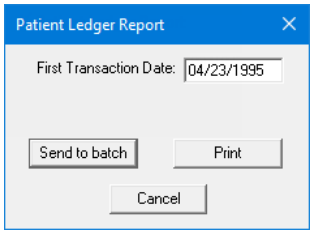
Patient Ledger Report

The Patient Ledger Report is very similar to the Family Ledger Report; however, instead of printing transactions for all family members, it shows transactions for the selected patient only. You can also generate this report for a range of patients from the Office Manager.

To print the Patient Ledger Report for one patient

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

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



2. Enter a **First Transaction Date**. All transactions posted after the entered date will be included on the report.
3. Click **Send to batch** or **Print**.

Using Fast Checkout

The **Fast Checkout** button combines the three tasks that are typically completed as a patient checks out after a visit. All at one time, you can collect a payment, generate an insurance claim, and print a receipt. For information about how to customize the **Fast Checkout** button to meet the needs of your office, see "Setting Up Checkout Options" in Chapter 1: Introduction and Initial Setup.

To use Fast Checkout

1. In Ledger, with a patient selected, if you have not already done so, post the completed procedures for the day for the patient.
2. On the toolbar, click the **Fast Checkout** button  .
3. Depending on the setup of the **Fast Checkout** button, any of the following may occur:
   - The **Checkout Options** dialog box appears. Select the desired options, and then click **OK**.
   - The **Enter Payment** dialog box appears. Enter the payment information, and then click **OK**.
   - Dentrix Enterprise creates an insurance claim.
   - Dentrix Enterprise prints or batches a walkout statement.

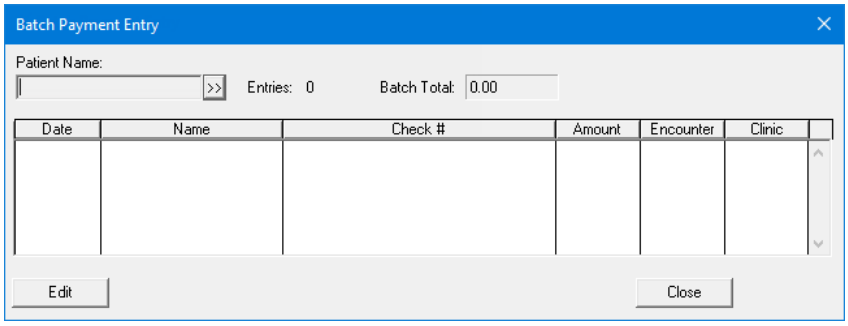
Posting Batch Guarantor Payments

With Dentrix Enterprise, you can quickly enter a stack of checks and payments from patients and/or guarantors, saving you valuable time.

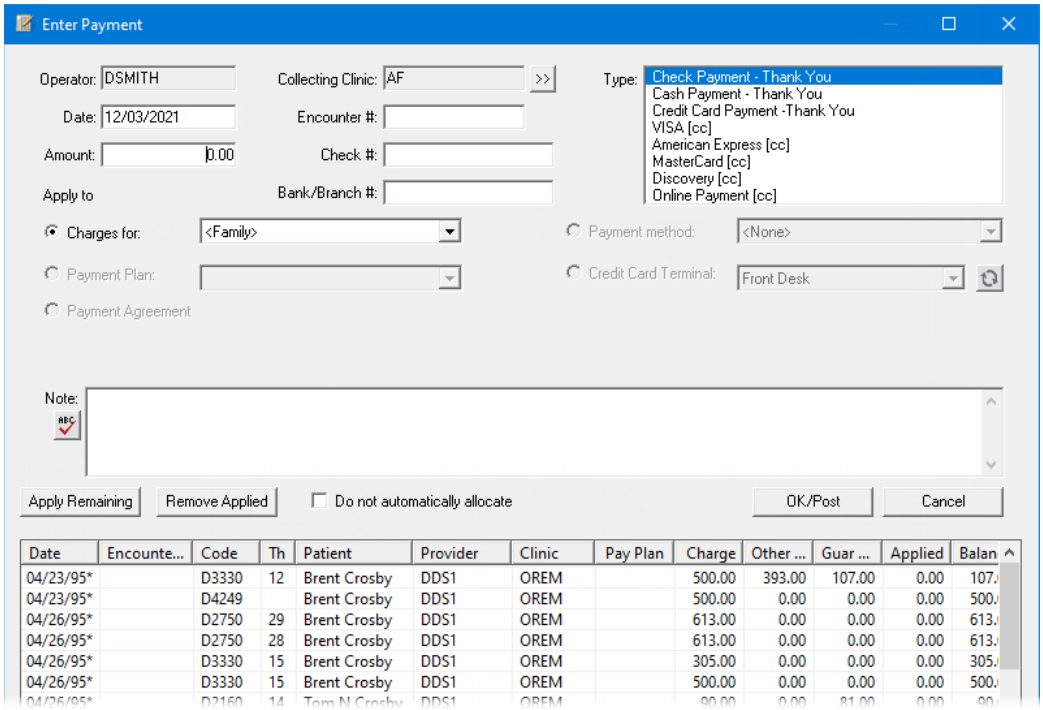
To post a batch of guarantor payments

1. In Ledger, from the **File** menu, click **Enter Batch Payments**.

   The **Batch Payment Entry** dialog box appears.



2. Click the **Patient Name** search button >> to search for and select a patient.
3. In the **Enter Payment** dialog box that appears, enter the payment information. For details about the options available for entering a payment, see "Posting Payments" in this chapter.



4. Click **OK/Post** to post the payment to Ledger and return to the **Batch Payment Entry** dialog box, where the payment now appears.

   Repeat steps 2 – 4 for all other guarantor payments you want to enter. When you are finished making payment entries, compare the number of entries made to the number of payments in hand.

5. Click **Close**.

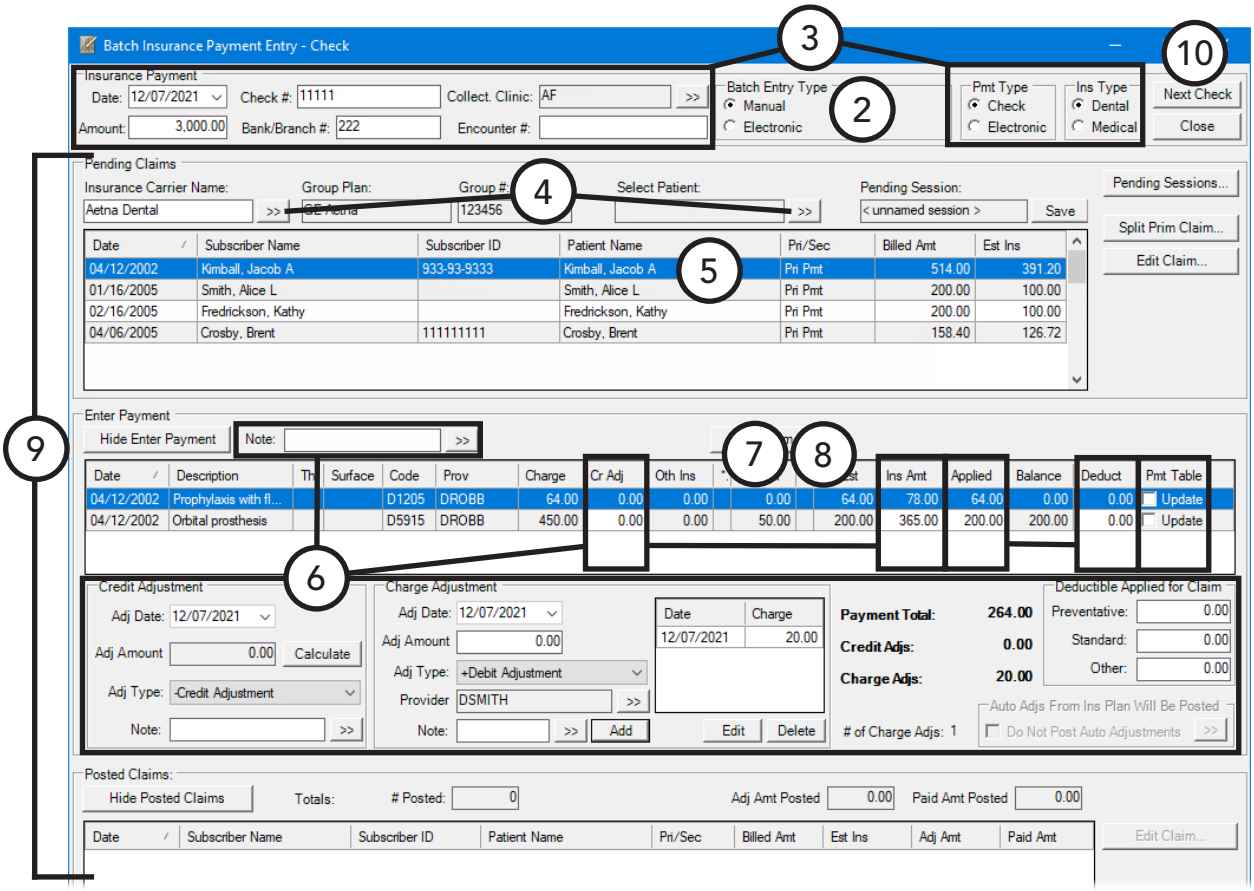
Posting Batch Insurance Payments

When an insurance carrier sends your office one check or electronic funds transfer (EFT) to cover multiple claims for multiple patients, with Dentrix Enterprise, you can post the large insurance check to multiple patients without having to switch back and forth between different accounts and insurance claims.

To post a batch of insurance payments manually

1. In Ledger, from the **File** menu, click **Enter Batch Ins. Payment**.

   The **Batch Insurance Payment Entry** dialog box appears.



   Note: If you need to resume or delete a batch insurance payment entry session, under **Pending Claims**, click **Pending Sessions**. The **Pending Sessions for Manual Batch Payments** dialog box appears. Select a session, and then click either **OK** (to resume it) or **Delete** (to delete it).

2. Under **Batch Entry Type**, select **Manual**.
3. Set up the following options:
   - **Pmt Type** – Select **Check** if a check was mailed to the office, or select **Electronic** if payment was received through an EFT.
   - **Collect. Clinic** – Click the search button >> to select the clinic that is collecting the payment.
   - **Ins Type** – Select the appropriate type of insurance: **Dental** or **Medical**.
   - **Amount** – Enter the amount of the check or EFT.
   - **Check #** – Enter the check number.
   - **Bank/Branch #** – Enter the bank or branch number.

4. Under **Pending Claims**, click the **Select Patient** or **Insurance Carrier Name** search button ››, select the correct patient or carrier, and then click **OK**.

   A list of all outstanding insurance claims for that carrier or patient appears.

5. Under **Pending Claims**, select a claim.

   Note: You can also perform any of the following tasks as needed:

   - To split a claim into two claims in order to post a partial insurance payment, with the claim selected, click **Split Prim Claim**.
   - To view a claim, edit claim information, or enter a dental or medical insurance payment, with the claim selected, click **Edit Claim**.

6. For the claim selected in step 5, under **Enter Payment**, perform any of the following tasks as needed:
   - To enter or change the credit adjustment for each procedure, select a procedure; in the **Cr Adj** column, double-click the corresponding box; enter the correct amount; and then either click the check mark  , or press Enter. The next procedure is selected, and the next box down in the same column becomes active, so you can enter the adjustment for each procedure in succession. Repeat as needed until you have entered the adjustment for all applicable procedures. The total amount of all credit adjustments for the selected claim will be posted as a single credit adjustment, using the date, type, and note as displayed under **Credit Adjustment** (which is below the procedure list). You can change the adjustment's details as needed.
   - To enter or change the details of the **Credit Adjustment** for the claim, do the following:
     a. Either change the **Cr Adj** for each procedure, or click **Calculate** to populate the **Cr Adj** for each procedure with the **Balance** for each procedure. The total of those credit adjustments appears in the **Adj Amount** box.
     b. By default, the date of the adjustment is today's date, but you can specify a different date as the **Adj Date**.
     c. Select the type of adjustment from the **Adj Type** list. The default selection is determined by the setting in the **Set Automatic Credit Allocation Options** dialog box.
     d. To enter a note for the adjustment, either enter in the **Note** box directly; or click the **Note** search button ››, enter the note, and then click **OK**.

     Note: The adjustment is attached to the claim, has the claim ID associated with it, and is viewable from the claim window.

   - To change the amount insurance is supposed to pay for each procedure (the actual insurance portion, not the estimated insurance portion), select a procedure; in the **Ins Amt** column, double-click the corresponding box; enter the correct amount; and then either click the check mark  , or press Enter. The next procedure is selected, and the next box down in the same column becomes active, so you can enter the insurance amount for each procedure in succession. Repeat as needed until you have entered the insurance amount for all applicable procedures.
   - To change the amount of the payment that is to be applied to each procedure, select a procedure; in the **Applied** column, double-click the corresponding box; enter the correct amount; and then either click the check mark  , or press Enter. The next procedure is selected, and the next box down in the same column becomes active, so you can enter the applied amount for each procedure in succession. Repeat as needed until you have entered the applied amount for all applicable procedures.
   - To enter the amount of the deductible that is to be applied to each procedure, select a procedure; in the **Deduct** column, double-click the corresponding box; enter the correct amount; and then either click the check mark  , or press Enter. The next procedure is selected, and the next box

down in the same column becomes active, so you can enter the applied deductible for each procedure in succession. Repeat as needed until you have entered the applied deductible for all applicable procedures.

- To update the payment table for a procedure (only if a deductible is not being applied and if the maximum benefit has not been exceeded), in the **Pmt Table** column, select **Update**. Repeat as needed for other procedures.
- To add a **Charge Adjustment** (you can have multiple per claim), do the following:
  a. By default, the date of the adjustment is today's date, but you can specify a different date as the **Adj Date**.
  b. Enter the amount of the adjustment in the **Adj Amount** box.
  c. Select the type of adjustment from the **Adj Type** list.
  d. To attach a provider to the adjustment, click the **Provider** search button >> to select the correct provider.
  e. To enter a note for the adjustment, either enter in the **Note** box directly; or click the **Note** search button >>, enter the note, and then click **OK**.
  f. Click **Add**.

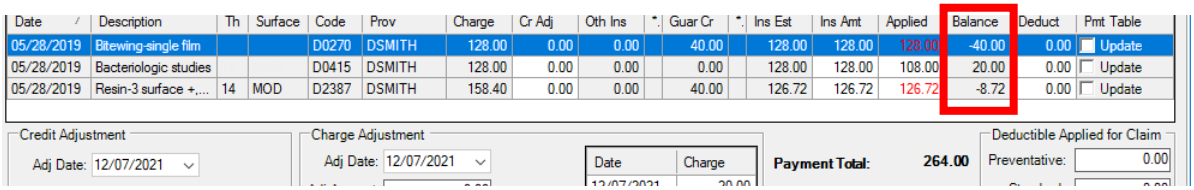
  Note: The adjustments are attached to the claim, have the claim ID associated with them, and are viewable from the claim window.

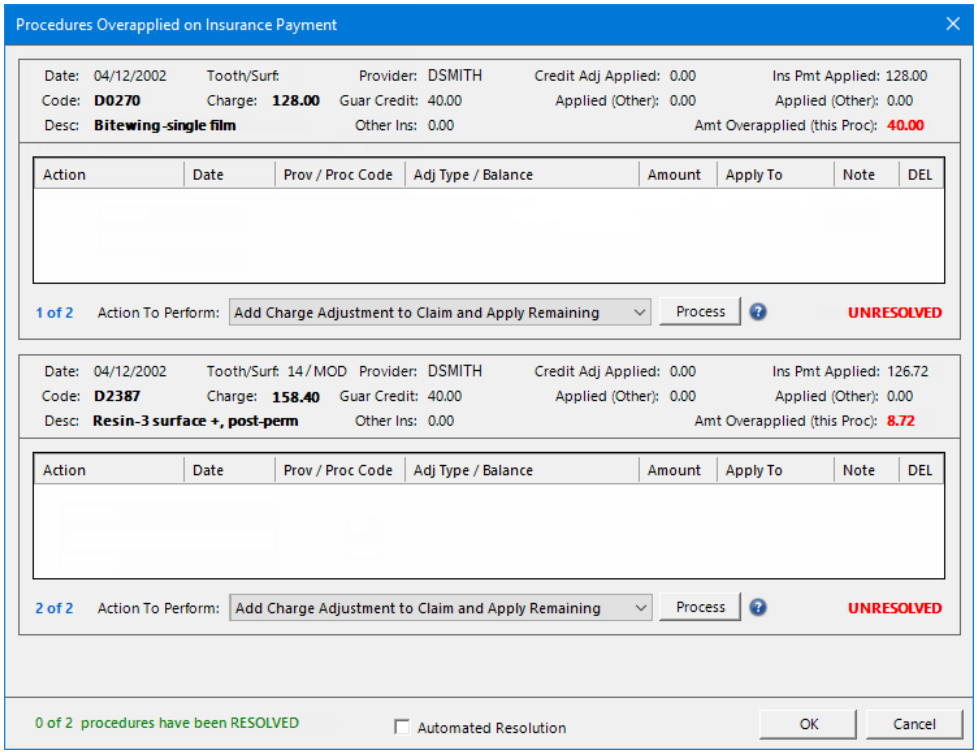
- To edit a **Charge Adjustment**, do the following:
  a. Select an item in the list (the **Date** and **Charge** for each item in the list appear for your reference).
  b. Click **Edit** to populate the details of that adjustment in the boxes to the left of the lst.
  c. Change the **Adj Date**, **Adj Amount**, **Adj Type**, **Provider**, and **Note** as needed.
  d. Click **OK**. (The label of the **Add** button changes to **OK** when you are editing an adjustment.)
- To delete a **Charge Adjustment**, do the following:
  a. Select an item in the list (the **Date** and **Charge** for each item in the list appear for your reference).
  b. Click **Delete**. The adjustment is deleted without confirmation.
- To modify the deductibles being applied for the claim, under **Deductible Applied for Claim**, change the values for **Standard**, **Preventive**, and/or **Other** as needed.
- If you have set up automatic adjustments for the insurance plan but don't want to post those adjustments, under **Auto Adjs From Ins Plan Will Be Posted**, select **Do Not Post Auto Adjustments**. With this check box selected, only adjustments on the EOB will be posted automatically as applicable, according to the setting in the **Set Automatic Credit Allocation Options** dialog box.
- To document information regarding the insurance payment, either enter in the **Note** box directly; or click the **Note** search button >>, enter the note, and then click **OK**.

7. Click **Post Claim**.

Note: If you attempt to select another claim under **Pending Claims**, attempt to close the **Batch Insurance Payment Entry** dialog box, or click **Next Check**, after having made any changes to the amounts (such as **Cr Adj** and **Applied**) for any procedure under **Enter Payment** without clicking **Post Claim**, a message appears. To post the claim with the changes before switching to the other claim, closing the dialog box, or clearing the dialog box for the next check, click **Post the Claim and Continue**; to discard the changes for the claim and continue, click **Continue without Posting**; or to keep the changes and return to the dialog box with the claim still selected, click **Cancel**.

If the **Balance** for any procedure under **Enter Payment** has a negative amount, the **Procedures Undercharged or Overpaid** dialog box appears; otherwise skip to step 9.





8. Do the following to resolve the undercharges/overpayments (or if you want to skip this step, click **OK**):

   a. For a procedure, select an option from the **Action To Perform** list:

   - **Add Charge Adj to Claim and Apply Remaining** – This option adds a charge adjustment to the claim and applies it to the remaining balance (up to the maximum allowed charge for the procedure).
   - **Suspend Credit for Refund or Credit to Patient** – This option adds offsetting adjustments to the claim to remove the balance, and posts a suspended credit to the patient's Ledger for a refund or credit.
   - **Allocate to Procedure with Remaining Balance** – This option allows you to allocate the remaining amount to other procedures on the claim with a remaining balance. After you click **Process**, the **Select Procedure** dialog box appears. Select a procedure, and then click **OK**.

- **Allocate to Existing Charge Adjustment on Claim** – This options allows you to allocate the remaining amount to any charge adjustments that were added to the claim previously (charges that appeared under **Charge Adjustment** in the **Batch Insurance Payment Entry** dialog box prior to opening the **Procedures Undercharged or Overpaid** dialog box). After you click **Process**, the **Select Charge Adjustment on Claim** dialog box appears. Select a charge adjustment, and then click **OK**.
- **Reduce Guarantor Credit Amt and Apply to Proc** – This option applies the guarantor credit to the remaining balance without using an adjustment.

b. Click **Process** to perform the selected action.

c. If the **Adj Type/Balance** box is empty, to select an adjustment type, double-click the box, select an adjustment type, and then click **OK**.

d. To change the value in the **Amount** box, double-click the box; enter the correct amount; and then either click the check mark  , or press Enter.

e. To change the selection in the **Apply To** box, select either **Ins Payment** or **Credit Adj** from the list to specify where to apply the **Amount**:

- If the amount is being applied to the insurance payment, it reduces the **Ins Pmt Applied** and **Amt Overapplied (this Proc)** amounts and increases the **Applied (Other)** payment amount. If the amount that is being applied is from a guarantor credit, it also reduces the **Guar Credit** amount.
- If the amount is being applied to the credit adjustment, it reduces the **Credit Adj Applied** and **Amt Overapplied (this Proc)** amounts and increases the **Applied (Other)** credit amount. If the amount that is being applied is from a guarantor credit, it also reduces the **Guar Credit** amount.

f. To view or edit the default text in the **Note** box, click the link, make any changes, and then click **OK**.

g. Repeat steps a–f as needed until the undercharge/overpayment for that procedure is resolved (**RESOLVED!** appears to the right of the **Action To Perform** list).

h. Repeat steps a–g as needed to resolve the undercharges/overpayments for other procedures.

i. Click **OK**.

If any procedures still have a negative balance when you click **OK**, a dialog box appears so that you can specify how you want to handle the undercharges/overpayments. For information about handling insurance overpayments, see the "Handling insurance overpayments" topic in the Dentrix Enterprise Help.

9. Repeat steps 5–8 as needed to enter insurance payments for other claims from a single check or EFT.

Notes:

- If you attempt to close the **Batch Insurance Payment Entry** dialog box before you have finished posting claims for the insurance payment, a message appears. To save the batch entry session so that you can resume it later, click **Yes**, enter a **Pending Session Name** to help you identify the session later, and then click **OK**.
- If you attempt to close the **Batch Insurance Payment Entry** dialog box, or click **Next Check**, while the **Amount** under **Insurance Payment** differs from the **Paid Amt Posted** under **Posted Claims**, a message appears. To return to the batch entry session so that you can reconcile the difference, click **Cancel**; to exit the batch entry session because you will return later to reconcile the difference, click **Yes**; or to exit the batch entry session and either complete or not complete the payment, click **No**. If you click **No**, on the next message that appears, select either **No** (if you will reconcile the payment later) or **Yes** (if you are done with the payment), and then click **OK**.

- Any claims posted as explained in steps 4–8 appear under **Posted Claims**. To edit the details of a claim, select the claim, and then click **Edit Claim**.
- If you end the batch entry session before all claims for the check or EFT are posted, all payments posted prior to the closing of the **Batch Insurance Payment Entry** dialog box remain posted to the individual accounts.

10. To post the payments from another check or EFT, click **Next Check**.

For information about posting batches of insurance payments from eEOBs, see the "Posting a batch of insurance payments from eEOBs" topic in the Dentrix Enterprise Help.

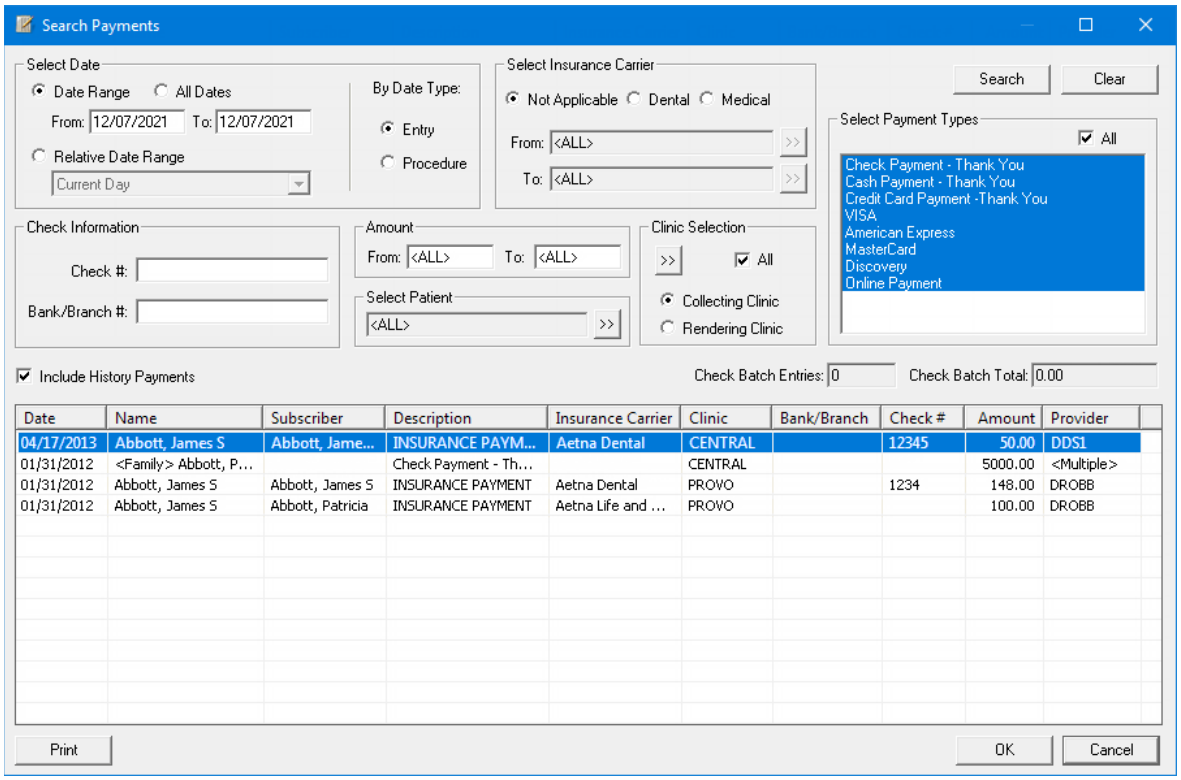
Searching for Payments

In Dentrix Enterprise, you can search for payments by check or bank number, amount, payment date, payment type, clinic, patient, or insurance name. also, you can print a report that lists the payments found by the search. Use this feature when you want to search for (and print a list of) insurance payments entered in a batch.

To search for payments

1. In Ledger, from the **File** menu, click **Search Payments**.

   The **Search Payments** dialog box appears.



2. Set up the following search options:
   - **Select Date** – Select your date range criteria.
   - **By Date Type** – Select whether you want to search by the date a payment was entered or by the date of a payment.
   - **Select Insurance Carrier** – Select your insurance carrier criteria.

- **Check Information** – Enter the **Check #** and **Bank/Branch #**.
- **Amount** – Enter the amount range by which you want to search in the **From** and **To** boxes, or leave **From** <ALL> **To** <ALL> entered to search for any amount.
- **Select Patient** – Click the search button ›› to select the patient whose payments you want to search for, or leave <ALL> selected to include all patients in the search.
- **Clinic Selection** – Select whether you want to search by **Collecting Clinic** or **Rendering Clinic**. Then, click the search button ›› to select the desired clinics, or select **All** to search in all clinics.
- **Select Payment Types** – Select the types of payments you want to search for , or select **All** to include all payment types.
- **Include History Payments** – Select this check box to include payments that are in history.

3. Click **Search** to begin your search.

   The search results appear in the list box in the bottom portion of the dialog box.

4. To print a copy of the search results, click **Print**. On the message that appears, click **Yes**.
5. To view a payment in the corresponding patient's Ledger, select that payment, and then click **OK**.

Working with Payment Plans

Payment plans are set up for a specific patient or for multiple family members. Dentrix Enterprise allows multiple payment plans per account. You can set up payment plans from the Family File or Ledger.

This section covers the following topics about payment plans:

- Creating Payment Plans
- Printing Payment Plan Documents

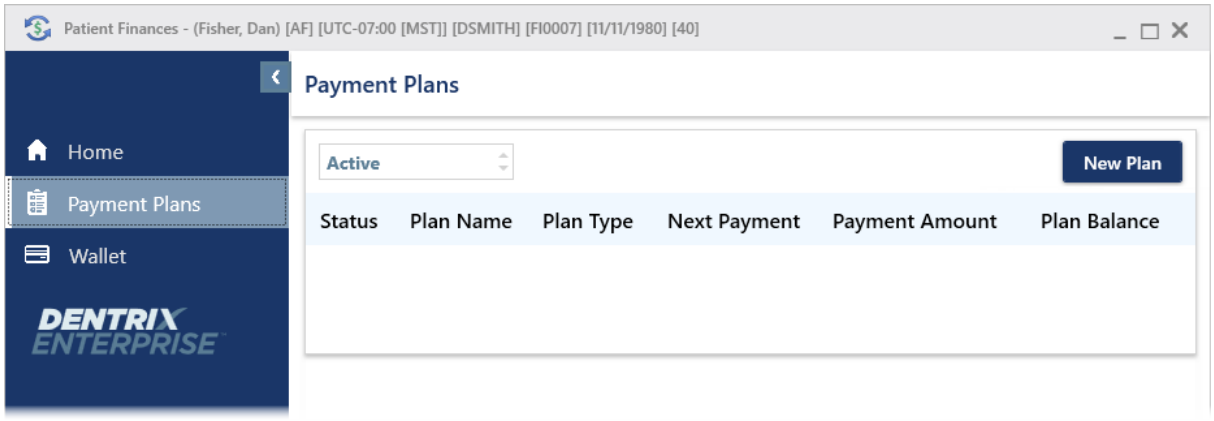
Creating Payment Plans

You can create a payment plan for clients from Ledger.

To create a payment plan

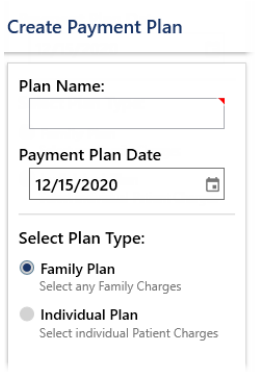
1. In Ledger, with a patient selected, click the **Patient Finances** button .

   The **Patient Finances** window opens.

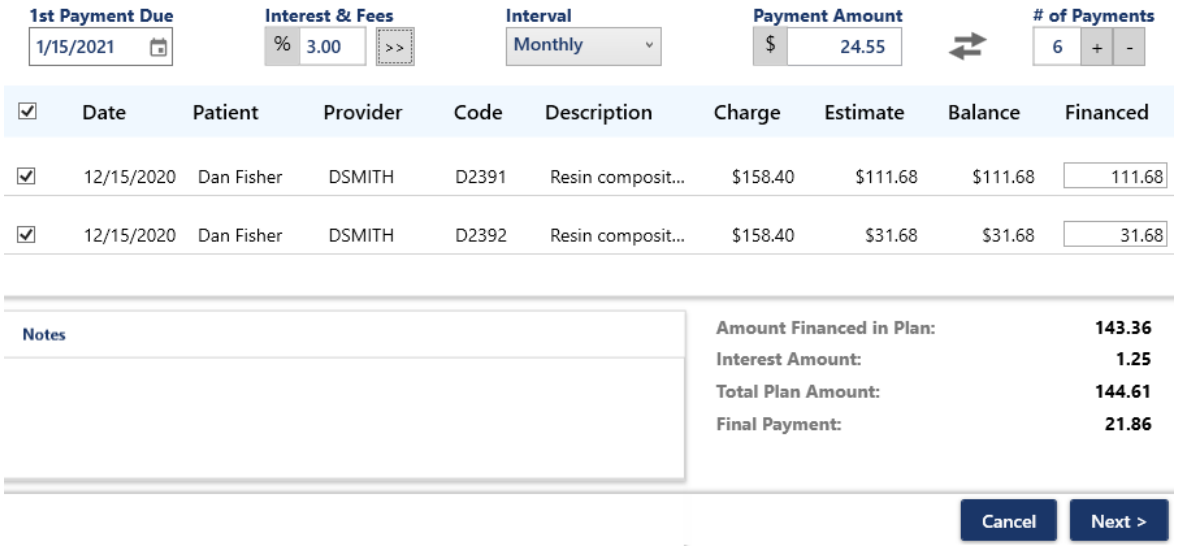


2. Select the **Payment Plans** tab.
3. Click **New Plan**.

The **Create Payment Plan** options appear.



4. Set up the following options:
   - **Plan Name** – A name to identify the plan.
   - **Payment Plan Date** – The date of the plan. The current date is displayed by default. You cannot select a past date.
   - **Plan Type** – Select one of the following options:
     - **Family Plan** – With this option selected, the procedures for all family members are available.
     - **Individual Plan** – With this option selected, the list of family members appears. Select the correct family member to view only that patient's procedures.



5. Select the check box of each procedure that you want to include, or select the check box at the top of the list to select all the procedures at once.

Notes:

- Only completed procedures that have an unpaid estimated patient portion appear.
- Procedures that are included in another payment plan do not appear.

For each procedure, the following financial information appears:

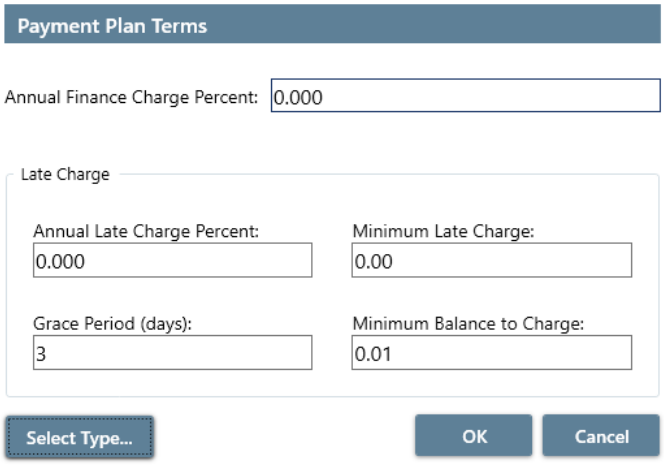
- **Charge** – The amount charged.
- **Estimate** – The estimated patient portion of the **Charge**.
- **Balance** – The remaining patient portion. This may be different from the **Estimate**, such as if a patient payment is applied.

- **Financed** – The amount to finance. When you select a procedure's check box, the **Balance** amount is inserted automatically in the **Financed** box.

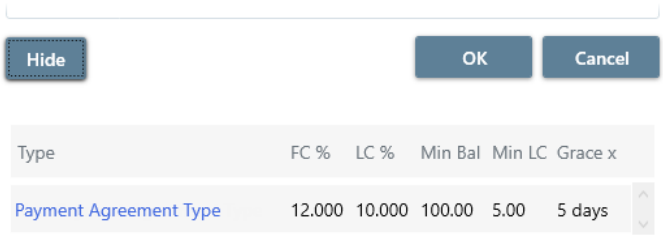
6. Set up the following terms:
   - **1st Payment Due** – The date when the first payment is due. This date must be at least one day after the **Payment Plan Date**. By default, the date is one month in the future.
   - **Interest & Fees** – By default the interest is 0.00. To specify a different interest rate and late fees, do the following:

     a. Click the search button >>.

     The **Payment Plan Terms** dialog box appears.



     b. To view your pre-set payment agreement types, click **Select Type**. Then, to insert the values from one of the types into the applicable boxes, click the name of the correct type.



     For details about setting up payment agreement types, see the "Adding and editing payment agreement types" in the Dentrix Enterprise Help.

     c. Change any of the following as needed:
        - **Annual Finance Charge Percent** – The finance charge percent is used to calculate the finance charge amount. Dentrix Enterprise will automatically calculate the amount to assess based on a monthly charge (for example, if 18% was entered as the annual percentage rate, then 1.5% would be charged monthly). If you do not want to apply finance charges, type 0 in the box.
        - **Annual Late Charge Percent** – If payment is missed, a late charge can be assessed. The late charge percent is used to calculate the amount of a late charge. Dentrix Enterprise will automatically calculate the amount to assess based on a monthly, semi-monthly, bi-weekly, or weekly charge. If you do not want to apply late charges, type 0 in the box.
        - **Minimum Late Charge** – The minimum amount to assess as a late charge.

- **Grace Period (days)** – The number of days (0–30) for the grace period. A late charge will not be assessed if a payment is late until after the specified number of days after the due date.
- **Minimum Balance to Charge** – The minimum balance will be compared to the plan balance. Only if the plan balance is greater than the minimum balance will a finance or late charge be assessed. The amount must be at least 0.01.

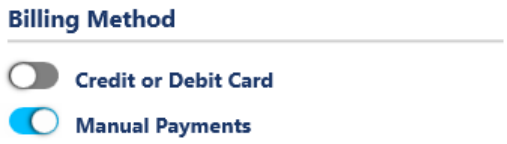
d. Click **OK**.

- **Interval** – Select the frequency of the payments: **Monthly** (the default), **Semi-Monthly**, **Bi-Weekly**, or **Weekly**.
- **Payment Amount** – The amount of each payment. The amount must be at least 5.00 and no more than the **Total Plan Amount** or 99999.99, whichever is less. By default, the **Payment Amount** is the **Total Plan Amount** divided by the **# of Payments**. If you change the **Payment Amount**, the **# of Payments** is updated automatically.
- **# of Payments** – The number of payments to be made. By default, the number is 6. The maximum number of payments is from 24 to 104, depending on the interval; you may need to adjust the **Payment Amount** to not exceed that limit. If you change the **# of Payments**, the **Payment Amount** is updated automatically.
- **Notes** – Any notes, up to 8,000 characters in length, regarding plan. The **Notes** box is available until you save the plan.

7. Click **Next**.

   The **Payment Method** options appear.

8. Under **Billing Method**, select **Manual Payments** to post payments manually in Dentrix Enterprise.



9. Click **Next**.

   The **Summary** appears.



   Note: To print documents regarding this plan, click **Print**.

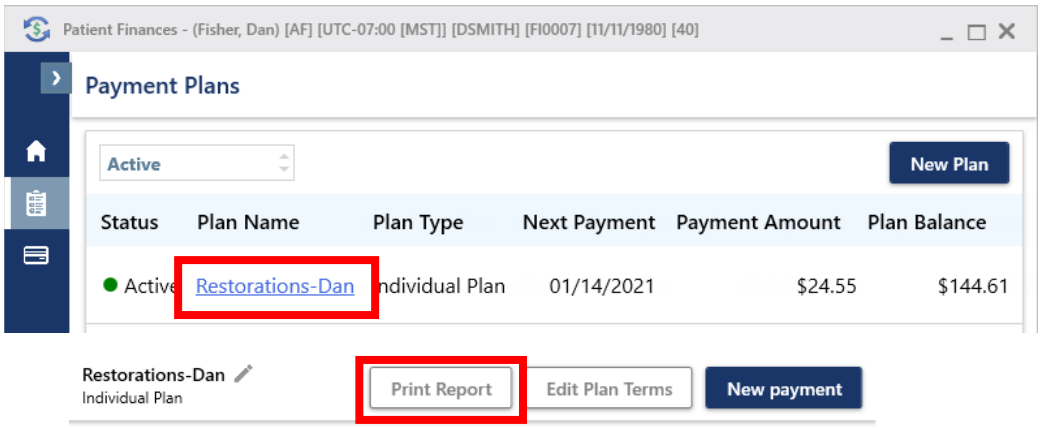
10. Click **Save**.

Printing Payment Plan Documents

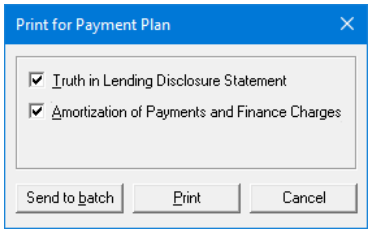
You can print payment plan documents to give to a patient or guarantor.

To print payment plan documents

1. On the **Payment Plans** tab, click a **Plan Name** link, and then click **Print Report**.



   The **Print for Payment Plan** dialog box appears.



2. Select the documents that you want to give to the patient/guarantor:
   - **Truth in Lending Disclosure Statement** – Discloses the terms of the agreement. It includes the annual percentage rate, the finance charge amount, the total amount financed, and the total amount paid at the end of the agreement.
   - **Amortization of Payments and Finance Charges** – Prints a schedule that lists the interest accrued on the balance amount for each payment interval.
3. Click either **Send to Batch** or **Print**.

Working with Future Due Payment Plans

Use future due payment plans when treatment will be completed over time and you want to charge an account monthly while the work is in progress, such as for orthodontics.

This section covers the following topics about future due payment agreements:

- Creating Future Due Payment Plans
- Posting Manual Charges to Future Due Payment Plans

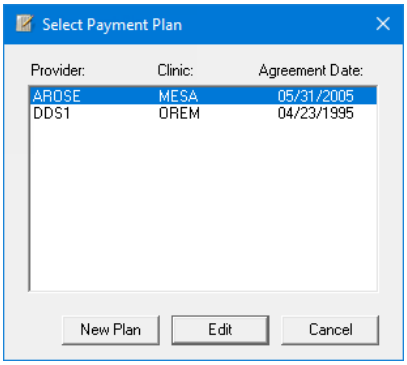
Creating Future Due Payment Plans

You can set up future due payment plans for individual patients.

To create a future due payment plan

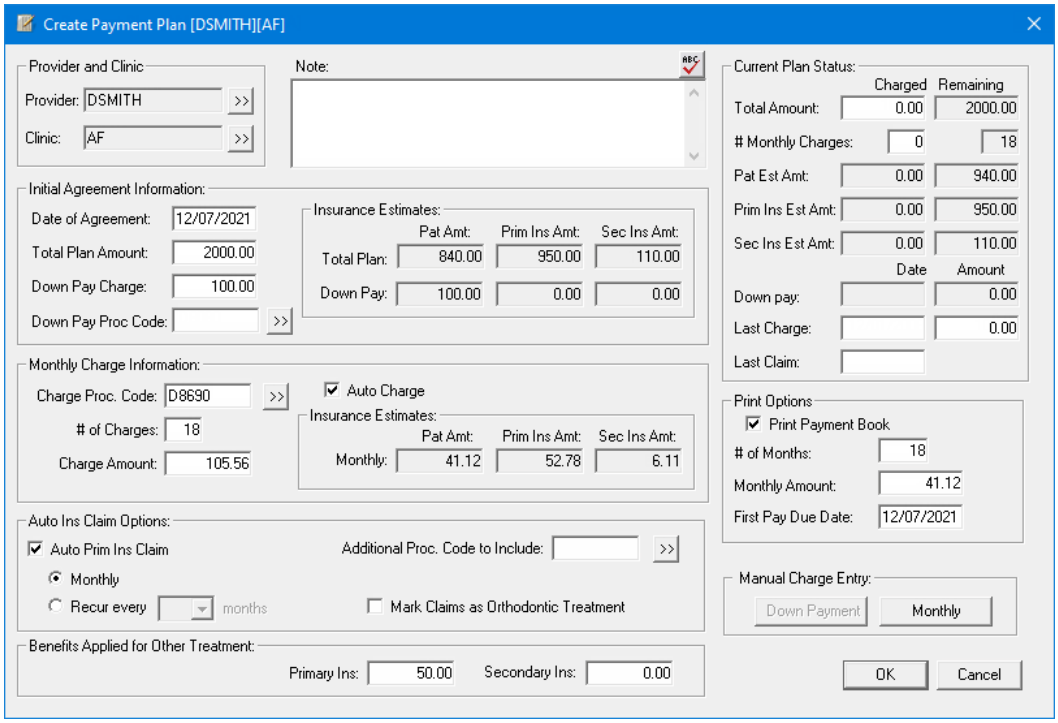
1. In Ledger, with a patient selected, from the **Transaction** menu, click **Process Future Due Payment Plan**.

   The **Select Payment Plan** dialog box appears and lists any previously created plans.



2. Click **New Plan**.

   The **Create Payment Plan** dialog box appears.



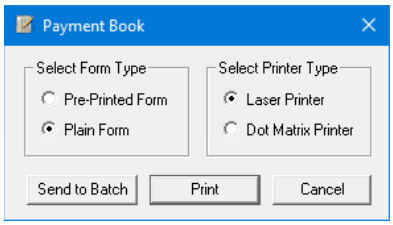
3. Set up the plan options:
   - **Provider and Clinic** – Dentrix Enterprise automatically displays the patient's primary **Provider** and the current **Clinic**. To change the provider and/or clinic, click the search buttons [>>], and then select the appropriate provider and/or clinic.
   - **Note** – Enter details or clarification for the payment plan in the **Note** box.
   - **Initial Agreement Information**
     - **Date of Agreement** – Dentrix Enterprise automatically inserts the current date as the date of the agreement. If necessary, you can change the date.
     - **Total Plan Amount** – Enter the total amount to be charged over time.
     - **Down Pay Charge** – If a down payment will be charged, enter the amount.
     - **Down Pay Proc Code** – Enter the procedure code for the down payment charge, or click the search button [>>] to select the code.
   - **Insurance Estimates** – Patient and insurance portions for the total amount and the down payment are displayed.
   - **Monthly Charge Information**
     - **Charge Proc Code** – Enter the procedure code, or click the search button [>>] to select the procedure code you want to use to post the monthly charge. If there is not an ADA code for the type of charge you need to post, you can create one. For details about procedure codes, see "Editing Procedure Codes" in Chapter 1: Introduction and Initial Setup.
     - **# of Charges** – Enter the **# of Charges** to have Dentrix Enterprise calculate the **Charge Amount**, or enter the **Charge Amount** to have Dentrix Enterprise calculate the **# of Charges**.
     - **Auto Charge** – To have a charge posted to the account automatically when updating future due payment plans each month, select this option. If this option is cleared, no charges will be posted to the account unless done manually.

- **Auto Ins Claim Options**
  - **Auto Pri Ins Claim** – To have a primary insurance claim generated, select this option. Next, select **Monthly** to have insurance claims created monthly when the charges are posted; or select **Recur every**, and then select the number of **months** to set a schedule for the insurance billing. Dentrix Enterprise will generate an insurance only if the specified number of months has elapsed since the last claim was generated for the future due payment plan.
  - **Additional Proc. Code to Include** – Enter an additional procedure code, or click the search button ›› to select a procedure code to include on the claim.
  - **Mark Claims as Orthodontic Treatment** – If the payment plan is being used for orthodontic work, select this option. When Dentrix Enterprise generates the automatic insurance claim, the orthodontic treatment information for the insurance claim information will be completed using the information entered for the payment plan.
- **Benefits Applied for Other Treatment** – The patient's used benefits for primary and secondary insurance before the payment plan is posted appear. The insurance estimates for the payment plan will be calculated using the amounts in the **Primary Ins** and **Secondary Ins** boxes. You can change these amounts if necessary.
- **Current Plan Status** – Information for the current payment plan appears, including remaining balance and number of monthly charges, patient and insurance estimates, date and amount of the down payment, date and amount of the last charge, and date of the last claim created for the payment plan. You can change the values of the total amount being charged and number of monthly charges, last amount charged and remaining, and date of the last claim.
- **Print Options** – To provide the patient with a payment or coupon book, select **Print Payment Book**. Next, enter the **# of Months** to print, the **Monthly Amount**, and the **First Pay Due Date**.
- **Manual Charge Entry** – If an amount has been entered in the **Down Pay Charge** box, to post a down payment charge, click **Down Payment**. In the **Down Payment Charge** dialog box, if necessary, edit the **Date**, and then click **Post Charge**.

4. Click **OK**.

   Tip: During your month-end processes, run the utility for processing the future due payment plans to post charges to individual accounts all at the same time as explained in "Processing Future Due Payment Plans" in this chapter.

5. If you had the option to print a payment book selected, the **Payment Book** dialog box appears. Click **Print** or **Send to Batch**.



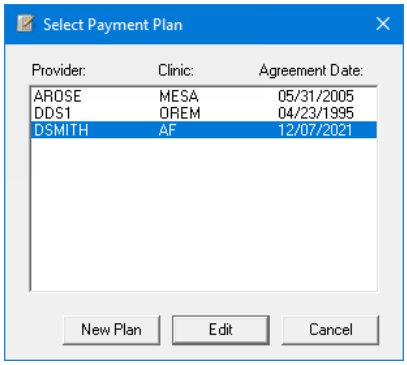
Posting Manual Charges to Future Due Payment Plans

At times it may be necessary to manually add a payment plan charge to a patient's Ledger.

To post a manual future due payment plan charge

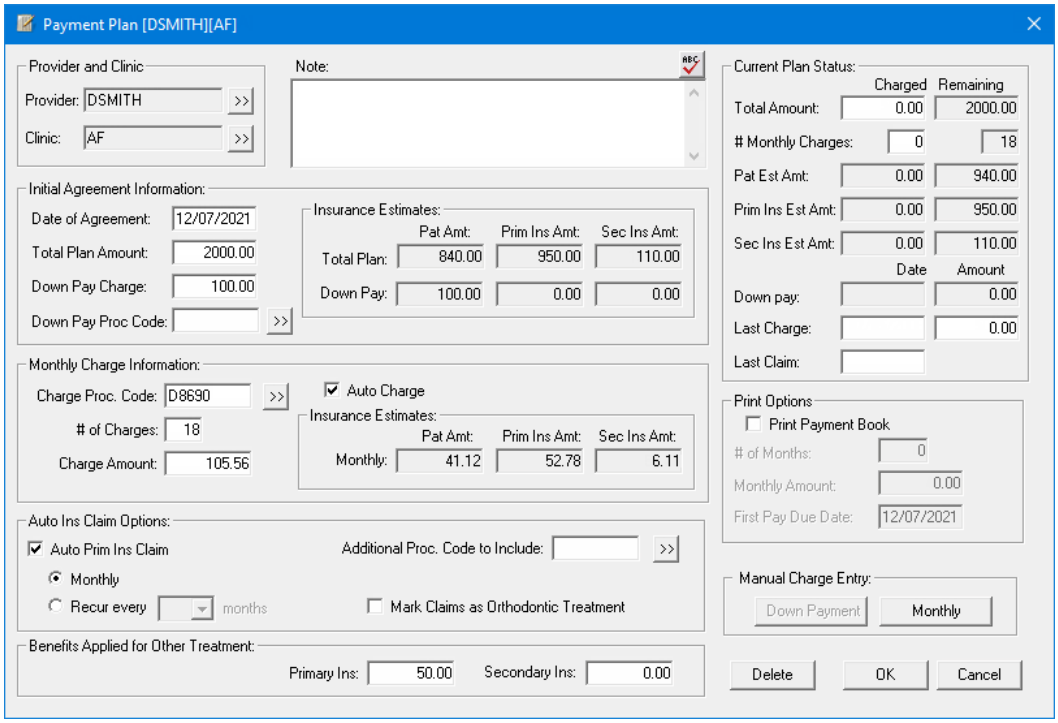
1. In Ledger, with a patient selected, from the **Transaction** menu, click **Process Future Due Payment Plan**.

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



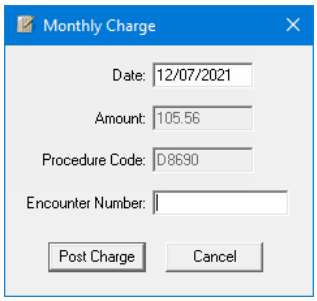
2. Double-click a payment plan.

   The **Payment Plan** dialog box appears.



3. Under **Manual Charge Entry**, click **Monthly**.

   The **Monthly Charge** dialog box appears.



4. If necessary, edit the **Date** of the transaction.
5. Click **Post Charge**.

Using the Suspended Credits Manager

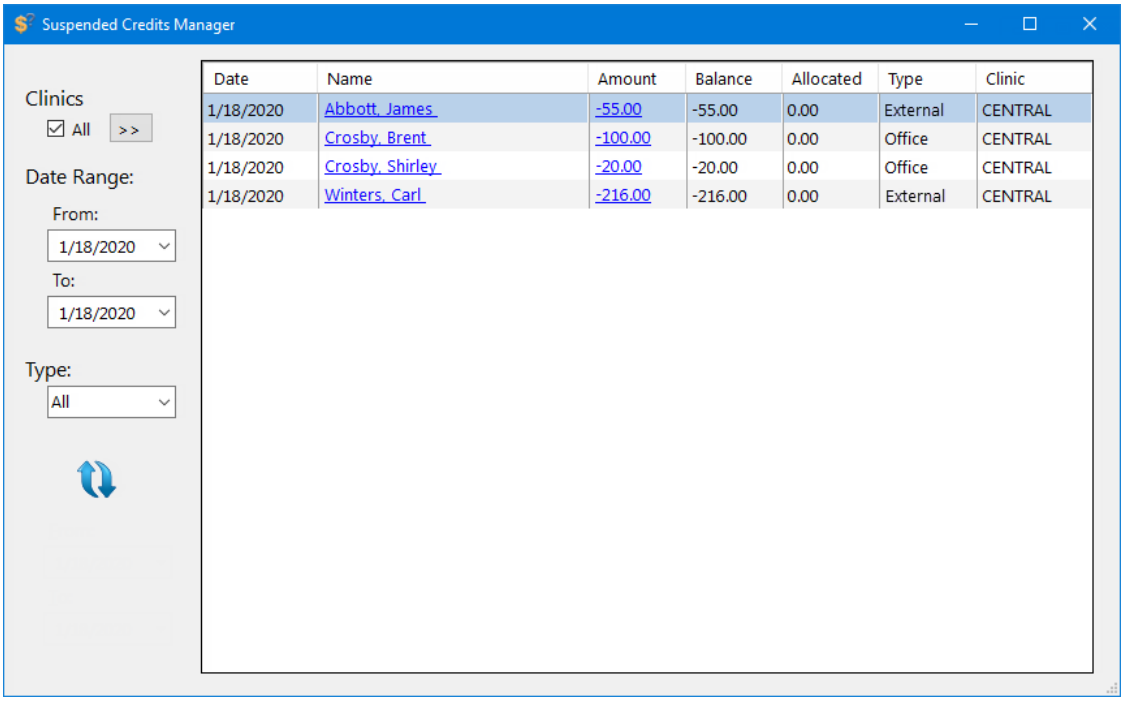
From the new **Suspended Credits Manager** window in Dentrix Enterprise, you can apply credits to charges without having to open each patient's Ledger one at a time. The Suspended Credits Manager makes it possible for you to manage suspended credits for all patients from a central area of Dentrix Enterprise.

Note: You can still apply suspended credits that are associated with a specific patient's account from that patient's Ledger without using the Suspended Credits Manager.

To apply suspended credits

1. In Office Manager or Ledger, click the **Suspended Credits Manager** button .

   The **Suspended Credits Manager** window opens.



2. Set up the following filters as needed to filter the list of payments that have suspended credits:
   - **Clinics** – Select the **All** check box to include payments for any collecting clinic, or click the search button >> to select the desired clinics. By default, only the clinic that you are currently logged in to is selected.
   - **Date Range** – Leave today's date selected to include only payments made today, or change the **From** and **To** dates to include payments within the specified date range.
   - **Type** – Select **All** to include payments entered in Dentrix Enterprise.
3. To apply the selected filters, or ensure that you have the most recent payments listed, click the **Refresh** button .
4. Click an **Amount** (which appears as a link) to open the corresponding payment and apply it to charges on the patient's or family's account.

Working with Notes in Ledger

Dentrix Enterprise can store important account and transaction information. The Ledger provides the following types of notes:

- Guarantor Notes
- Transaction Notes
- Procedure Notes

Guarantor Notes

Guarantor notes are attached to an account in Ledger but are also available in the Family File and Appointment Book. They consist of the following note types:

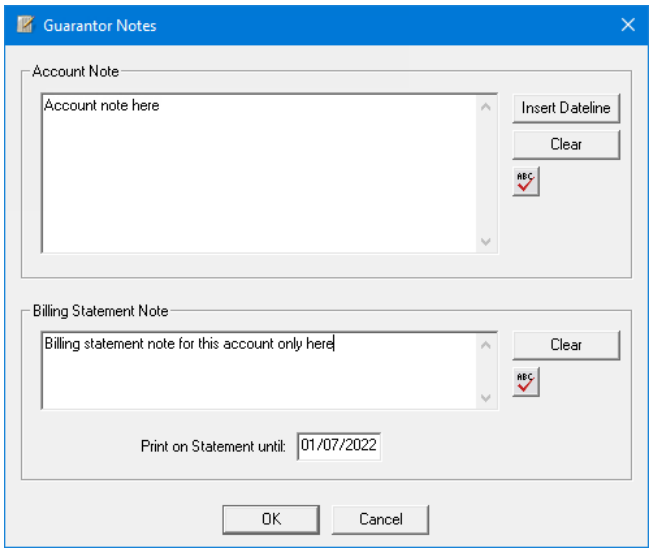
- **Account note** – This will usually contain information specific to the financial situation of an account.
- **Billing statement note** – This can contain account-specific information that prints automatically on an account's billing statement. This note can be anything from a payment reminder to a congratulations on a new baby.

Account Note

To add an account note

1. In Ledger, with a patient selected, click **Guarantor Notes** button .

   The **Guarantor Notes** dialog box appears.



2. Click **Insert Dateline** to insert the current date at the position of the text cursor to record when the note is being input.
3. In the **Account Note** box, enter any relevant account notes.
4. Click **OK**.

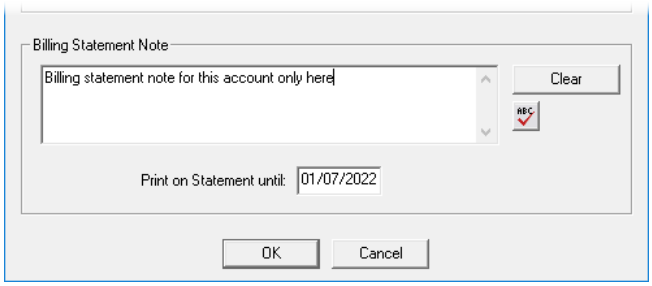
Note: Changes made in the **Guarantor Notes** dialog box affect the **Patient Finances** window, changes made in the **Patient Finances** window affect the **Guarantor Notes** dialog box.

Billing Statement Note

To add or clear a billing statement note

1. In Ledger, with a patient selected, click **Guarantor Notes** button .

   The **Guarantor Notes** dialog box appears.



2. In the **Billing Statement Note** box, enter a statement note. This note will be seen by patients, so grammar and spelling are important.
3. Many notes are only relevant for a certain length of time. To have Dentrix Enterprise clear a time-sensitive note, enter a **Print on Statement until** date. After the date entered passes, Dentrix Enterprise will no longer print the note on the account's statements. By default, the date is one month in the future.
4. Click **OK**.

Note: Changes made in the **Guarantor Notes** dialog box affect the **Patient Finances** window, changes made in the **Patient Finances** window affect the **Guarantor Notes** dialog box.

Transaction Notes

Each transaction type in Ledger includes a note box, allowing you to add clarification to any type of entry. You can enter notes while posting a transaction or editing an existing current transaction. For details about entering a note when adding a transaction, see "Entering Transactions" in this chapter.

To add a note to an existing transaction

1. In Ledger, with a patient selected, double-click a transaction.
2. In the edit or delete dialog box that appears, enter a **Note**, and then click **OK**.

Procedure Notes

With a procedure note, you can add clarification to a completed procedure. Ledger procedure notes are directly linked to the Patient Chart procedure notes and, consequently, are generally used to note clinical information about the procedure rather than financial data. For details about procedure notes, see the "Adding and editing ADA-CDT dental codes" topic in the Dentrix Enterprise Help.

Performing Month-end Routines

Dentrix Enterprise provides several utilities that you can run on a monthly basis to keep your accounts in good order.

Important: Before running any of these utilities, close all Dentrix Enterprise modules on all computers, create a backup of your Dentrix Enterprise database on the server, and then open Ledger on one computer and enable "single-user mode" (as explained in "Changing the Database Mode" in Chapter 8: Office Manager) to help avoid data corruption.

Tip: To view a list of users who are currently logged on to Dentrix Enterprise, in the Office Manager, from the **Maintenance** menu, click **Database User List**.

This section covers the following topics about month-end processes:

- Applying Finance Charges
- Applying Late Charges
- Processing Future Due Payment Plans
- Running the Month-end Update

Applying Finance Charges

Finance charges are applied to accounts with and without payment agreements at the same time. If Dentrix Enterprise determines that a finance charge should be assessed for an account with a payment agreement set up, it will refer to the payment agreement terms when assessing the charge.

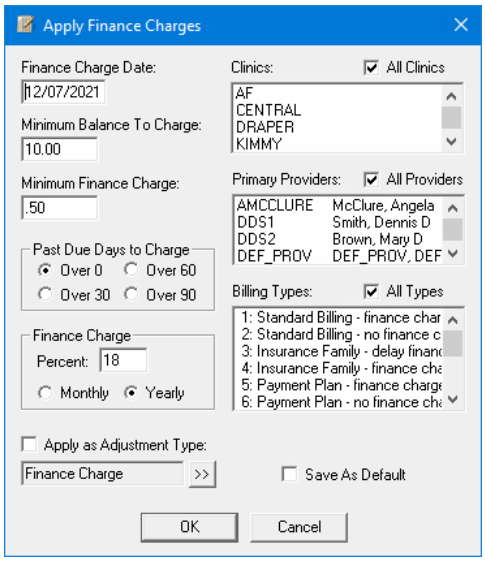
It is recommended that applying finance charges be done on a monthly basis. While you can run the utility at any time during the month, it is important to run it consistently and at approximately the same time each month.

For information about how to post a finance charge to an individual account manually, see "Posting Finance and Late Charges" in this chapter.

To apply finance charges

1. Close all Dentrix Enterprise modules on all computers before continuing.
2. From the server, back up of your Dentrix Enterprise database.
3. Open Ledger on one computer.
4. Switch to single-user mode from the Office Manager.
5. In Ledger, from the **Month End** menu, click **Finance Charge**.

The **Apply Finance Charges** dialog box appears.



6. Set up the following options:

- **Finance Charge Date** – Finance charges are calculated according to the aged balance for each family account as of the finance charge date. The **Finance Charge Date** is also used as the transaction date for each finance charge entry.
- **Minimum Balance to Charge** – The minimum balance will be compared to each aged account balance. Only those accounts with an aged balance greater than the minimum will have a finance charge applied.
- **Minimum Finance Charge** – The minimum finance charge will be charged to accounts when the calculated finance charge is less than the amount entered.
- **Past Due Days to Charge** – Finance charges will be calculated on the portion of each account balance that is past due according to the **Past Due Days to Charge** option selected and the aging of the account as of the **Finance Charge Date**. The **Past Due Days to Charge** defaults to **Over 0** days, assuming charges are due to be paid when they are incurred, but can be changed. If you do not want to charge finance charges to current accounts, you do not use **Over 0**.
- **Finance Charge** – The finance charge percent will be used to calculate the finance charge amount. Enter the **Percent to charge**, and then click **Monthly** or **Yearly**. Finance charges are always calculated on a monthly basis, so if the **Yearly** option is selected, the percentage entered will be divided by 12 months (for example, if 18% is entered as a yearly amount, Dentrix Enterprise will apply 1.5% to accounts each time you apply finance charges with this utility).
- **Apply as Adjustment Type** – If you want the finance charge to be posted as a charge adjustment, select this option, and then click the search button >> to select an adjustment type.
- **Clinics** – Select the clinics with patients to whom you want to apply finance charges, or select **All Clinics** to include all clinics.
- **Primary Providers** – Select the primary providers of patients to whom you want to apply finance charges, or select **All Providers** to include all primary providers.
- **Billing Types** – Select the billing types of patients to whom you want to apply finance charges, or select **All Types** to apply finance charges to all accounts regardless of billing type.

  Tip: If you do not want to charge finance charges to billing types that are labeled "No Finance Charges," you must clear **All Types** and then select only the billing types that should receive finance charges.

7. If you want to save the current settings for the next time you run this utility, select **Save as Default**.
8. Click **OK**. On the confirmation message that appears, click **OK**.

   Note: A progress bar appears and displays a count as each account is processed. You can click **Abort** if you need to stop applying finance charges, but any finance charges that have already been calculated before the button was clicked will still be applied (to delete those charges, you can print the Finance Charge Report from DXOne Reporting as a reference for when you go to each guarantor's Ledger that appears on the report to delete the charge).

9. Turn off single-user mode from the Office Manager.

Applying Late Charges

Late charges are applied to accounts with payment agreements that have failed to make a payment within the grace period of their payment due date. The utility can be run on a monthly basis.

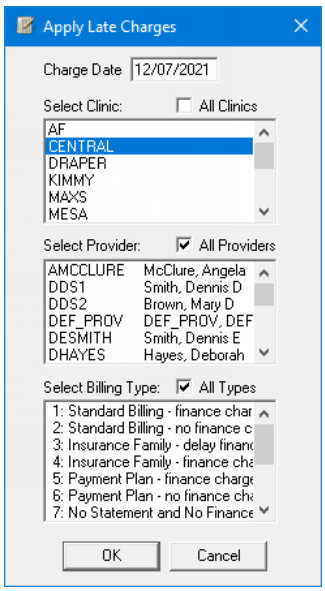
It is recommended that applying late charges be done on a monthly basis. While you can run the utility at any time during the month, it is important to run it consistently and at approximately the same time each month.

For information about how to apply late charges to an individual account manually, see "Posting Finance and Late Charges" in this chapter.

To apply late charges

1. Close all Dentrix Enterprise modules on all computers before continuing.
2. From the server, back up of your Dentrix Enterprise database.
3. Open Ledger on one computer.
4. Switch to single-user mode from the Office Manager.
5. In Ledger, from the **Month End** menu, click **Late Charge**.

   The **Apply Late Charges** dialog box appears.



6. Set up the following options:
   - **Charge Date** – The **Charge Date** is also used as the transaction date for each late charge entry.
   - **Select Clinic** – Select the clinics with patients to whom you want to apply late charges, or select **All Clinics** to include all clinics.

- **Primary Providers** – Select the primary providers of patients of patients to whom you want to apply late charges, or select **All Providers** to include all primary providers.
- **Billing Types** – Select the billing types of patients to whom you want to apply late charges, or select **All Types** to apply late charges to all accounts regardless of billing type.

  Tip: If you do not want to charge late charges to billing types that are labeled "No Finance Charges," you must clear **All Types** and then select only the billing types that should receive late charges.

7. Click **OK**. On the confirmation message that appears, click **OK**.

   Note: A progress bar appears and displays a count as each account is processed. You can click Abort if you need to stop applying late charges, but any late charges that have already been calculated before the button was clicked will still be applied (to delete those charges, you can print the Late Charge Report from DXOne Reporting as a reference for when you go to each guarantor's Ledger that appears on the report and delete the charge).

8. Turn off single-user mode from the Office Manager.

Processing Future Due Payment Plans

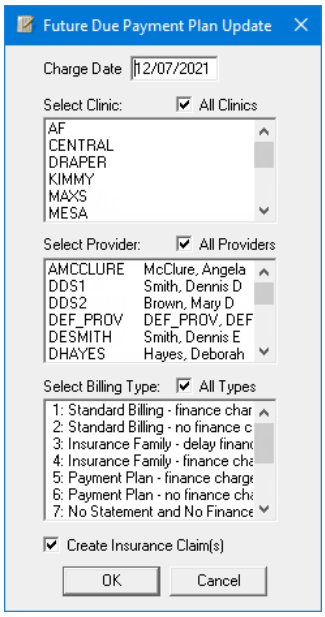
You can post charges due on all accounts with a future due payment plan. The utility should be run on a monthly basis.

While you can run the utility at any time during the month, it is important to run it consistently and at approximately the same time each month.

To process future due payment plans

1. Close all Dentrix Enterprise modules on all computers before continuing.
2. From the server, back up of your Dentrix Enterprise database.
3. Open Ledger on one computer.
4. Switch to single-user mode from the Office Manager.
5. In Ledger, from the **Month End** menu, click **Future Due Payment Plan**.

   The **Future Due Payment Plan Update** dialog box appears.



6. Set up the following options:
   - **Charge Date** – The **Charge Date** is also used as the transaction date for each payment plan charge entry.
   - **Select Clinic** – Select the clinics with patients to whom you want to apply payment plan charges, or select **All Clinics** to include all clinics.
   - **Primary Providers** – Select the primary providers of patients to whom you want to apply payment plan charges, or select **All Providers** to include all primary providers.
   - **Billing Types** – Select the billing types of patients to whom you want to apply payment plan charges, or select **All Types** to apply payment plan charges to all accounts regardless of billing type.
   - **Create Insurance Claims** – To have Dentrix Enterprise create insurance claims for the payment plan charges posted, select this option.
7. Click **OK**.
8. Turn off single-user mode from the Office Manager.

Running the Month-end Update

Running the month-end update is a crucial management routine. It is recommended that you perform this update each month. The month-end update completes many maintenance tasks important to getting accurate patient data quickly:

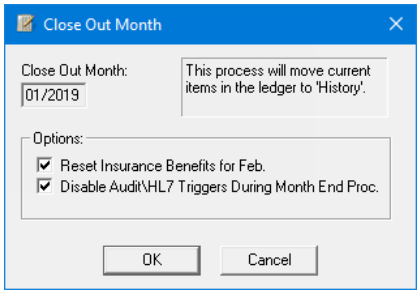
- **Aging account balances** – Close each month so that account balances will not remain current on your aging reports.
- **Moving procedures to history** – All procedures posted during the month being closed will be moved into history, locking out changes and deletions. This portion of the process is vital for providing solid documentation if faced with litigation.
- **Creating totals records** – To speed report generation, Dentrix Enterprise creates a monthly totals record each time a month is closed. Without this monthly record, Dentrix Enterprise must calculate analysis information each time a report is generated, which can greatly slow the report generation process.
- **Resetting insurance benefits (optional)** – For all patients who have dental insurance coverage that resets during the month being updated, the benefits used and deductible applied amounts will be reset.

You cannot close out the current month. You must wait until the first day of the next month before Dentrix Enterprise will allow you to close out that month (for example, you cannot close out the month of June until the first day of July).

To run the month-end update

1. Close all Dentrix Enterprise modules on all computers before continuing.
2. From the server, back up of your Dentrix Enterprise database.
3. Open Ledger on one computer.
4. Switch to single-user mode from the Office Manager.
5. In Ledger, from the **Month End** menu, click **Update**.

   The **Close Out Month** dialog box appears.



   Dentrix Enterprise requires that months be closed out in chronological order. Dentrix Enterprise will display the correct month to be closed out in the **Close Out Month** box. You cannot edit this date.
6. To have Dentrix Enterprise reset all dental insurance plans whose benefit renewal month is the month following the **Close Out Month**, select **Reset Insurance Benefits for [month]**.
7. To speed up the month end process, select **Disable Audit Triggers During Month End Proc**.

8. Click **OK**.

   Note: The amount of time required to run the update depends on many factors, including the processor speed of your server. However, a very important factor in the speed of the utility is the amount of information already in history. If you wait to close out the month, leaving two to three months current at a time, the update has more data to process and will take more time to run. Running the update monthly will reduce the time required considerably, as Dentrix Enterprise has less data to sort through.

9. Turn off single-user mode from the Office Manager.

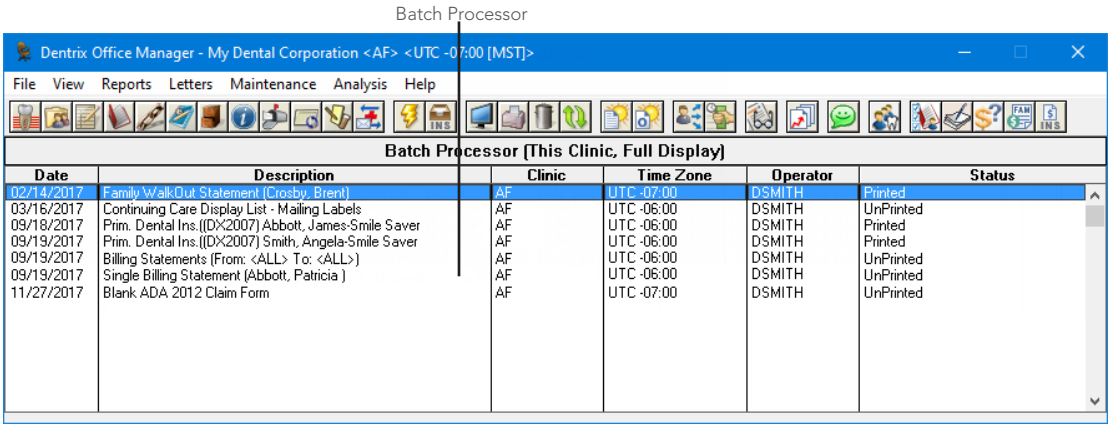
Chapter 8: Office Manager

The Dentrix Enterprise Office Manager provides powerful tools to enhance the management processes of your practice. This chapter covers the following topics:

- The Office Manager Window
- Changing Fee Schedules Automatically
- Changing the Database Mode
- Maintaining Employers
- Maintaining Insurance Carriers
- Analyzing Referrals
- Purging Appointments
- Purging Dental Insurance Benefits Used
- Generating Office Manager Reports
- Generating Billing Statements
- Printing Blank ADA Claim Forms
- Creating Letters
- Creating a Batch of Primary Insurance Claims
- Submitting Electronic Claims
- Sending Statements with QuickBill
- Signing Mulitple Clincal Notes
- Using the Document Center Audit Documents Utility
- Using the Clinical Note Review Dashboard
- Dynamic Reporting

The Office Manager Window

The **Office Manager** window consists of a menu bar, toolbar, and Batch Processor.



This section covers the following topics to help you understand how to use the **Office Manager** window:

- The Office Manager Toolbar
- The Batch Processor
- Previewing Reports
- Printing Reports
- Deleting Reports

The Office Manager Toolbar

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

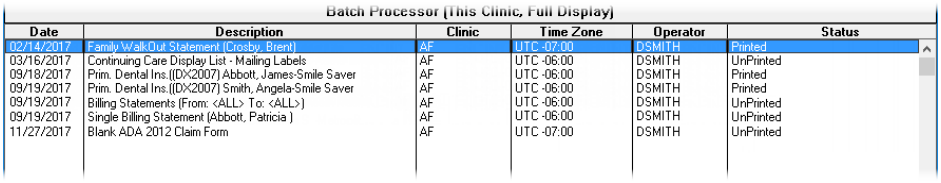


The function of the buttons specific to Office Manager are explained in the following table.

	Click the **Electronic Billing Submission** button to send billing statements and/or a batch of billing statements to a clearinghouse to have them mailed for you.
	Click the **Electronic Claim Submission** button to submit dental and/or medical insurance claims electronically.
	Click the **Create Batch Primary Ins Claims** button to generate multiple claims for procedures posted within a specified date range
	Click the **Print Preview** button to display the report selected in the Batch Processor.
	Click the **Print Report(s)** button to send the reports selected in the Batch Processor to the printer set up for use in Office Manager.
	Click the **Delete Report(s)** button to delete all or certain reports.
	Click the **Refresh/Clear Selection** button to deselect any reports that are selected in the Batch Processor.
	Click the **Day Sheet Report** button to generate a day sheet.
	Click the **Operator Day Sheet Report** button to send the operator day sheet to the Batch Processor.
	Click the **Referral Analysis** button to monitor referrals or enter gratuities.
	Click the **Collections Manager** button to view and manage collections information to help you as you contact patients regarding their accounts.
	Click the **DXOne Reports** button to generate and manage reports.
	Click the **Dynamic Reporting Interface** button to open Dynamic Reporting to view an interactive, dynamic reporting dashboard.

The Batch Processor

The Batch Processor is a report management tool that allows you to print and/or preview reports generated and sent to the Batch Processor.



Date	Description	Clinic	Time Zone	Operator	Status
02/14/2017	Family WalkOut Statement (Crosby, Brent)	AF	UTC -07:00	DSMITH	Printed
03/16/2017	Continuing Care Display List - Mailing Labels	AF	UTC -06:00	DSMITH	UnPrinted
09/18/2017	Prim. Dental Ins.([DX2007) Abbott, James-Smile Saver	AF	UTC -06:00	DSMITH	Printed
09/19/2017	Prim. Dental Ins.([DX2007) Smith, Angela-Smile Saver	AF	UTC -06:00	DSMITH	Printed
09/19/2017	Billing Statements (From: <ALL> To: <ALL>)	AF	UTC -06:00	DSMITH	UnPrinted
09/19/2017	Single Billing Statement (Abbott, Patricia)	AF	UTC -06:00	DSMITH	UnPrinted
11/27/2017	Blank ADA 2012 Claim Form	AF	UTC -07:00	DSMITH	UnPrinted

For each report listed, the Batch Processor displays the date the report was generated, a brief description of the report, and a status that indicates if the report has been printed, displayed, or sent (for claims and pre-estimates).

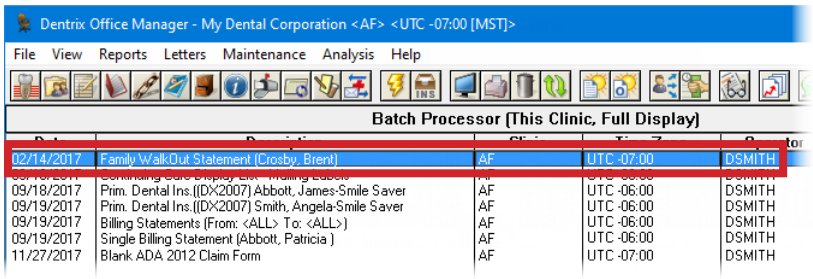
Tip: Since the Batch Processor can easily become crowded with reports from every clinic, you can specify the reports you want to have displayed in the Batch Processor and the sort order of those reports. For informationabout setting up the view of the Batch Processor, see the "Setting up the Office Manager view" topic in the Dentrix Enterprise Help.

Previewing Reports

You can preview a report before printing it. You can preview one or two pages at a time, zoom out to see more of the page, zoom in to see more detail, and easily navigate between reports and pages of the current report. While you are previewing a report, the report appears in a format as close to the printed report as possible.

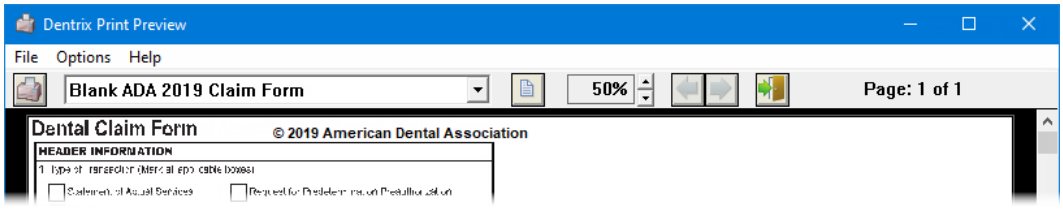
To preview a report

1. In Office Manager, from the Batch Processor, select the reports you want to preview.



2. From the **File** menu, click **Print Preview**.

   The **Print Preview** window appears.



3. Do any of the following for the report you are previewing:
   - **Print Report** –To print the report being displayed or all reports in the preview session, from the **File** menu, click **Print Report**.
   - **Report Title** – Select a report from the list to view that report (if you are previewing multiple reports).

- **View One Page / Two Page** – To switch between viewing one or two pages (displayed side by side), from the **Options** menu, click **View One Page** or **View Two Pages**.
- **Zoom** – To increase or decrease the zoom percentage (from 10% to 200%), from the **Options** menu, point to **Zoom**, and then click the appropriate percentage.
- **Previous / Next Page** – To advance to the next page in a multi-page report, click the right arrow button. To go to a previous page of a multi-page report, click the left arrow button.

4. To close the Print Preview window, from the **File** menu, click **Exit**.

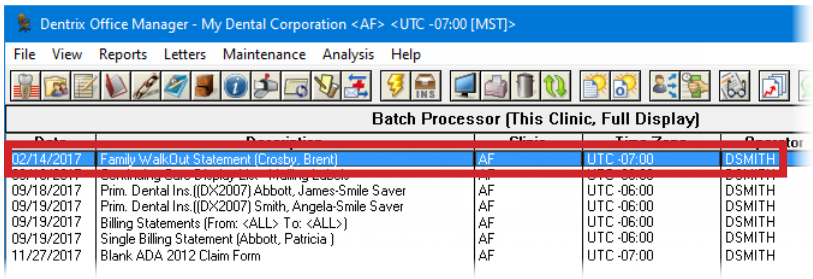
Printing Reports

If you do not want to preview a report, you can send it directly to the Office Manager printer.

Tip : To print certain pages of a report or to print more than one copy of a report, you must print that report from the Print Preview window so that you can enter the page range and the number of copies.

To print a report from the Batch Processor

1. In Office Manager, from the Batch Processor, select the reports that you want to print.



Tips:

- To select multiple reports, while pressing the Ctrl key, click each report.
- To deselect a report in the Batch Processor, from the **File** menu, click **Clear**; or select a different report.

2. With reports selected, from the **File** menu, click **Print**. Dentrix Enterprise sends the report to the printer set up for Office Manager.

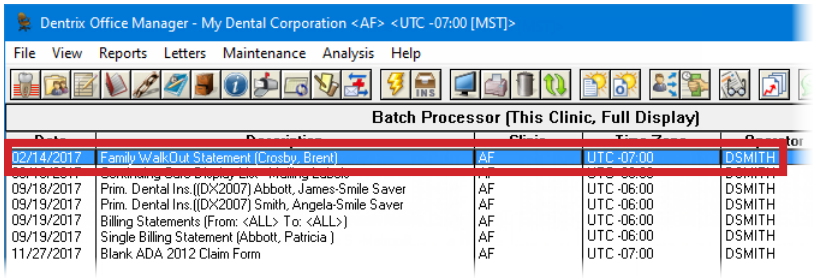
Deleting Reports

You can delete any report from the Batch Processor that is not being previewed.

Note: Do not try to delete a report that is currently being previewed. A report being previewed may have "Displayed" or "Schd" (followed by a number) in the **Status** column.

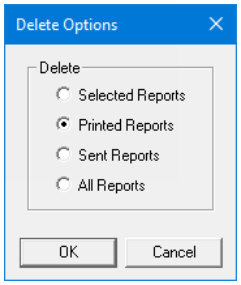
To delete a report from the Batch Processor

1. In Office Manager, from the Batch Processor, select the reports that you want to delete.



2. From the **File** menu, click **Delete**.

   The **Delete Options** dialog box appears.



3. Select one of the following options:
   - **Selected Reports** – To delete the reports selected in the Batch Processor
   - **Printed Reports** – To delete all printed and displayed reports listed in the Batch Processor
   - **Sent Reports** – To delete all sent claims listed in the Batch Processor (used with electronic claims)
   - **All Reports** – To delete all reports listed in the Batch Processor
4. Click **OK**.

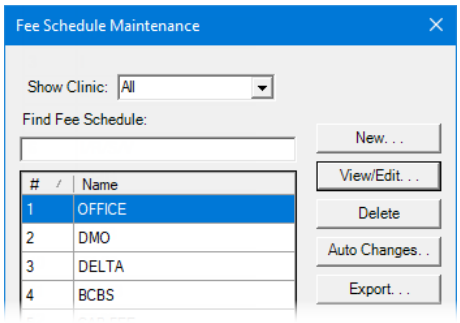
Changing Fee Schedules Automatically

When you are logged in to the Central clinic, you can make changes to an entire fee schedule, or specific segments of a fee schedule, without having to manually enter each amount for a procedure.

To make automatic fee schedule changes

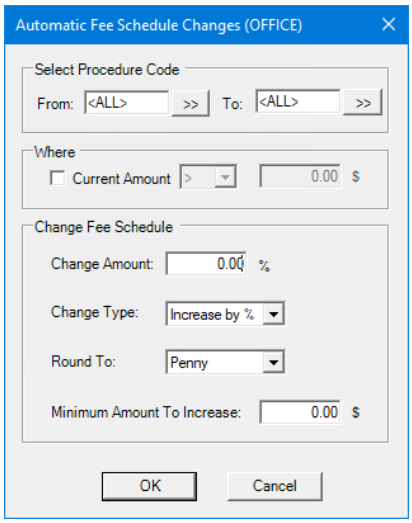
1. In Office Manager, from the **Maintenance** menu, point to **Practice Setup**, and then click **Fee Schedule Maintenance**. (This option is available only if you are logged in to the Central clinic.)

   The **Fee Schedule Maintenance** dialog box appears.



2. Select the fee schedule that you want to update.
3. Click **Auto Changes**.

   The **Automatic Fee Schedule Changes** dialog box appears.

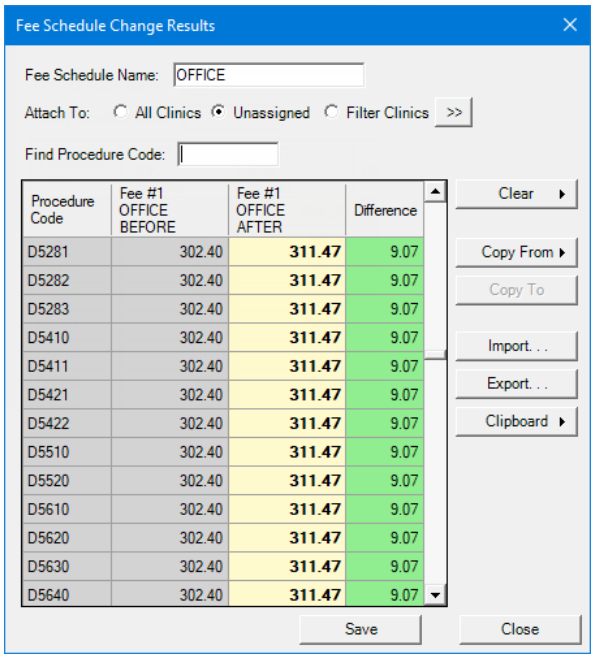


4. To select the procedure code range for which you want to change the fee schedule, under **Select ProcedureCode**, click the **From** and **To** search buttons >> to select the first and last procedure code in the desired range. Or, leave **From** <ALL> **To** <ALL> selected to include all procedures.
5. To specify a condition that a procedure's fee must meet for that procedure to get updated, under **Where**, select the **Current Amount** check box. Select greater than (**>**), greater than or equal to (**>=**), less than (**<**), less than or equal to (**<=**), or equals (**=**). Enter the amount (**$**).
6. Under **Change Fee Schedule**, set up the following options:
   - **Change Amount** – Enter how much you want to increase or decrease the fee by (depending on the **Change Type** selection, this is a dollar amount ($) or a percentage (%).
   - **Change Type** – Select how you want to increase or decrease the fees: **Increase by %**, **Increase by $**, **Decrease by %**, or **Decrease by $**.

- **Round To** – Select whether you want to round the new fees to the nearest **Dollar**, **Dime**, or **Penny** (the default selection is controlled by a Central clinic setting).
- **Minimum Amount To Increase** – Enter the minimum amount required for a fee in the fee schedule to be changed.

7. Click **OK**.

   Once Dentrix Enterprise has processed the changes, it will display the entire fee schedule for you to review in the **Fee Schedule Change Results** dialog box.



8. Do any of the following:

   - To change a procedure code's amount (as displayed in the **BEFORE** column), click that procedure code's fee in the **AFTER** column, and then enter the new amount. The background color of the **AFTER** cell changes to yellow, and the **Difference** between the original and the new fee appears with a green background (for an increase) or a red background (for a decrease). Repeat this process as needed to change other amounts.

     Tip: To help you quickly find a procedure code, begin typing a procedure code in the **Find Procedure Code** box. The first matching code is selected.

   - To replace all the amounts in this fee schedule with those from another fee schedule, click **Copy From**, and then search for and select the desired fee schedule.
   - To replace amounts in this fee schedule with those from a .csv, .xls, or .xlsx file, click **Import**, and then search for and select the desired file.
   - To change all amounts to zeros, click **Clear**, click **Clear only the fee amounts**, and then click **Yes**.
   - To change all amounts to zeros and clear the **Fee Schedule Name** box, click **Clear**, click **Clear only the fee amounts**, and then click **Yes**.
   - To copy the data (procedure codes, before amounts, after amounts, and differences) as text to the Windows Clipboard, click **Clipboard**, and then click **Copy to Clipboard - tab delimited** or **Copy to Clipboard - comma delimited**. You can paste the Clipboard contents into another program.

     Tip: You can use the contents of a copied fee schedule comparison to create a .csv, .xls, or .xlsx file that you can import into Dentrix Enterprise to create a new fee schedule.

- To export the data (procedure codes, before amounts, after amounts, and differences) as text to a comma-delimited or tab-delimited file, click **Export** to specify a name, a file type (.csv or .txt), and a location for the .csv or .txt file.

  Tip: You can use the contents of an exported fee schedule comparison to create a .csv, .xls, or .xlsx file that you can import into Dentrix Enterprise to create a new fee schedule.

9. Click **Save**.

Changing the Database Mode

You can turn on single-user mode for operations that require that Dentrix Enterprise be closed on all but one computer. After those operations have been completed, you must turn off single-user mode.

To turn on singe-user mode

In Office Manager, from the **Maintenance** menu, point to **Practice Setup** > **Database Mode Setup**, and then click **Enable Single User Mode**. On the confirmation message that appears, click **Yes**.

To turn off single-user mode

In Office Manager, from the **Maintenance** menu, point to **Practice Setup** > **Database Mode Setup**, and then click **Disable Single User Mode**. On the confirmation message that appears, click **Yes**.

Maintaining Employers

With the Employer Maintenance utility, you can add, edit, and delete employers without selecting a patient. Additionally, you can join and purge duplicate employers. For information about adding and editing employers from Office Manager, see the "Adding and editing employers" topic in the Dentrix Enterprise Help.

This section covers the following topics about employers:

- Joining Employers
- Purging Employers

Joining Employers

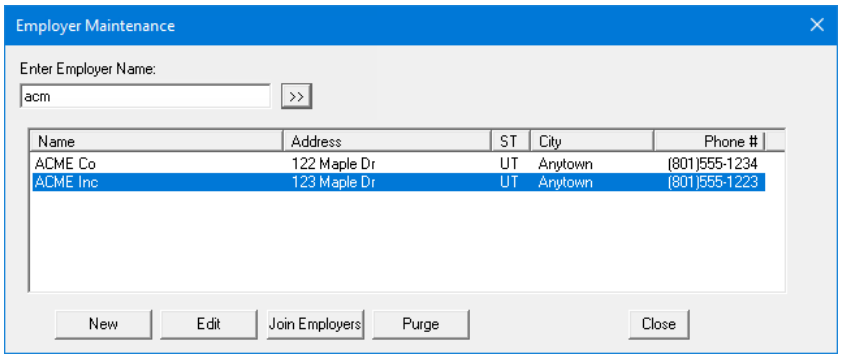
You can combine duplicate employers.

Tip: You do not need to enable single-user mode when running this utility, but run it outside of peak office times.

To join employers

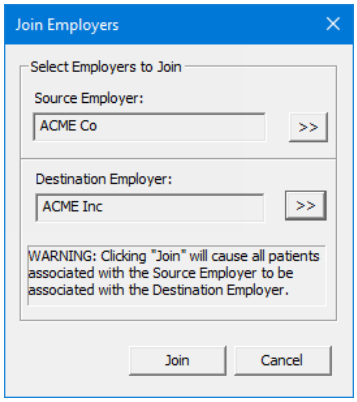
1. In Office Manager, from the **Maintenance** menu, point to **Reference**, and then click **Employer Maintenance**.

   The **Employer Maintenance** dialog box appears.



2. Click **Join Employers**.

   The **Join Employers** dialog box appears.



3. Click the **Source Employer** search button >> to select the employer that you want to merge into another.
4. Click the **Destination Employer** search button >> to select the employer that you want the source employer to be changed to.

5. Click **Join**. On the confirmation message that appears, click **Yes**. Then, another message appears and states that the employers have been joined, so click **OK**.

   The source employer is now the destination employer. All patients with the source employer now have the destination employer attached to their records in the Family File.

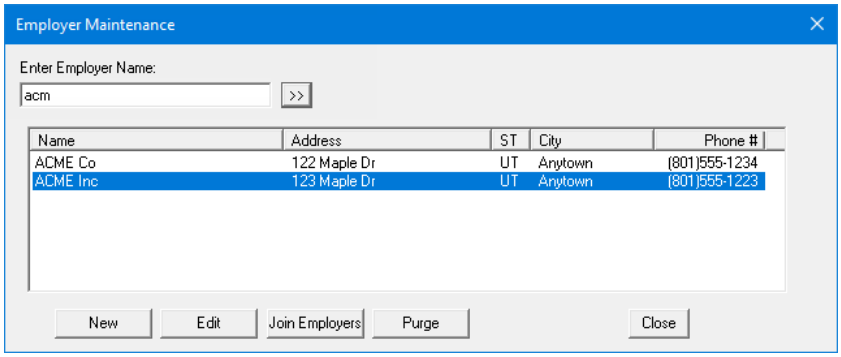
Purging Employers

You can purge employers from Dentrix Enterprise that are no longer attached to any patients.

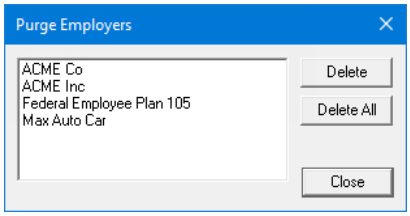
To purge an employer

1. In Office Manager, from the **Maintenance** menu, point to **Reference**, and then click **Employer Maintenance**.

   The **Employer Maintenance** dialog box appears.



2. Click **Purge**. The **Purge Employers** dialog box appears and lists all employers that are not attached to any patients.



   Tip: If an employer you want to delete is not listed, the employer is attached to at least one patient. You must clear that employer from those patients in the Family File before it can be deleted. To find patients with a certain employer, print the Employers and Employed Patients Report for that employer from the DXOne Reporting module. For information about this report, see "Reference Reports" in Chapter 9: DXOne Reporting.

3. To delete all employers listed, click **Delete All**; or, to delete a certain employer, select that employer, and then click **Delete**.
4. Click **Close**.

Maintaining Insurance Carriers

With the Insurance Maintenance utility, you can add, edit, and delete insurance plans without selecting a patient. Additionally, you can join and purge duplicate insurance plans. For information about adding and editing insurance plans from Office Manager, see the "Adding and editing insurance plans" topic in the Dentrix Enterprise Help.

This section covers the following topics about insurance:

- Joining Insurance Plans
- Purging Insurance Plans

Joining Insurance Plans

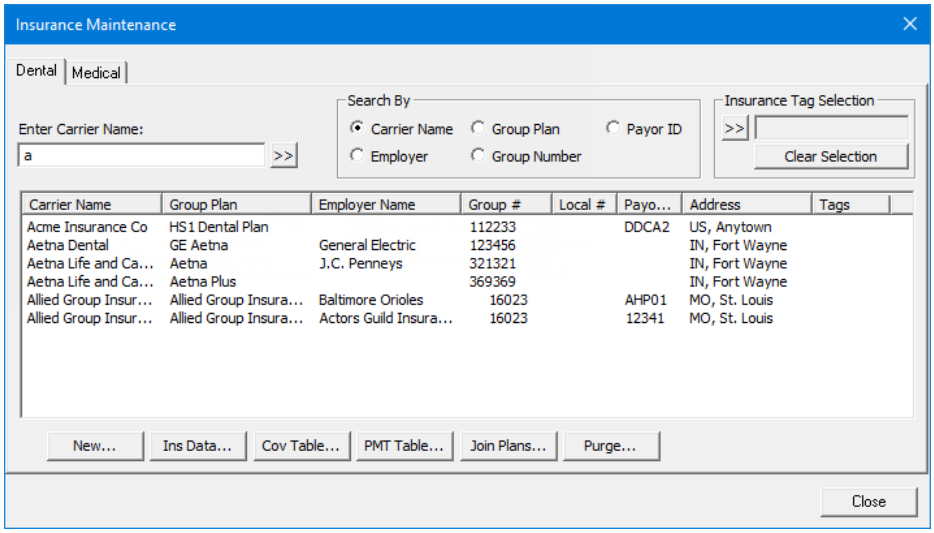
You can combine duplicate insurance plans without moving subscribers one by one to another plan. Joining plans does not delete the old, unused insurance plan; it only moves the subscribers to a new plan so that the old plan can be purged.

Tip: It is not necessary to be in single-user mode when joining insurance plans, but do not use this utility during peak office times.

To join insurance plans

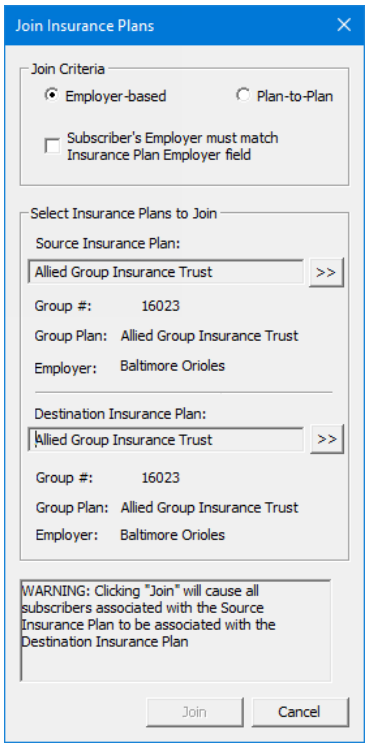
1. In Office Manager, from the **Maintenance** menu, point to **Reference**, and then click **Insurance Maintenance**.

   The **Insurance Maintenance** dialog box appears.



2. Click **Join Plans**.

The **Join Insurance Plans** dialog box appears.



3. Select one of the following join criteria:
   - **Employer-based** – To move all subscribers attached to one particular insurance plan linked to a specific employer to another insurance plan that is linked to the same employer. Then, select the **Subscriber's Employer must match Insurance Plan Employer Field** check box if you want to move only subscribers who are assigned the same employer in the Family File.
   - **Plan-to-Plan** – To join insurance plans regardless of employers.
4. Click the **Source Insurance Plan** search button >> to select the plan you want to join with another.
5. Click the **Destination Insurance Plan** search button >> to select the plan you want the **Source Insurance Plan** to be transferred to.
6. Click **Join**. On the confirmation message that appears, click **OK**. Then, another message appears and states that the plans have been joined, so click **OK**.

   The source plan is now the destination plan. All patients with the source plan now have the destination plan attached to their records in the Family File.

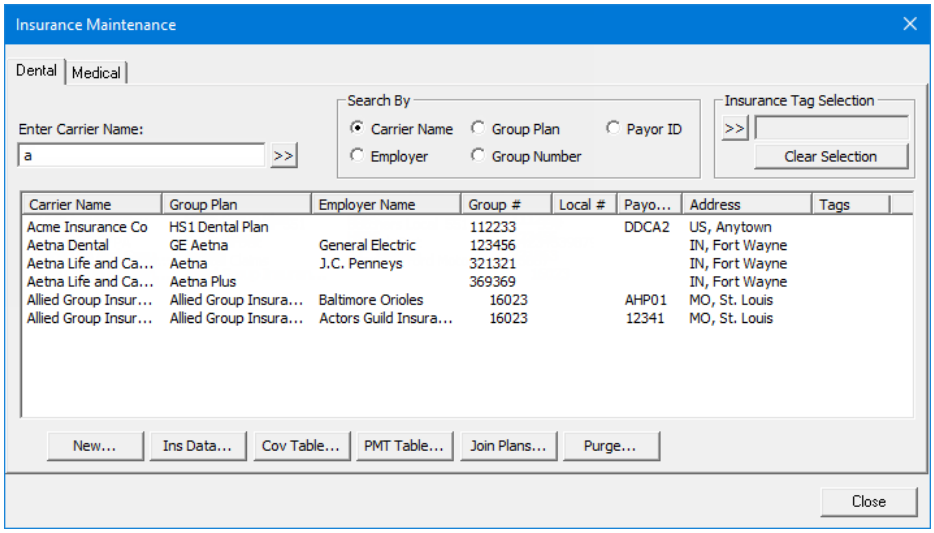
Purging Insurance Plans

You can purge insurance plans from Dentrix Enterprise that are not attached to any outstanding insurance claims.

To purge an insurance plan

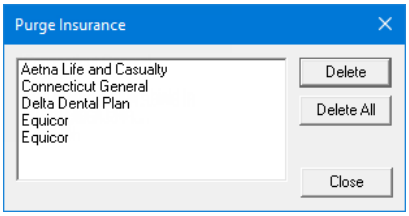
1. In Office Manager, from the **Maintenance** menu, point to **Reference**, and then click **Insurance Maintenance**.

   The **Insurance Maintenance** dialog box appears.



2. Click **Purge**.

   The **Purge Insurance** dialog box appears.



   Tip: If an insurance plan you want to delete is not listed, the plan is attached to at least one outstanding claim. Those claims must be paid before the plan can be deleted. To find outstanding claims for a certain carrier, print the Insurance Claim Aging Report for that carrier from the DXOne Reporting module. For information about this report, see "Ledger Reports" in Chapter 9: DXOne Reporting.

3. To delete all insurance plans listed, click **Delete All**; or, to delete a certain plan, select that plan, and then click **Delete**. On the confirmation message that appears, click **OK**.
4. Click **Close**.

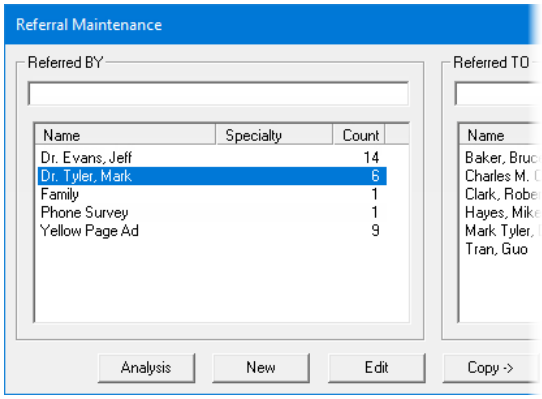
Analyzing Referrals

You can use the Dentrix Enterprise analysis tool to view referral production and manage gratuities.

To analyze the production of a referral source

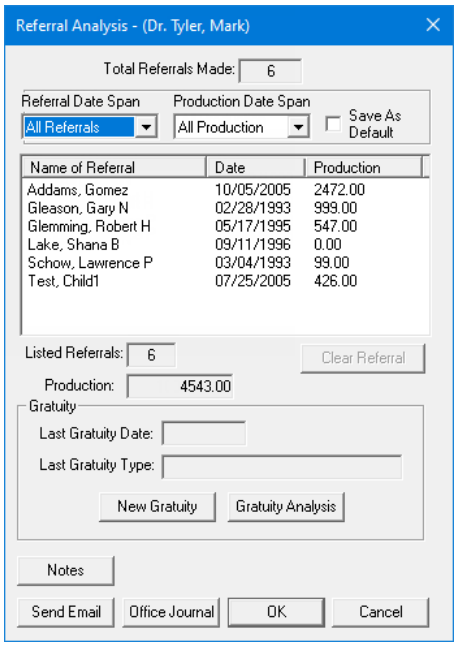
1. In Office Manager, from the **Maintenance** menu, point to **Reference**, and then click **Referral Maintenance**.

   The **Referral Maintenance** dialog box appears.



2. Select the referral you want to analyze.
3. Click **Analysis**.

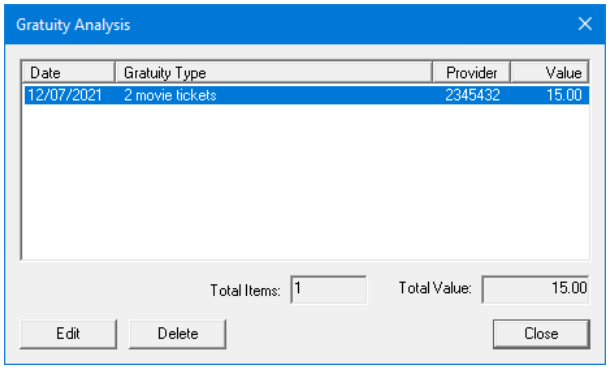
   The **Referral Analysis** dialog box appears. The dialog box lists the number of **Total Referrals Made** to/by this referral source.



4. Set up the following options:
   - **Referral Date Span** – From the list, select a date span. All patients who have been referred to/by the referral source within the date span appear in the list box.
   - **Production Date Span** – For referral sources only, from the list, select a date span. The production for the specified date span of each referral appears in the **Production** column of the list box. Also, the total production generated by the listed referrals for the production date span appears in the **Production** box.
5. To enter a gratuity given to a referral source, click **New Gratuity**. In the **New Gratuity** dialog box, enter the date the gratuity was given and the amount of the gratuity, select the type of gratuity sent, and then click **OK**.

   Tips:
   - To add a new gratuity type in the **New Gratuity** dialog box, from the **Type** list, select "<Add Gratuity Type>," enter a new type and amount, and then click **Add**.
   - To record the gratuity in each referred patient's Office Journal, in the **New Gratuity** dialog box, select **Add Journal**, and then click the **Provider** search button >> to select the provider for whom you also want to record the Office Journal entries.
6. To view an analysis of the gratuities given to a referral, click **Gratuity Analysis**.

   The **Gratuity Analysis** dialog box appears. This dialog box lists all gratuities and the total value of each.



7. Click **Close** to return to the **Referral Analysis** dialog box.
8. Click **OK**.

Purging Appointments

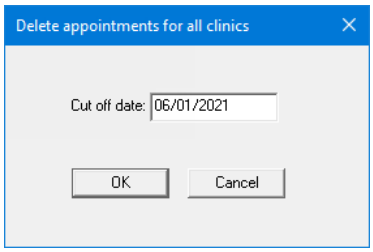
If you are logged in to the Central clinic, you can purge appointments in the Appointment Book before a certain date for all clinics.

Tip: You can purge appointments for only the clinic you are logged in to from the Appointment Book.

To purge appointments

1. In Office Manager, from the **Maintenance** menu, point to **Reference**, and then click **Purge Appointment**.

   The **Delete Appointments for All Clinics** dialog box appears.



2. Enter a **Cut off date**. All appointments in all clinics prior the date entered will be purged.
3. Click **OK**. On the confirmation message that appears, click **OK**.

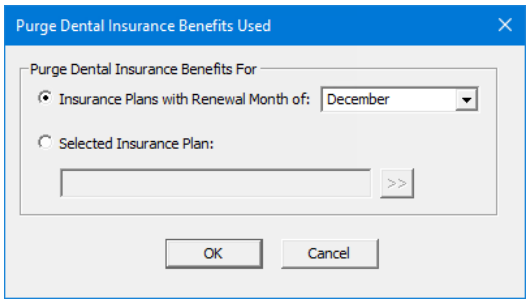
Purging Dental Insurance Benefits Used

With the Purge Insurance Benefits Used utility, you can selectively zero out insurance coverage benefits used. Purging used benefits will clear all of the current year's benefits for the insurance plans that have the previous year's benefits cleared.

To purge used insurance benefits

1. In Office Manager, from the **Maintenance** menu, point to **Reference**, and then click **Purge Dental Ins Benefits Used**.

   The **Purge Dental Insurance Benefits Used** dialog box appears.



2. Select one of the following options:
   - **Insurance Plans with Renewal Month of**– To clear used benefits (reset them to $0) for insurance plans with benefits that renew on a specific month, select this option, and then select the appropriate month from the list.
   - **Selected Insurance Plan** – To clear used benefits from a specific insurance plan, select this option, and then click the search button >> to select the appropriate insurance plan.
3. Click **OK**.

   Tip: During the month-end update, Dentrix Enterprise will automatically purge benefits used for those insurance companies that renew their benefits the next calendar month.

Generating Office Manager Reports

Dentrix Enterprise provides many reports that you can use to gather information from your database. While some reports can be printed from the Ledger, the Patient Chart, the Appointment Book, the Family File, or DXOne Reporting, Office Manager has the following categories of reports you can generate:

- Reference reports
- Management reports
- Billing statements
- Ledger reports
- List reports
- Blank ADA claim forms

All reports you generate from Office Manager will appear in the Batch Processor.

For a comprehensive explanation of all the options for running these reports, see the "Generating Office Manager reports" topic and its subtopics in the Dentrix Enterprise Help. Also, to see samples of and read an explanation of what appears on each report, refer to the *Dentrix Enterprise Reports Reference*.

Reference Reports

In Office Manager, from the **Reports** menu, point to **Reference**, and then click a reference report option:

- **Procedure Code List** – The Procedure Code List is a list of procedure codes, including the procedure code number, description, abbreviated procedure codes, time allotted for each procedure, appointment type, paint type, and treatment area.
- **Dental Diagnostic Code List** – The Dental Diagnostic Code List is a list of all dental diagnostic codes that have been entered.
- **Multi Code List** – The Multi-Code List is a list of all multi-codes or a range of multi-codes.
- **Standard Coverage Table Report** – The Standard Coverage Tables Report lists the coverage tables that are set up in Office Manager. The report includes the coverage percentage, co-payment, and pre-authorization flag for each range of procedures.
- **Insurance Coverage Tables Report** – The Insurance Coverage Tables Report lists the coverage tables that have been set up for each selected insurance plan.
- **Updated Dental Insurance Payment Tables Report** – The Updated Dental Insurance Payment Tables Report lists all procedures and the covered dollar amount for procedures listed in the payment table for the selected dental insurance carriers.
- **Custom Practice Information Report** – The Custom Practice Information Report lists information that can be customized in Practice Definitions: billing types, payment types, adjustment types, custom notes, medical alerts, appointment status types, and appointment check list.
- **Registration Information Report** – The Registration Information Report lists the practice information and serial number of your Dentrix Enterprise software.

Management Reports

In Office Manager, from the **Reports** menu, point to **Management**, and then click a management report option:

- **Day sheet (charges and receipts)** – The day sheet is a report designed to help you keep track of your daily production and collection figures. It lists all transactions posted during the day (or date range specified) including procedures, payments, adjustments, and finance charges. The day sheet can be customized to include or exclude specified information, and can be printed in a variety of formats.

Ledger Reports

In Office Manager, from the **Reports** menu, point to **Ledger**, and then click a ledger report option:

- **Family Ledger Report** – The Family Ledger report includes all transactions for all patients in the family posted since the beginning date specified. The date of treatment, tooth number, description, patient, charges, payments and a running balance are included on the report. Depending on report settings, the current balance of each patient in the family is also displayed on the report.
- **Patient's Ledger Report** – The Patient's Ledger report includes all transactions for a patient(s) posted since the beginning date specified. The date of treatment, tooth number, description, patient, charges, payments, and a running balance are also included on the report.
- **Payment Agreement Report** – The Payment Agreement Report displays analysis and management information for monitoring payment agreements. The report includes information on the agreement terms, the remaining balance for the payment agreement, and missed payments, and the last payment date and amount.
- **Future Due Payment Plan Report** – The Future Due Payment Plan Report displays payments that can be expected based on established payment plans by month. You can also run the Monthly Totals Report.
- **Referral Recap Report** – The Referral Recap Report lists completed and treatment-planned work for each referral source that appears on the report. Each referred patient will appear on a separate page.

List Reports

In Office Manager, from the **Reports** menu, point to **Lists**, and then click a list reports option:

- **Daily Appointment List** – The Daily Appointment List consists of three separate reports:
  - **Operatory Appointment List** – This report 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.
  - **Daily Appointment List** – This report gives the same information as the Operatory List, but in a different format, and includes the patient phone numbers.
- **Unscheduled Appointment List** – The Unscheduled Appointment List displays patient appointments that have been broken (and not rescheduled) or placed on the wait/will call list during a specified time period. This list can aid your office in rescheduling those appointments.
- **Unscheduled Treatment Plans Report** – The Unscheduled Treatment Plans Report displays patients for whom there has not been an appointment scheduled for their treatment-planned procedures.
- **Treatment Plan Approval Report** – The Treatment Plan Approval Report lists pre-treatment estimate insurance claims that have been received and accepted. The treatment plan, estimate amount, and whether the pre-treatment was accepted or rejected are also included on the report.

- **Treatment Plan Approval Status Report** – The Treatment Plan Approval Status Report lists treatment-planned procedures for selected approval statuses, along with relevant patient and procedure information.
- **Insurance Eligibility Report** – The Insurance Eligibility Report lists insurance carriers and the patients eligible for coverage under each carrier and includes information such as the patient's eligibility date, subscriber's name and ID, insurance carrier's address, group plan number, and patient's next appointment.
- **Perio Exam List** – The Perio Exam Lists is a list of patients who have had a periodontal exam created within a specified date range.
- **New Patient List** – The New Patient List is a list of all patients in the practice whose first visit dates fall within a specified date range. You can also print mailing and chart labels for this list of patients. The list includes each patient's name, address and first visit date.
- **Patient Notes Report** – The Patient Notes Report displays any notes you have entered for a patient. You can indicate which patients to print based on name, provider, or billing type, and you can select which types of notes to include.

Generating Billing Statements

Billing statements provide guarantors with a record of their financial transactions with the practice.

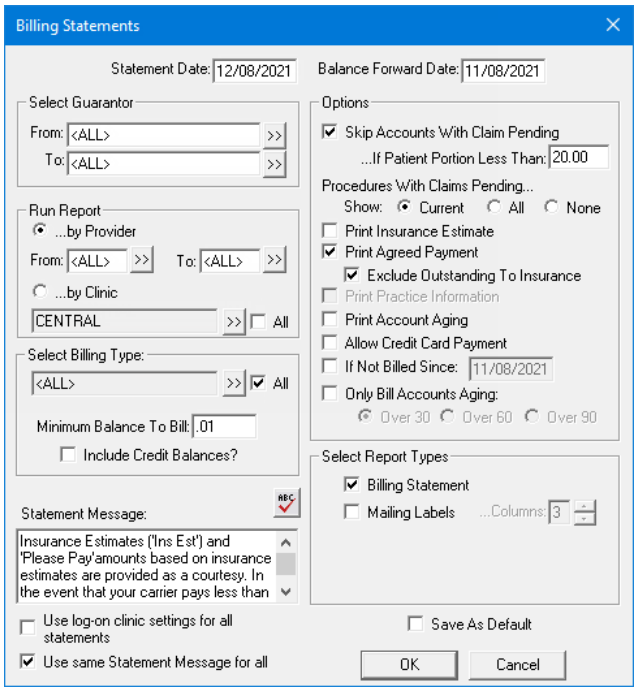
Printer-generated billing statements can save you the cost of pre-printed forms without losing the professional look of pre-printed forms. However, if you intend to use pre-printed forms, be sure to purchase forms that are supported by Dentrix Enterprise.

For information about where to specify the billing statement form that you want to use, see "Setting Up Practice Defaults" in Chapter 1: Introduction and Initial Setup. Also, for information about how to set up billing statements to include the central office, clinic, or provider information, see "Setting Up Clinics" in Chapter 1: Introduction and Initial Setup.

To generate billing statements

1. In Office Manager, from the **Reports** menu, click **Billing**.

   The **Billing Statements** dialog box appears.



2. Set up the following options:

   - **Statement Date** – Enter a cutoff date. The statements will include procedures up to and including the date entered, and all statement calculations will be as of that date.
   - **Balance Forward Date** – Enter a balance forward date. Dentrix Enterprise will calculate the total of all outstanding procedures posted up to the date entered and give the total balance forward amount on the statements rather than an itemization of procedures.
   - **Select Guarantor** – Click the search buttons [>>] to select the range of guarantors for whom you want to generate statements, or leave **From** <ALL> **To** <ALL> selected to include all guarantors.

- **Run Report** – Select how you want to generate statements:
  - **By Provider** – To generate statements by provider, select this option, and then click the search buttons ›› to select a range of providers to generate statements for those providers' patients; or leave **From** <ALL> **To** <ALL> selected to include patients for all providers.
  - **By Clinic** – To generate statements by clinic, select this option, and then click the search button ›› to select the clinics that have the patients for whom you want to generate statements. Or, select the **All** check box to include patients in all clinics.
- **Select Billing Type** – Click the search button ›› to select the billing types of patients for whom you want to generate statements. Or, select the **All** check box to include patients with any billing type.
- **Minimum Balance to Bill** – Dentrix Enterprise will generate statements for patients who have a balance equal to or greater than the amount entered. For example, if you enter 20, Dentrix Enterprise will generate statements for patients who have a balance of at least $20.
- **Include Credit Balances?** –To generate statements for patients who have a credit balance, select this option.
- **Statement Message** – Enter a message (such as "All payments are due on or before the 5th day of the month.") that you want to have appear at the bottom of each statement. This box is available only if the **Use same Statement Message for all** check box is selected; in which case, this message will be the default message either on statements generated from this computer or on statements generated for all clinics from any computer (depending on whether the **Use log-on clinic settings for all statements** check box is clear or selected).

  Tip: For information about entering a customized billing statement note for any individual guarantor, see "Billing Statement Notes" in Chapter 7: Ledger.

- **Use same Statement Message for all** – To use the same message on statements sent to patients of any clinic, select this check box. To use the custom message specified for a given clinic on statements that are sent to patients of that clinic. If the clinic does not have a custom message specified, no message will appear on the statements that are sent to patients of that clinic.
- **Options** – Select the options you want to use to determine which accounts will receive a bill and what to include on the statements:
  - **Skip Accounts with Claim Pending** – To skip an account if the patient has any outstanding claims for which the guarantor portion of the balance is less than the dollar amount you specify in the **If Patient Portion Less Than** box.
  - **Procedures With Claims Pending**
    - **Current** – To include procedures posted in the current month for which a claim has been created and is still pending (not received).
    - **All** – To include all procedures posted for which a claim has been created and is still pending (not received).
    - **None** – To exclude all procedures for which there is still a claim pending.
  - **Print Insurance Estimate** – To include the estimated amount that dental insurance will pay on pending claims.
  - **Print Agreed Payment** – To have a box labeled "Please Pay This Amount," which reflects the patient portion of the balance or the payment amount required for a payment agreement set up previously, appear on statements.

    To have the "Please Pay" amount exclude the entire amount that has been billed to insurance on a pending claim, even if some of it is a patient portion, select **Exclude Outstanding to Insurance**.

- **Print Practice Information** – If your default billing statement is not the Full Form/Download Form, and if you are using a pre-printed form without your practice information already printed on it, select this option.
- **Print Account Aging** – If your default billing statement is the Full Form/Download Form, to include an aging summary on the statements that are formatted to allow report aging, select this option.
- **Allow Credit Card Payment** – If your default billing statement is the Full Form/Download Form, to include credit card payment options on the statement, select this option.
- **If Not Billed Since** – To skip patients for whom a billing statement has already been printed since the date you specify. (The last statement date appears in each account's Ledger.)

  Tip: This option works well for practices that print billing statements from the Ledger when an insurance payment is received for an account. You can use cyclical billing as statements are printed for individual accounts throughout the month and then printed from Office Manager in a batch to ensure that each account has received a statement for the month.

- **Only Bill Accounts Aging** – To generate statements for patients whose balance has aged at least as much as the aging bracket you select: **Over 30**, **Over 60**, or **Over 90**.

- **Select Report Types** – Select the desired report types:
  - **Billing Statement** – To print statements for all guarantors who fall within the specified parameters.
  - **Mailing Labels** – To print mailing labels with the guarantor's name and address. Be sure to enter the number of **Columns** of labels your label sheets have on them.
- **Use log-on clinic settings for all statements** – To apply the current settings specified for this clinic to all clinics, select this check box. Use this option if you want everyone to have the same default statement settings for all clinics while logged on to any computer. You must click **OK** with the **Save As Default** check box selected to update the default settings for all clinics.
- **Save As Default** – To save the current settings for the next time you generate statements from this computer (or from any computer if the **Use log-on clinic settings for all statements** check box is selected).

3. Click **OK** to send the billing statements to the Batch Processor.

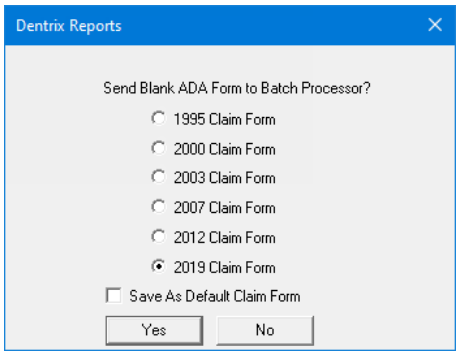
Printing Blank ADA Claim Forms

There may be a circumstance when you need to print a blank ADA claim form.

To generate a blank ADA claim form

1. In Office Manager, from the **Reports** menu, click **Blank ADA Form**.

   The **Dentrix Reports** dialog box appears.



2. Select the claim form that you want to print.
3. Click **Yes**.

Creating Letters

With Dentrix Enterprise, you can create custom reports and letters as Microsoft Word documents or as data files for use in spreadsheet programs, such as Microsoft Excel.

Dentrix Enterprise provides an interface between your patient database and Microsoft Word (if installed) that allows you to create any letters that are applicable to the success and development of your practice. You can have Dentrix Enterprise merge information from patient records into your letters, based on various ranges, parameters, and filters that you establish.

Dentrix Enterprise comes complete with pre-defined letter templates in seven categories that you can use and modify in conjunction with your patient database. For information about how to customize any letter from Microsoft Word, see the "Customizing Dentrix Enterprise letters" topic in the Dentrix Enterprise Help. For information about how to create your own letters and add them to any of the categories for future use, see the "Creating custom letters" and "Adding letters to categories" topics in the Dentrix Enterprise Help.

This section covers the following topics about letter merges:

- Merging Dentrix Enterprise Letters
- Creating Appointment Reminder Cards
- Creating Cards for Patients Without Appointments

Merging Dentrix Enterprise Letters

You can create letters by merging information from Dentrix Enterprise into Microsoft Word documents. This section covers the pre-defined templates installed with Dentrix Enterprise.

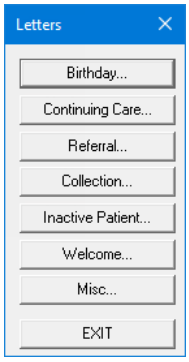
To merge a Dentrix Enterprise letter

1. Open and minimize Microsoft Word.



2. In Office Manager, click **Letters** on the menu bar.

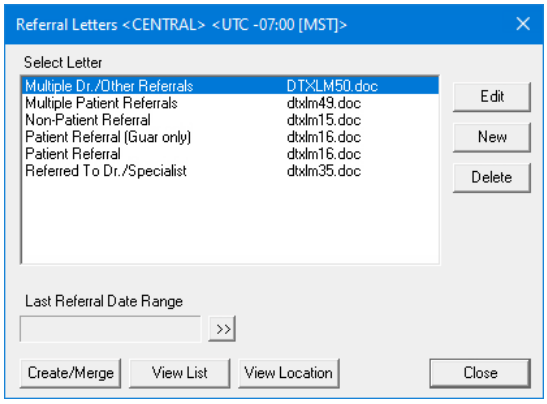
   The **Letters** window appears.



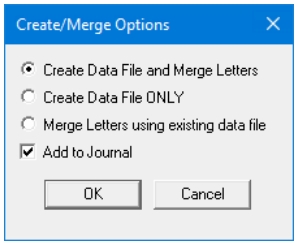
3. Click the category button of the letter type you want to create:
   - **Birthday** – Birthday letters for patients with a birth date in a specified range.
   - **Continuing Care** – Continuing care (recall or recare) notices to patients within a recall date range.
   - **Referral** – Referral letters for anyone who has referred or to whom you are referring patients within a specified range of first visit dates or referral dates.
   - **Collection** – Collection notices for patients within a specified range of last payment dates.

- **Inactive Patient** – Notices for patients within a specified range of last visit dates.
- **Welcome** – "Welcome to the Practice" letters for patients within a specified range of first visit dates.
- **Misc** – Custom letters for specific patients in your database. You will probably put many of the custom letters you create in this category.

4. In the dialog box that appears, select a letter, set up a date range (if applicable), and then click **Create/Merge**.



The **Create/Merge Options** dialog box appears.



5. Select **Create Data File and Merge Letters**.

   For details about the **Create Data File ONLY** and **Merge Letters using existing data file** options, see the "Other create and merge options" topic in the Dentrix Enterprise Help.

6. If you want Dentrix Enterprise to add an entry to each patient's Office Journal, indicating that a letter was sent to that patient, select **Add to Journal**.

7. Click **OK**.

   When the merge is complete, in Microsoft Word, you can print the letters. Then, close Microsoft Word without saving the changes to the document.

   Warning: If you save the changes to the document, patient information will be permanently saved in the letter template, rendering the template unusable.

Creating Appointment Reminder Cards

You can create reminder cards to send to patients with upcoming appointments.

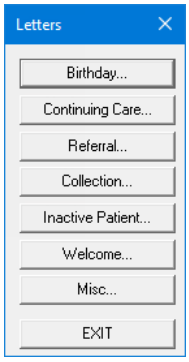
To create appointment reminder cards

1. Open and minimize Microsoft Word.



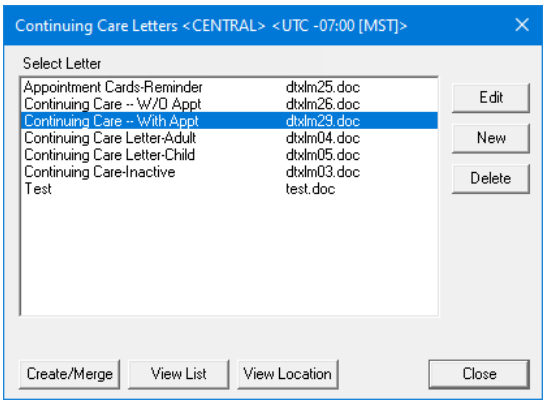
2. In Office Manager, click **Letters** on the menu bar.

   The **Letters** window appears.



3. Click **Continuing Care**.

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

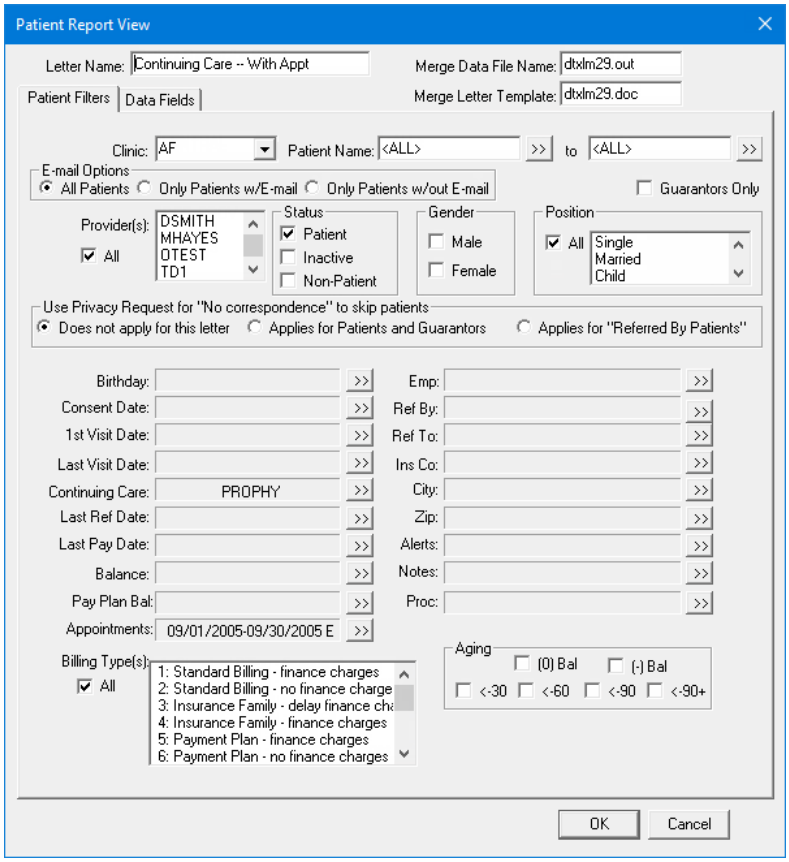


4. Select **Continuing Care -- With Appt**.

   Note: This is the default for the letter template name when Dentrix Enterprise is initially installed, but the name might have been changed.

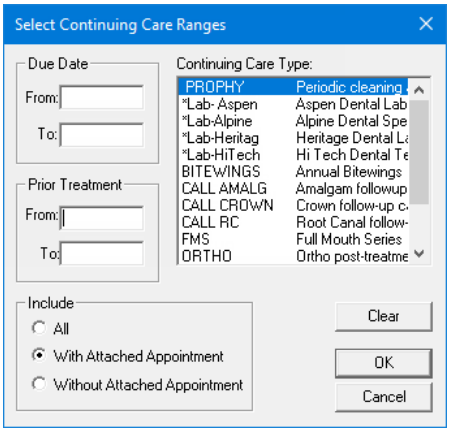
5. Click **Edit**.

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



6. In the **Merge Letter Template** box, enter one of the following template document names, based on the type of cards you are using:
   - **dtxlm29.doc** – 2-wide, laser cards.
   - **dtxlm24.doc** – Single-wide, dot matrix cards.
   - **dtxlm27.doc** – 2-wide, dot matrix cards.
7. Set up the continuing care filter:
   a. Click the **Continuing Care** search button [>>].

      The **Select Continuing Care Ranges** dialog box appears.



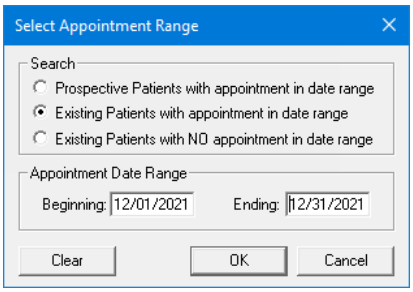
   b. Under **Due Date** and **Prior Treatment Date**, leave **From** and **To** blank.
   c. Under **Include**, select **With Attached Appointment**.
   d. Under **Continuing Care Type**, select the appropriate continuing care type.

e. Click **OK**.

8. Set up the appointment filter:

   a. Click the **Appointments** search button.

      The **Select Appointment Ranges** dialog box appears.



   b. Under **Search**, select **Existing patients with appointment in date range**.

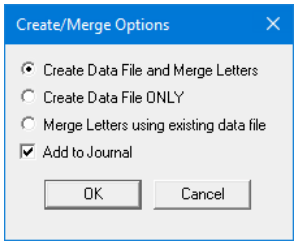
   c. Under **Appointment Date Range**, enter the **Beginning** and **Ending** dates of the range of appointments for which you are printing cards.

   d. Click **OK**.

9. Click **OK** to return to the **Select Continuing Care Ranges** dialog box.

10. With **Continuing Care -- With Appt** still selected, click **Create/Merge**.

    The **Create/Merge Options** dialog box appears.



11. Select **Create Data File and Merge Letters**, and **Add to Journal** (if desired), and then click **OK**.

    When the merge is complete, in Microsoft Word, you can print the cards. Then, close Microsoft Word without saving the changes to the document.

    Warning: If you save the changes to the document, patient information will be permanently saved in the letter template, rendering the template unusable.

Creating Cards for Patients Without Appointments

You can create reminder cards to send to patients without appointments who need to schedule a return visit.

To create cards for patients without appointments

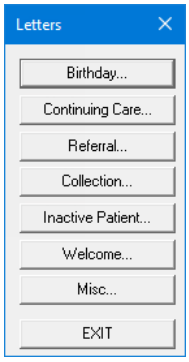


1. Open and minimize Microsoft Word.



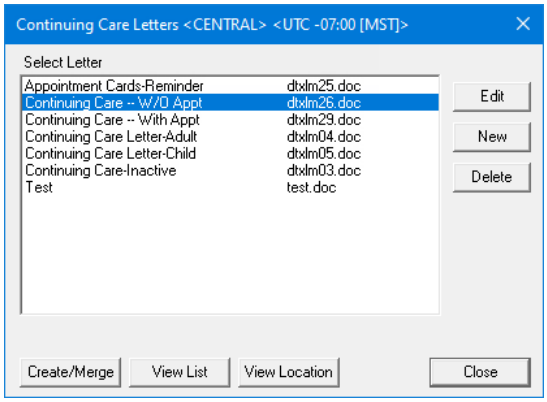
2. In Office Manager, click **Letters** on the menu bar.

   The **Letters** window appears.



3. Click **Continuing Care**.

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

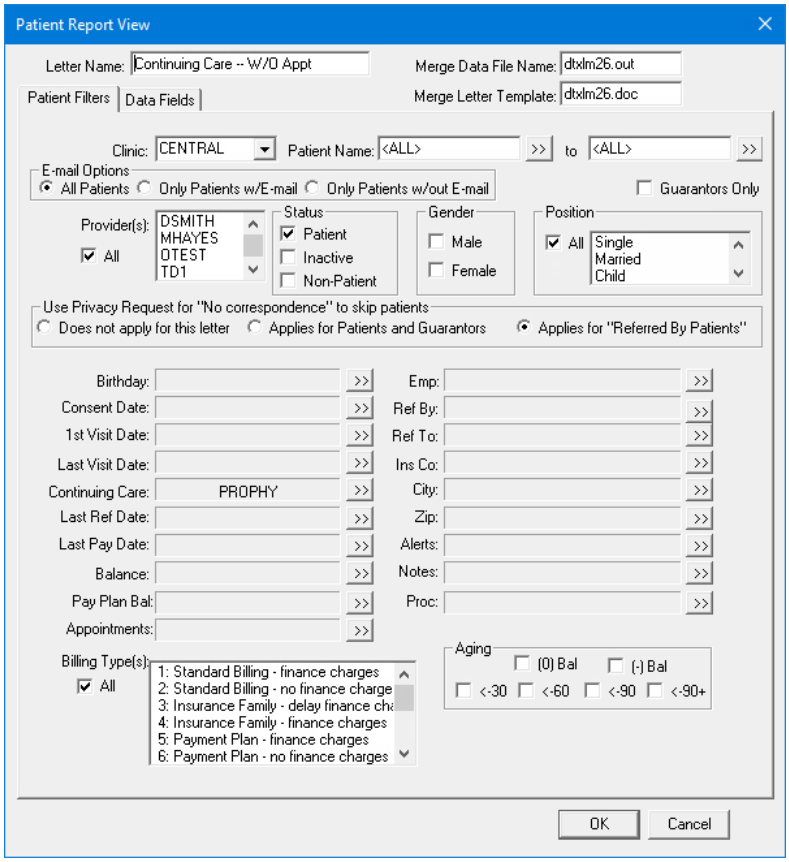


4. Select **Continuing Care -- W/O Appt**.

   Note: This is the default for the letter template name when Dentrix Enterprise is initially installed, but the name might have been changed.

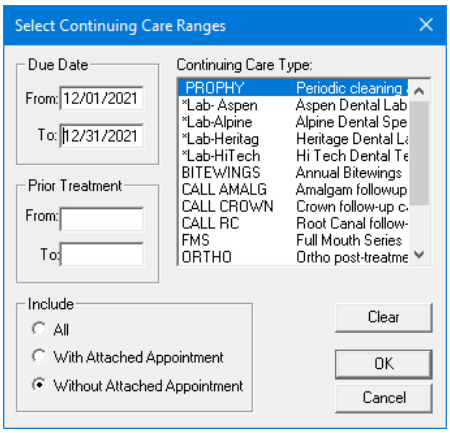
5. Click **Edit**.

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



6. In the **Merge Letter Template** box, enter one of the following template document names, based on the type of cards you are using:
   - **dtxlm26.doc** – 2-wide, laser cards.
   - **dtxlm23.doc** – Single-wide, dot matrix cards.
   - **dtxlm28.doc** – 2-wide, dot matrix cards.
7. Set up the continuing care filter:
   a. Click the **Continuing Care** search button >>.

      The **Select Continuing Care Ranges** dialog box appears.

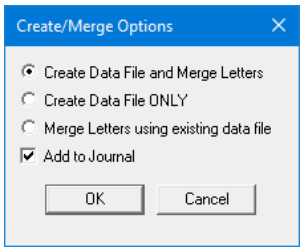


   b. Under **Due Date**, enter the **Beginning** and **Ending** dates of the range for which you want to print cards.
   c. Under **Include**, select **Without Attached Appointment**.
   d. Under **Continuing Care Type**, select the appropriate continuing care type.

e. Click **OK**.

8. Click **OK** to return to the **Select Continuing Care Ranges** dialog box.
9. With **Continuing Care -- W/O Appt** still selected, click **Create/Merge**.

   The **Create/Merge Options** dialog box appears.



10. Select **Create Data File and Merge Letters**, and **Add to Journal** (if desired), and then click **OK**.

    When the merge is complete, in Microsoft Word, you can print the cards. Then, close Microsoft Word without saving the changes to the document.

    Warning: If you save the changes to the document, patient information will be permanently saved in the letter template, rendering the template unusable.

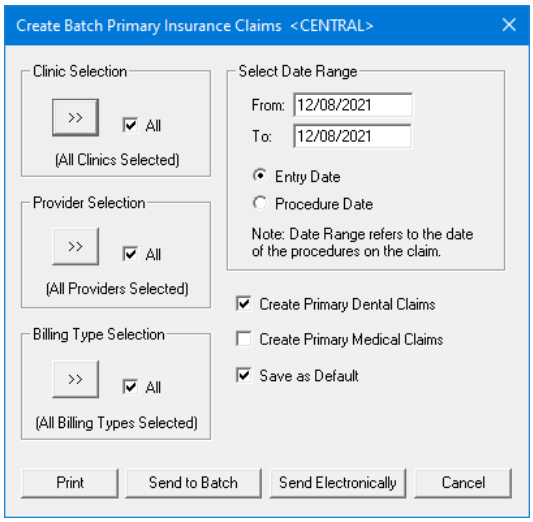
Creating a Batch of Primary Insurance Claims

In the Office Manage, you can create and batch, create and print, or create and send electronically all insurance claims for all procedure codes that are not currently attached to a primary insurance claim, are not flagged as "Do not bill to insurance," and fall within a specified date range. You can create batch insurance claims for multiple clinics only if you are logged in to the Central clinic; otherwise, you can create batch insurance claims for only the clinic that you are logged in to.

To create a batch of primary insurance claims

1. In Office Manager, from the **File** menu, click **Batch Ins Claims**.

   The **Create Batch Primary Insurance Claims** dialog box appears.



2. Set up the following options:
   - **Clinic Selection** – Click the search button >> to select the clinics you want to include on the report, or leave **All** selected to include all clinics.
   - **Provider Selection** – Click the search button >> to select the providers you want to include on the report, or leave **All** selected to include all providers.
   - **Billing Type Selection** – Click the search button >> to select the billing types you want to include on the report, or leave **All** selected to include all billing types.
   - **Select Date Range** – The date range defaults to the current system date. If necessary, in the **From** and **To** boxes, enter the date range for which you want to generate insurance claims. Also, select whether to search for procedures on primary insurance claims by **Entry Date** or **Procedure Date**.
   - **Create Primary Dental Claims** – Select this option to include all primary dental insurance claims in the specified date range.
   - **Create Primary Medical Claims** – Select this option to include all primary medical insurance claims in the specified date range.
   - **Save as Default** – Select this option to save the current settings for the next time you create batch insurance claims.
3. Click **Print** to print the primary insurance claims, **Send to Batch** to send the primary insurance claims to the Batch Processor, or **Send Electronically** to send the primary insurance claims electronically to the clearinghouse. On the message that appears and displays the total number of primary dental and medical claims that will be created, click **OK**.

Submitting Electronic Claims

eTrans is an add-on program that you can use to transmit insurance claims electronically from Dentrix Enterprise to insurance carriers. You must first register your practice if you want to use this service. Talk to your trainer, or contact eServices Customer Support at (800) 734-5561 for more information on how to purchase and install eTrans.

Note: You can send electronic claims only from a computer with an Internet connection.

To submit electronic claims with eTrans

1. Create insurance claims, sending them to the Batch Processor.
2. In Office Manager, do one of the following:
   - To submit all or some of the batched claims, from the **File** menu, click **ECS**.
   - To submit specific claims, select the appropriate claims in the Batch Processor, and then, from the **File** menu, click **ECS**.

For more information on sending and editing electronic claims, setting up eTrans, and viewing reports regarding your electronic claims, refer to the *eTrans User's Guide*, which is available for download from the Resource Center at www.DentrixEnterprise.com.

Sending Statements with QuickBill

If you have purchased, installed, and properly configured QuickBill, you can send billing statements electronically to a clearinghouse where they are professionally printed, folded, and mailed to guarantors.

For information on setting up QuickBill, refer to the *QuickBill User's Guide*, which is available for download from the Resource Center at www.DentrixEnterprise.com.

To send statements electronically

1. Generate billing statements, sending them to the Batch Processor.
2. In Office Manager, select the appropriate billing statements and/or a batch of statements in the Batch Processor.
3. From the **File** menu, click **EBS**. On the confirmation message that appears, click **Yes**.

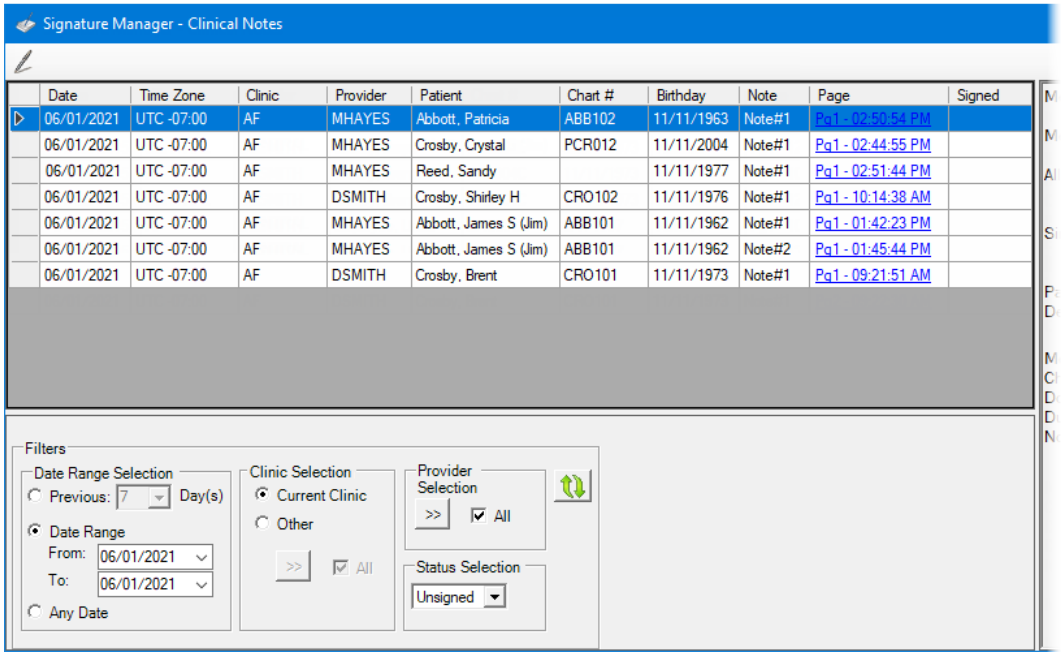
Signing Mulitple Clincal Notes

You can sign multiple clinical notes at one time from Office Manager.

To sign multiple clinical notes

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

   The **Signature Manager** dialog box appears.

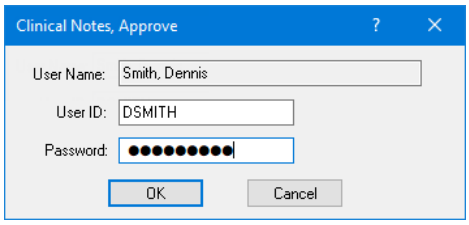


2. Set up the following **Filters** as needed:
   - **Date Range Selection** – Select one of the following options:
     - **Previous** – To view clinical notes for the specified number of days prior to today's date. Enter the number of days.
     - **Date Range** – To view clinical notes within the 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.

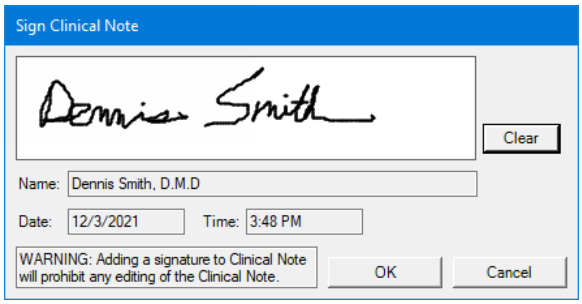
4. Click each clinical note to review it. Then, select the clinical notes that you want to sign. To select multiple notes, while holding down the Ctrl key, click each note; or, while holding down the Shift key, click the first and last notes to select those notes and all notes in between them.
5. Click the **Sign** button .

   The **Clinical Notes, Approve** dialog box appears.



6. Enter your password, and then click **OK**.

   The **Sign Clinical Note** dialog box appears.



7. Sign, and then click **OK**.

National Patient Information Reporting System

From Dentrix Enterprise (DXE), you can generate encounter and registration files to store in the National Data Warehouse (NDW) for the National Patient Information Reporting System (NPIRS).

Notes:

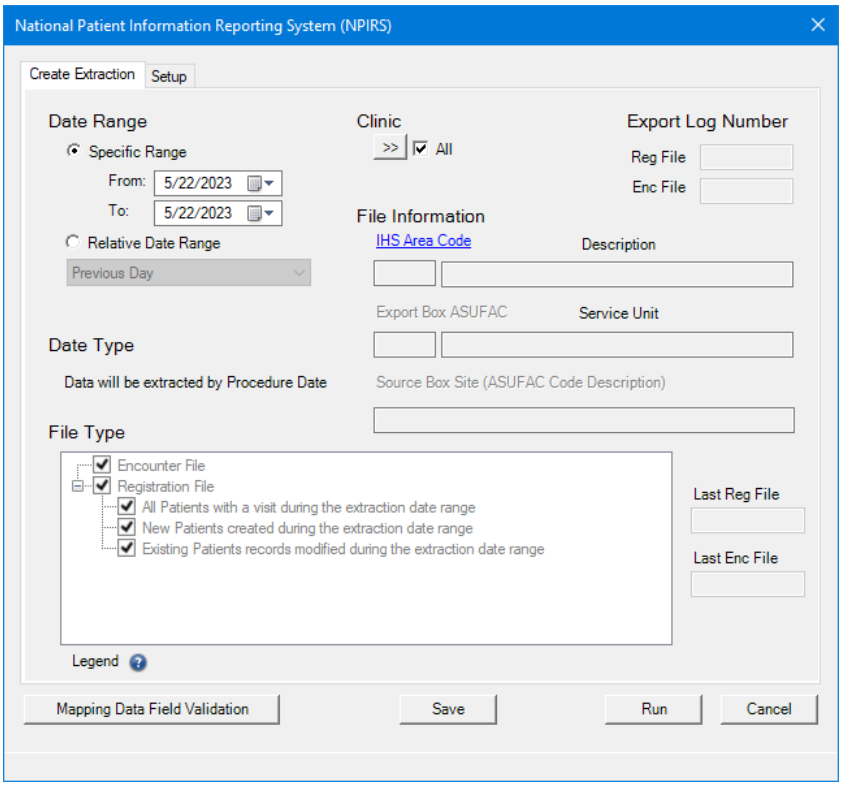
- This feature is intended for IHS facilities only.
- This data extraction utility is available only if the global setting **NPIRS/NDW Data Extraction** is enabled.
- To store the necessary information for the files, there are now IHS standard code definitions, which can be customized, in your DXE database.

To generate files for NPIRS

1. In Office Manager, on the **Data Extraction** menu, click **National Patient Information Reporting System (NPIRS)**.

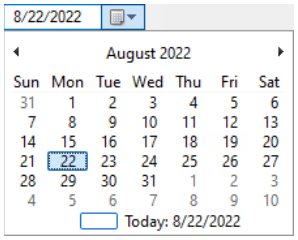
   The **National Patient Information Reporting System (NPIRS)** dialog box appears.
2. Set up the options on the following tabs:

- **Create Extraction**



- **Data Range** – To specify the date range of the data extraction, do one of the following:
  - To include patients with posted procedures that have dates within a range that you specify, select the **Specific Range** option. With this option selected, do one of the following:
    - Enter a date range (in a m/d/yyyy format) in the **From** and **To** boxes.
    - To select a date, do the following for **From** and **To**:

      a. Click the corresponding calendar icon to view a month calendar.



      b. Navigate to the correct month, using the left and right arrows.

      Note: To quickly change the year and month, click the month-year at the top of the calendar, navigate to the correct year, using the left and right arrows, and then click the correct month.

      c. Click the correct day.

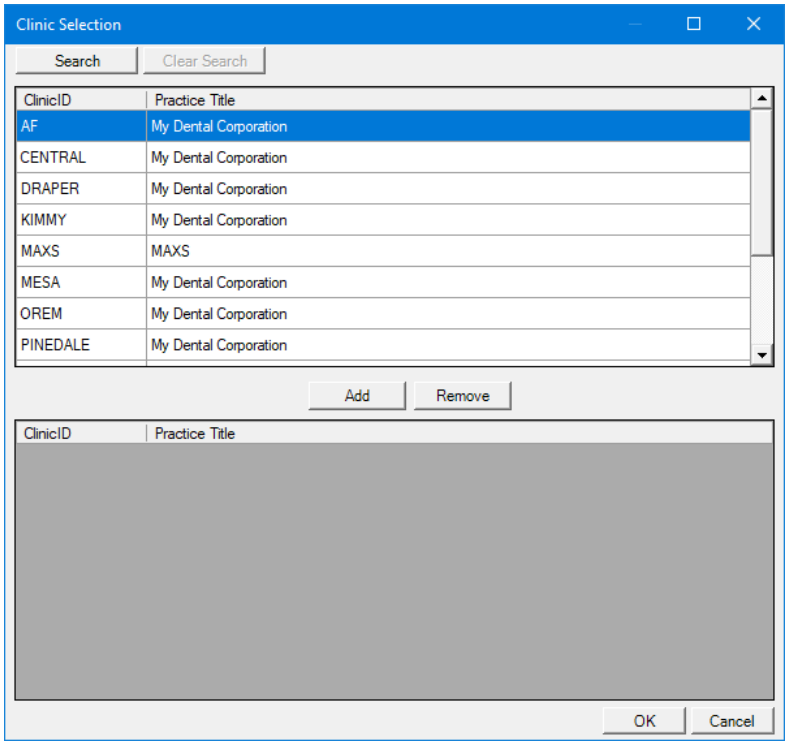
- To include patients with posted procedures that have dates within a range that is relative to the report date, select the **Relative Date Range** option. With this option selected, select one of the following relative date ranges from the list:
  - Previous Day
  - Previous Week
  - Previous Month
  - Previous 3 Months
  - Previous 6 Months
  - Previous Fiscal Year
  - Previous Calendar Year

  Note: Using a relative date range is recommended if you want to save the current report settings as the default settings so you do not have to manually enter a date range each time you generate the files.

- **Clinic** – The clinics whose patient data will be exported. To specify clinics, do one of the following:
  - To include all clinics, leave the **All** check box selected.
  - To include specific clinics, do the following:

    a. Click the search button [>>].

    The **Clinic Selection** dialog box appears.

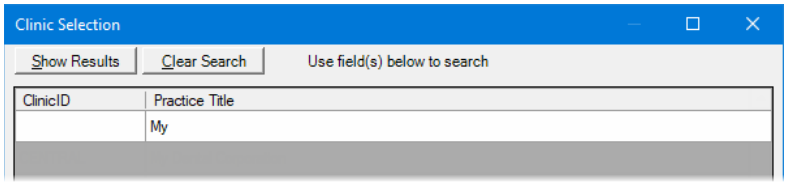


Note: If your user account has been granted the "View All Patients" security right for the Central clinic, all clinics appear in the upper list; otherwise, the clinics for which your user account has been granted the "My Clinics, View" security right (in the "Practice/ Clinic Setup" category) appear in the upper list; however, if your user account has not been granted that right to any clinic, only the clinic that you are currently logged in to appears in the upper list.

b. To search for a clinic by ID and/or practice name, do the following:

i. Click **Search**.

ii. Enter the first character or more of a clinic ID and/or practice title in the **ClinicID** and/or **Practice Title** boxes, respectively.



iii. Click **Show Results** to view a list of matching clinics in the upper list.

Note: To return to viewing the list of all the clinics, click **Search**, click **Clear Search** to clear the search criteria that you entered, and then click **Show Results**.

c. In the upper list, select one or more clinics.

Note: To select multiple clinics, click a clinic, and then, while pressing the Ctrl key, click the other desired clinics. To select a range of adjacent clinics, click the first clinic of the desired range of clinics, and then, while pressing the Shift key, click the last clinic of the desired range of clinics.

d. Click **Add**.

e. Repeat steps b-d as needed to add other clinics.

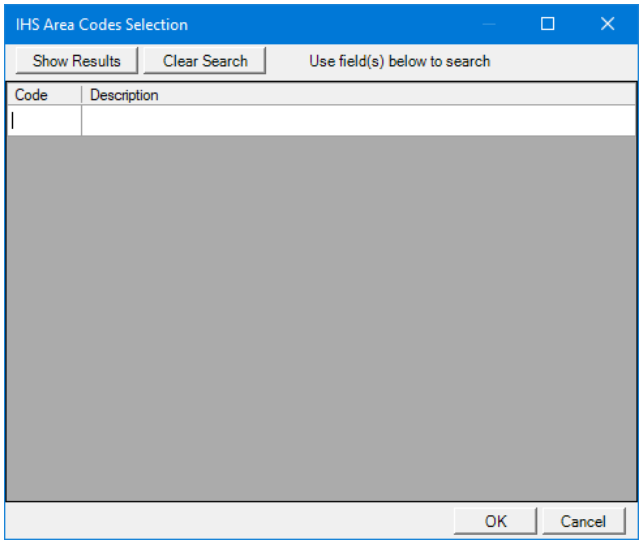
Note: To not include a clinic that you added, select that clinic in the lower list, and then click **Remove**.

f. Click **OK**.

- **File Information**:
  - **IHS Area Code** – To specify the IHS area code, do the following:

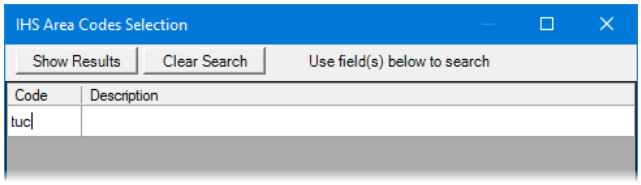
a. Click the **IHS Area Code** link.

The **IHS Area Codes Selection** dialog box appears.

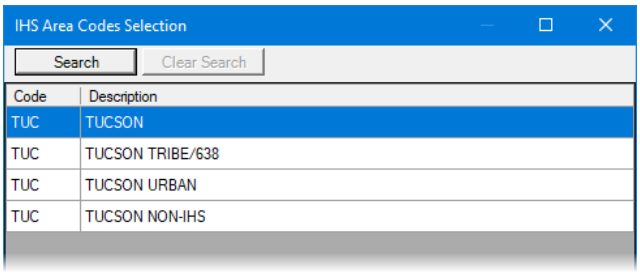


b. Do one of the following:

- To get a list of all area codes, do not enter any search criteria.
- To search for area codes by code and/or description, enter the first character or more of a code and/or description in the **Code** and/or **Description** boxes, respectively.



c. Click **Show Results** to view a list of matching area codes.

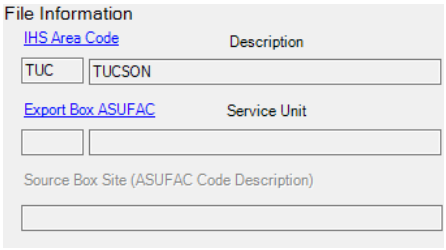


Note: To clear the search criteria that you entered so you can search again, click **Search**, and then click **Clear Search**. Then, repeat steps b-c.

d. Do one of the following:

- Select an area code, and then click **OK**.
- Double-click an area code.

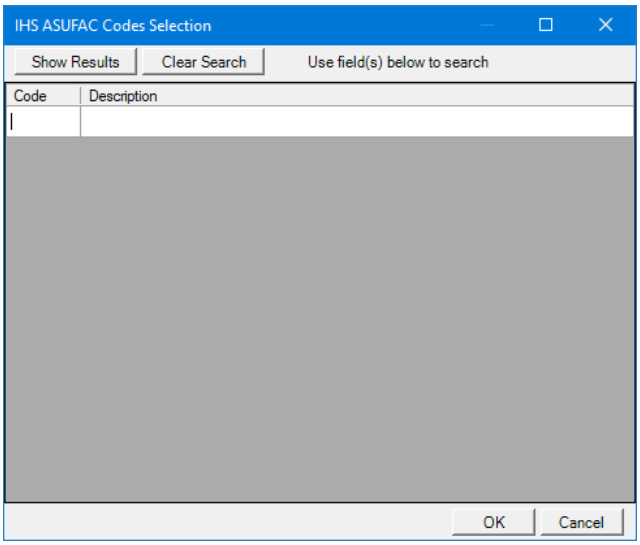
- **Export Box ASUFAC** – This link is available only if an IHS area code is selected.



To specify the export ASUFAC code, do the following:

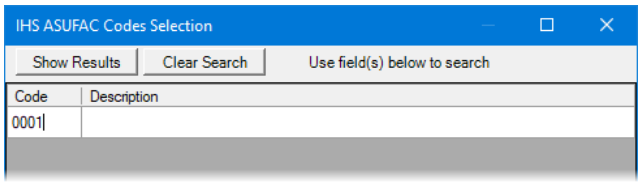
a. Click the **Export Box ASUFAC** link.

The **IHS ASUFAC Codes Selection** dialog box appears.

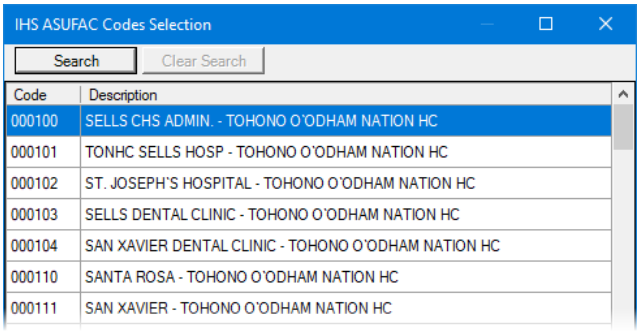


b. Do one of the following:

- To get a list of all ASUFAC codes, do not enter any search criteria.
- To search for ASUFAC codes by code and/or description, enter the first character or more of a code and/or description in the **Code** and/or **Description** boxes, respectively.



c. Click **Show Results** to view a list of matching ASUFAC codes.

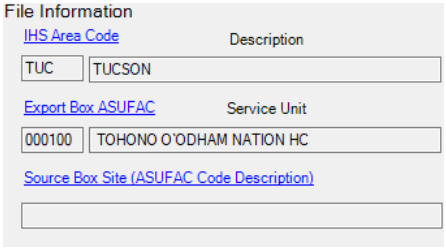


Note: To clear the search criteria that you entered so you can search again, click **Search**, and then click **Clear Search**. Then, repeat steps b–c.

d. Do one of the following:

- Select an ASUFAC code, and then click **OK**.
- Double-click an ASUFAC code.

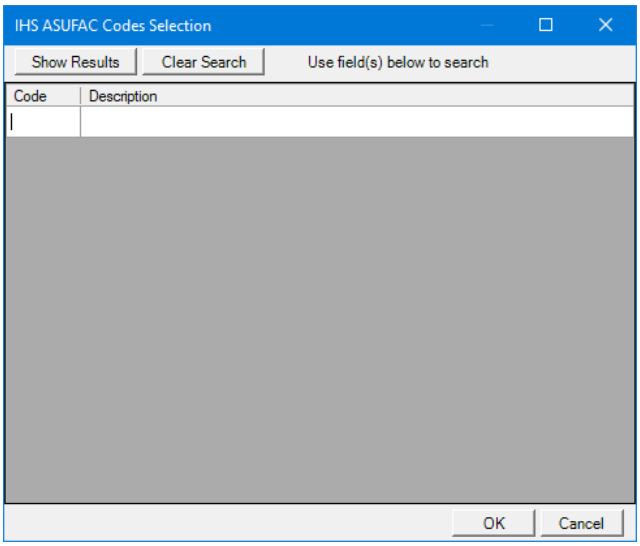
- **Source Box Site (ASUFAC Code Description)** – This link is available only if an export ASUFAC code is selected.



To specify the source ASUFAC code, do the following:

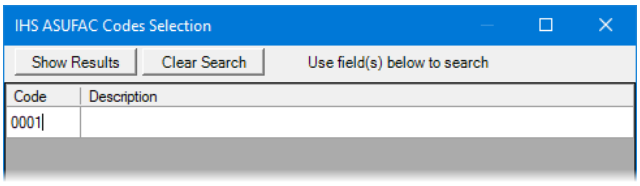
a. Click the **Source Box Site (ASUFAC Code Description)** link.

The **IHS ASUFAC Codes Selection** dialog box appears.

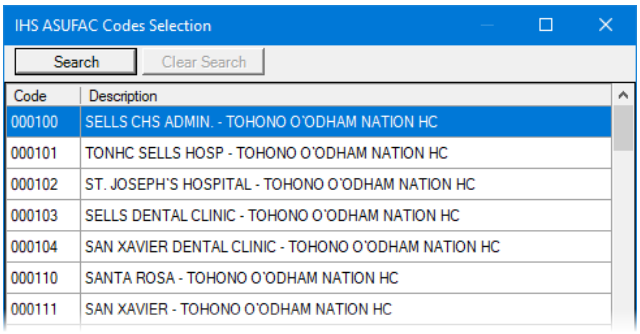


b. Do one of the following:

- To get a list of all ASUFAC codes, do not enter any search criteria.
- To search for ASUFAC codes by code and/or description, enter the first character or more of a code and/or description in the **Code** and/or **Description** boxes, respectively.



c. Click **Show Results** to view a list of matching ASUFAC codes.

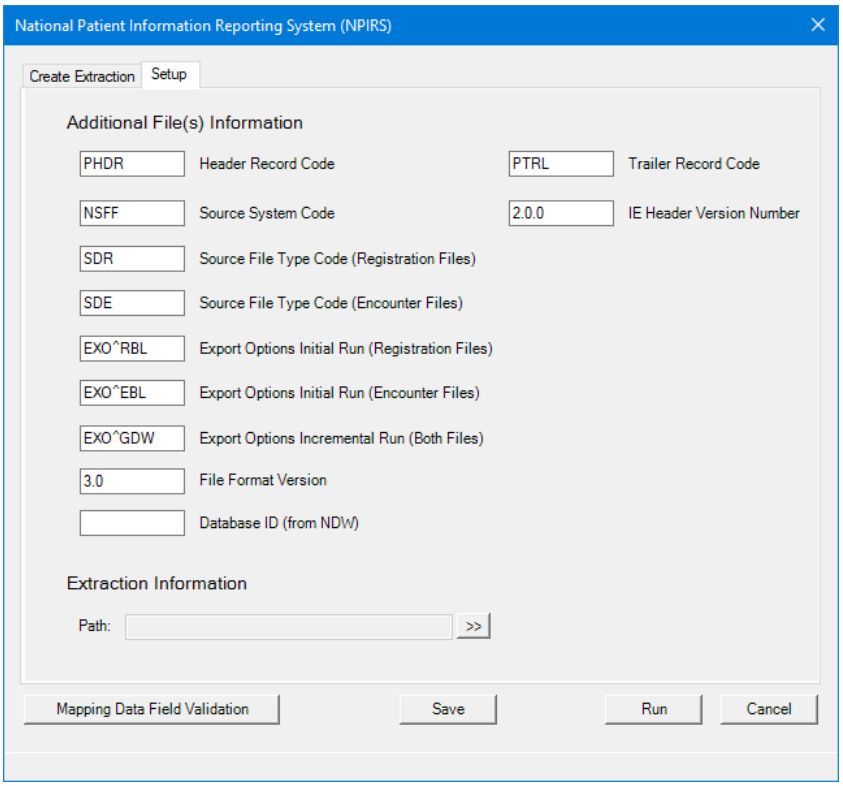


Note: To clear the search criteria that you entered so you can search again, click **Search**, and then click **Clear Search**. Then, repeat steps b-c.

d. Do one of the following:

- Select an ASUFAC code, and then click **OK**.
- Double-click an ASUFAC code.

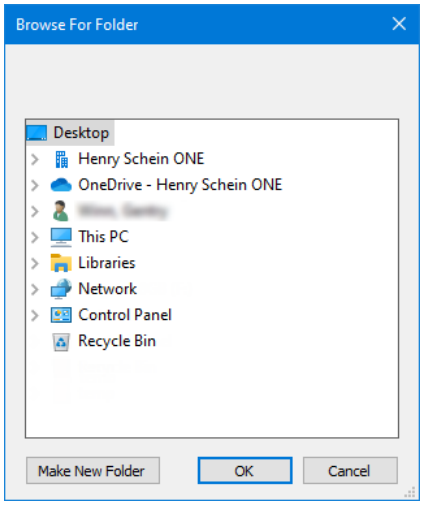
- **File Type** – Select which files to generate:
  - **Encounter File**.
  - **Registration File** – With this check box selected, select at least one of the following check boxes to specify which patients' data to include:
    - **All Patients with a visit during the extraction date range**.
    - **New Patients created during the extraction date range**.
    - **Existing Patients records modified during the extraction date range**.
- **Setup**



- **Additional File(s) Information** – Make sure that all the following information for the files is correct:
  - **Header Record Code** – Such as `PHDR`.
  - **Source System Code** – Such as `NSFF`.
  - **Source File Type Code (Registration Files)** – Such as `SDR`.
  - **Source File Type Code (Encounter Files)** – Such as `SDE`.
  - **Export Options Initial Run (Registration Files)** – Such as `EXO^RBL`.
  - **Export Options Initial Run (Encounter Files)** – Such as `EXO^EBL`.
  - **Export Options Incremental Run (Both Files)** – Such as `EXO^GDW`.
  - **File Format Version** – Such as `3.0`.
  - **Database ID (from NDW)** – An ID up to five digits long.
  - **Trailer Record Code** – Such as `PTRL`.
  - **IE Header Version Number** – Such as `2.0.0`.
- **Extraction Information** - To specify the directory where the exported files will be saved, do the following:

  a. Click the **Path** search button [>>].

  The **Browse For Folder** dialog box appears

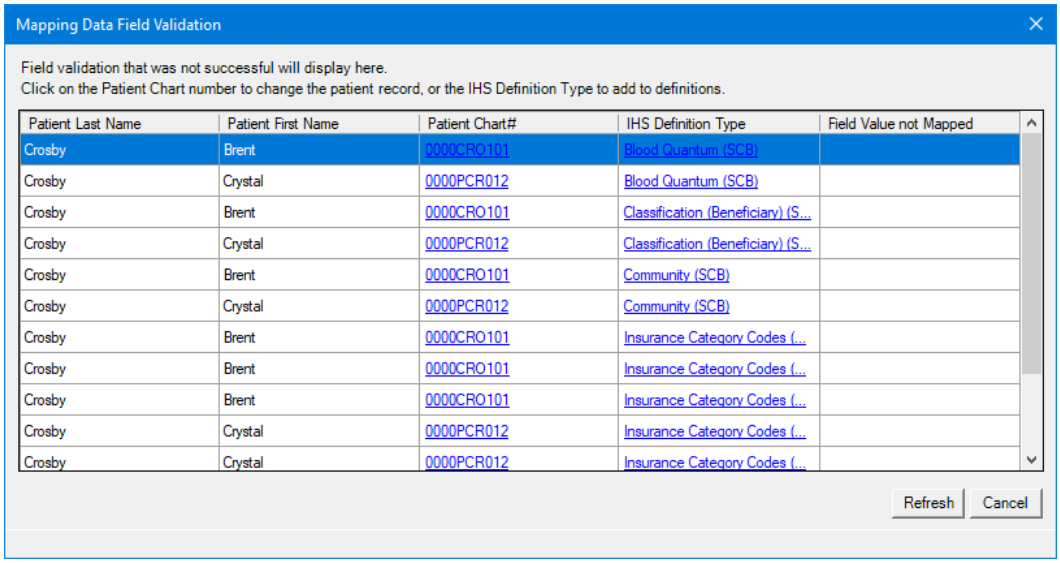


  b. Select the correct folder.

  c. Click **OK**.

3. To save the options on both tabs as the default for the next time you generate the files, click **Save**.

4. To verify mappings, click **Mapping Data Field Validation**. Then, for each patient listed in the **Mapping Data Field Validation** dialog box, click the corresponding **Patient Chart #** link to update the patient's record, and/or click the corresponding **IHS Definition Type** link to add a definition.



5. Click **Run**.
6. On the message that appears when the extraction is complete, click **OK**.

Note: To view the extracted data, open the .txt files that were created in the specified export directory. For a detailed explanation of the NPIRS files, refer to the topic about understanding encounter and registration files for NPIRS.

Understanding Encounter and Registration Files for NPIRS

The encounter and registration files that you can generate from Dentrix Enterprise for National Patient Information Record System (NPIRS) are created and stored in a specified location using a certain naming convention. Also, the files contain data in a certain format from patient records and options specified for the data extraction.

File Naming Convention

When you generate a file, Dentrix Enterprise uses the following naming convention:

{Source File Type Code (see H13)} + {Export Box ASUFAC (see H7)} + {Julian date (YYYYJJJ)} + .txt

- Encounter file name example: SDE0001002023142.txt
- Registration file name example: SDR0001002023142.txt

File Records

- An encounter file consists of a header record, one or more encounter records, and a trailer record.
- A registration file consists of a header record, one or more registration records, and a trailer record.

File Record Fields

Each record starts on a new line. Each field in a record is separated by a pipe character (|). The following tables identify each field in a given file and where in Dentrix Enterprise the values for those fields come from.

Header Record Fields(#1–15)

Field #	Field Name	Field Value	
H1	Header Record Code	Office Manager > **Data Extraction** > **National Patient Information Record System (NPIRS)** > **Setup** > **Header Record Code**.	See Figure 18.
H2	Source System Code	Office Manager > **Data Extraction** > **National Patient Information Record System (NPIRS)** > **Setup** > **Source System Code**.	See Figure 18.
H3	Process Code	Empty	
H4	Export ID	Empty	
H5	IHS Area Code	Office Manager > **Data Extraction** > **National Patient Information Record System (NPIRS)** > **Create Extraction** > **IHS Area Code**.	See Figure 17.
H6	File Creation Date	Office Manager > **Data Extraction** > **National Patient Information Record System (NPIRS)** > **Run**. Generated automatically in a ccyymmdd format.	See Figure 16.
H7	Export Box ASUFAC	Office Manager > **Data Extraction** > **National Patient Information Record System (NPIRS)** > **Create Extraction** > **Export Box ASUFAC**.	See Figure 17.
H8	Source Box Site	Office Manager > **Data Extraction** > **National Patient Information Record System (NPIRS)** > **CreateExtraction** > **Source Box Site (ASUFAC Code Description)**.	See Figure 17.
H9	Beginning Date	Office Manager > **Data Extraction** > **National Patient Information Record System (NPIRS)** > **Create Extraction** > **Date Range** (**SpecificRange** or **Relative Date Range**) in a ccyymmdd format.	See Figure 17.
H10	Ending Date	Office Manager > **Data Extraction** > **National Patient Information Record System (NPIRS)** > **Create Extraction** > **Date Range** (**SpecificRange** or **Relative Date Range**) in a ccyymmdd format.	See Figure 17.
H11	Export Log Number	Office Manager > **Data Extraction** > **National Patient Information Record System (NPIRS)** > **Create Extraction** > **Export Log Number** (**Reg File** or **Enc File**).	See Figure 17.
H12	IE Header Version Number	Office Manager > **Data Extraction** > **National Patient Information Record System (NPIRS)** > **Setup** > **IEHeader Version Number**.	See Figure 18.
H13	Source File Type Code	Office Manager > **Data Extraction** > **National Patient Information Record System (NPIRS)** > **Setup** > **Source File Type Code (Registration Files)** or **Source File Type Code (Encounter Files)**.	See Figure 18.

Field #	Field Name	Field Value	
H14	Export Options	Office Manager > **Data Extraction** > **National Patient Information Record System (NPIRS)** > **Setup** > **Export Options Initial Run (Registration Files)**, **Export Options Initial Run (Encounter Files)**, or **Export Options Incremental Run (Both Files)**.	See Figure 18.
H15	File Format Version	Office Manager > **Data Extraction** > **National Patient Information Record System (NPIRS)** > **Setup** > **File Format Version**.	See Figure 18.

Encounter Record Fields (#1–124)

Field #	Field Name	Field Value	
E1	Unique Encounter Code	Office Manager > **Data Extraction** > **National Patient Information Record System (NPIRS)** > **Setup** > **Database ID (from NDW)** + Procedure ID from the database (DDB_PROC_LOG_BASE.PROC_LOGID). Notes: The Unique Encounter Code has 15 digits total. If the PROC_LOGID has fewer than 10 digits, additional zeros are included before the PROC_LOGID. If the PROC_LOGID has more than10 digits, only the last 10 are included.	See Figure 18.
E3	Encounter Create Date	Creation/entry date from the database (DDB_PROC_LOG_BASE.CREATEDATE) in a ccyymmdd format.	
E4	Encounter Last Update	Last modified date from the database (DDB_PROC_LOG_BASE.DDB_LAST_MOD) in a ccyymmdd format.	
E5	Encounter Delete Flag	Empty	
E2	Unique Registration Code	Office Manager > **Data Extraction** > **National Patient Information Record System (NPIRS)** > **Setup** > **Database ID (from NDW)** + Patient ID from the database (DDB_PAT_BASE.PATID). Notes: • The Unique Registration Code has 15 digits total. • If the PATID has fewer than10 digits, additional zeros are included before the PATID. • If the PATID has more than10 digits, only the last 10 are included.	See Figure 18.

Field #	Field Name	Field Value	
E6	Chart Facility Code	Office Manager > **Data Extraction** > **National Patient Information Record System (NPIRS)** > **Create Extraction** > **Export Box ASUFAC**.	See Figure 17.
E7	Chart Number	Family File > **Patient Information** > **Chart #**. Notes: • If the Chart # has fewer than10 digits, additional zeros are included before the Chart #. • If the Chart # has more than 10 digits, only the last 10 are included.	See Figure 1.
E8	Date of Birth	Family File > **Patient Information** > **Birthdate** in a ccyymmdd format.	See Figure 1.
E9	Gender	FamilyFile > **Patient Information** > **Sex**: M (male); F (female); otherwise, U.	See Figure 1.
E10	SSN	FamilyFile > **Patient Information** > **SS#**. Note: Dashes (-) are not included.	See Figure 1.
E11	SSN Pseudo Flag	Empty	
E12	Tribe Code	Family File > **Patient Information** > **Additional Info** > **Tribe of Membership**: **Code**.	See Figure 4.
E13	Community of Residence Code	Family File > **Patient Information** > **Additional Info** > **Current Community**.	See Figure 4.
E14	Beneficiary Classification Code	Family File > **Patient Information** > **Additional Info** > **Beneficiary Classification**: **Code**.	See Figure 4.
E15	Service/Admission Date	Ledger > Enter or edit procedure > **Date** in a ccyymmdd format.	See Figure 11.
E16	Location of Encounter	Ledger > Enter or edit procedure > **Clinic**.	See Figure 11.
E17	Service Type Code	6	
E18	Service Category Code	A	
E19	Clinic Code	56	
E20	Provider Affiliation Code	Empty	
E21	Provider Discipline Code	The specialty (Office Manager > **Maintenance** > **Practice Setup** > **Clinic Resource Setup**>**Provider Information**> **Specialty**) of the provider of a procedure (Ledger > Enter or edit procedure > **Provider**). Possible values for specialty: 46 (dental hygienist); 52 (dentist); 60 (dental assistant); 61(dental laboratory technician); otherwise, 52 (any other selected specialty).	See Figure 15 and Figure 11.
E22	Diagnostic Code 1	Ledger > Edit procedure > **Medical Cross Coding** > **Diagnostic Codes** (applies only for ICD-10 codes).	See Figure 13.
E23	Cause of Injury 1	Empty	

Field #	Field Name	Field Value	
E24	Diagnostic Code 2	Ledger > Edit procedure > **Medical Cross Coding** > **Diagnostic Codes** (applies only for ICD-10 codes).	See Figure 13.
E25	Cause of Injury 2	Empty	
E26	Diagnostic Code 3	Ledger > Edit procedure > **Medical Cross Coding** > **Diagnostic Codes** (applies only for ICD-10 codes).	See Figure 13.
E27	Cause of Injury 3	Empty	
E28	Diagnostic Code 4	Ledger > Edit procedure > **Medical Cross Coding** > **Diagnostic Codes** (applies only for ICD-10 codes).	See Figure 13.
E29	Cause of Injury 4	Empty	
E30	Diagnostic Code 5	Ledger > Edit procedure > **Medical Cross Coding** > **Diagnostic Codes** (applies only for ICD-10 codes).	See Figure 13.
E31	Cause of Injury 5	Empty	
E32	Diagnostic Code 6	Ledger > Edit procedure > **Medical Cross Coding** > **Diagnostic Codes** (applies only for ICD-10 codes).	See Figure 13.
E33	Cause of Injury 6	Empty	
E34	Diagnostic Code 7	Ledger > Edit procedure > **Medical Cross Coding** > **Diagnostic Codes** (applies only for ICD-10 codes).	See Figure 13.
E35	Cause of Injury 7	Empty	
E36	Diagnostic Code 8	Ledger > Edit procedure > **Medical Cross Coding** > **Diagnostic Codes** (applies only for ICD-10 codes).	See Figure 13.
E37	Cause of Injury 8	Empty	
E38	Diagnostic Code 9	Ledger > Edit procedure > **Medical Cross Coding** > **Diagnostic Codes** (applies only for ICD-10 codes).	See Figure 13.
E39	Cause of Injury 9	Empty	
E40	Diagnostic Code 10	Ledger > Edit procedure > **Medical Cross Coding** > **Diagnostic Codes** (applies only for ICD-10 codes).	See Figure 13.
E41	Cause of Injury 10	Empty	
E42	ICD Procedure Code 1	Empty	
E43	ICD Procedure Code 2	Empty	
E44	ICD Procedure Code 3	Empty	
E45	Admission Service	Empty	
E46	Admission Type	Empty	
E47	Cause of Death	Empty	
E48	Discharge Date	Empty	
E49	Discharge Service Code	Empty	
E50	Discharge Type Code	Empty	
E51	Length of Stay	Empty	
E52	Prescription Quantity	Patient Prescription: Number of prescriptions within date range. Note: If null, 0 is inserted.	See Figure 14.
E53	Disposition on ER Visits	Empty	

Field #	Field Name	Field Value	
E54	Dentist's SSN	OfficeManager > **Maintenance** > **Practice Setup** > **Clinic Resource Setup** > **Provider Information** > **SS #**. Note: Dashes (-) are not included.	See Figure 15.
E55	Dental Delivery Code	Empty	
E56	Dental Cost	Sum of procedure fees rounded to the nearest dollar (Ledger > Enter or edit procedures within date range > **Amount**).	See Figure 11.
E57	ADA Code 1	Ledger>Enteroreditprocedure> **Procedure** code.	See Figure 11.
E58	ADA Units 1	Ledger > Enter or edit procedure > **Tooth** or **Tooth Range**: Number of teeth specified for the procedure, or 1 for a treatment area without a tooth number specified.	See Figure 11 and Figure 12.
E59	ADA Code Fee Amount 1	Ledger > Enter or edit procedure > **Amount**.	See Figure 11.
E60	ADA Code 2	Ledger > Enter or edit procedure > **Procedure** code.	See Figure 11.
E61	ADA Units 2	Ledger > Enter or edit procedure > **Tooth** or **Tooth Range**: Number of teeth specified for the procedure, or 1 for a treatment area without a tooth number specified.	See Figure 11 and Figure 12.
E62	ADA Code Fee Amount 2	Ledger > Enter or edit procedure > **Amount**.	See Figure 11.
E63	ADA Code 3	Ledger > Enter or edit procedure > **Procedure** code.	See Figure 11.
E64	ADA Units 3	Ledger > Enter or edit procedure > **Tooth** or **Tooth Range**: Number of teeth specified for the procedure, or 1 for a treatment area without a tooth number specified.	See Figure 11 and Figure 12.
E65	ADA Code Fee Amount 3	Ledger > Enter or edit procedure > **Amount**.	SeeFigure 11.
E66	ADA Code 4	Ledger > Enter or edit procedure > **Procedure** code.	SeeFigure 11.
E67	ADA Units 4	Ledger > Enter or edit procedure > **Tooth** or **Tooth Range**: Number of teeth specified for the procedure, or 1 for a treatment area without a tooth number specified.	SeeFigure11 andFigure12.
E68	ADA Code Fee Amount 4	Ledger > Enter or edit procedure > **Amount**.	SeeFigure 11.
E69	ADA Code 5	Ledger > Enter or edit procedure > **Procedure** code.	SeeFigure 11.
E70	ADA Units 5	Ledger > Enter or edit procedure > **Tooth** or **Tooth Range**: Number of teeth specified for the procedure, or 1 for a treatment area without a tooth number specified.	SeeFigure11 andFigure12.
E71	ADA Code Fee Amount 5	Ledger > Enter or edit procedure > **Amount**.	SeeFigure 11.
E72	ADA Code 6	Ledger > Enter or edit procedure > **Procedure** code.	SeeFigure 11.

Field #	Field Name	Field Value	
E73	ADA Units 6	Ledger > Enter or edit procedure > **Tooth** or **Tooth Range**: Number of teeth specified for the procedure, or 1 for a treatment area without a tooth number specified.	SeeFigure11 andFigure12.
E74	ADA Code Fee Amount 6	Ledger > Enter or edit procedure > **Amount**.	SeeFigure 11.
E75	ADA Code 7	Ledger > Enter or edit procedure > **Procedure** code.	SeeFigure 11.
E76	ADA Units 7	Ledger > Enter or edit procedure > **Tooth** or **Tooth Range**: Number of teeth specified for the procedure, or 1 for a treatment area without a tooth number specified.	SeeFigure11 andFigure12.
E77	ADA Code Fee Amount 7	Ledger > Enter or edit procedure > **Amount**.	SeeFigure 11.
E78	ADA Code 8	Ledger > Enter or edit procedure > **Procedure** code.	SeeFigure 11.
E79	ADA Units 8	Ledger > Enter or edit procedure > **Tooth** or **Tooth Range**: Number of teeth specified for the procedure, or 1 for a treatment area without a tooth number specified.	SeeFigure11 andFigure12.
E80	ADA Code Fee Amount 8	Ledger > Enter or edit procedure > **Amount**.	SeeFigure 11.
E81	ADA Code 9	Ledger > Enter or edit procedure > **Procedure** code.	SeeFigure 11.
E82	ADA Units 9	Ledger > Enter or edit procedure > **Tooth** or **Tooth Range**: Number of teeth specified for the procedure, or 1 for a treatment area without a tooth number specified.	SeeFigure11 andFigure12.
E83	ADA Code Fee Amount 9	Ledger > Enter or edit procedure > **Amount**.	SeeFigure 11.
E84	ADA Code 10	Ledger > Enter or edit procedure > **Procedure** code.	SeeFigure 11.
E85	ADA Units 10	Ledger > Enter or edit procedure > **Tooth** or **Tooth Range**: Number of teeth specified for the procedure, or 1 for a treatment area without a tooth number specified.	See Figure 11 and Figure 12.
E86	ADA Code Fee Amount 10	Ledger > Enter or edit procedure > **Amount**.	See Figure 11.
E87	ADA Code 11	Ledger > Enter or edit procedure > **Procedure** code.	See Figure 11.
E88	ADA Units 11	Ledger > Enter or edit procedure > **Tooth** or **Tooth Range**: Number of teeth specified for the procedure, or 1 for a treatment area without a tooth number specified.	See Figure 11 and Figure 12.
E89	ADA Code Fee Amount 11	Ledger > Enter or edit procedure > **Amount**.	See Figure 11.
E90	ADA Code 12	Ledger > Enter or edit procedure > **Procedure** code.	See Figure 11.
E91	ADA Units 12	Ledger > Enter or edit procedure > **Tooth** or **Tooth Range**: Number of teeth specified for the procedure, or 1 for a treatment area without a tooth number specified.	See Figure 11 and Figure 12.

Field #	Field Name	Field Value	
E92	ADA Code Fee Amount 12	Ledger > Enter or edit procedure > **Amount**.	See Figure 11.
E93	ADA Code 13	Ledger > Enter or edit procedure > **Procedure** code.	See Figure 11.
E94	ADA Units 13	Ledger > Enter or edit procedure > **Tooth** or **Tooth Range**: Number of teeth specified for the procedure, or 1 for a treatment area without a tooth number specified.	See Figure 11 and Figure 12.
E95	ADA Code Fee Amount 13	Ledger > Enter or edit procedure > **Amount**.	See Figure 11.
E96	ADA Code 14	Ledger > Enter or edit procedure > **Procedure** code.	See Figure 11.
E97	ADA Units 14	Ledger > Enter or edit procedure > **Tooth** or **Tooth Range**: Number of teeth specified for the procedure, or 1 for a treatment area without a tooth number specified.	See Figure 11 and Figure 12.
E98	ADA Code Fee Amount 14	Ledger > Enter or edit procedure > **Amount**.	See Figure 11.
E99	ADA Code 15	Ledger > Enter or edit procedure > **Procedure** code.	See Figure 11.
E100	ADA Units 15	Ledger > Enter or edit procedure > **Tooth** or **Tooth Range**: Number of teeth specified for the procedure, or 1 for a treatment area without a tooth number specified.	See Figure 11 and Figure 12.
E101	ADA Code Fee Amount 15	Ledger > Enter or edit procedure > **Amount**.	See Figure 11.
E102	CHS Paid Amount	Empty	
E103	Vendor Type Code	Empty	
E104	Authorizing Facility	Empty	
E105	Authorization Number	Empty	
E106	Provider Tax ID	OfficeManager > **Maintenance** > **Practice Setup** > **Clinic Resource Setup** > **Provider Information** > **TIN #**.	See Figure 15.
E107	Payment Status Code	Empty	
E108	Claim Number	Claim ID from the database (DDB_PROC_LOG_BASE.CLAIMID).	
E109	HCPCS / CPT Code 1	Ledger > Edit procedure > **Medical Cross coding** > **AMA CPT**.	See Figure 13.
E110	HCPCS / CPT Code 2	Ledger > Edit procedure > **Medical Cross coding** > **AMA CPT**.	See Figure 13.
E111	HCPCS / CPT Code 3	Ledger > Edit procedure > **Medical Cross coding** > **AMA CPT**.	See Figure 13.
E112	HCPCS / CPT Code 4	Ledger > Edit procedure > **Medical Cross coding** > **AMA CPT**.	See Figure 13.
E113	HCPCS / CPT Code 5	Ledger > Edit procedure > **Medical Cross coding** > **AMA CPT**.	See Figure 13.
E114	HCPCS / CPT Code 6	Ledger > Edit procedure > **Medical Cross coding** > **AMA CPT**.	See Figure 13.

Field #	Field Name	Field Value	
E115	HCPCS / CPT Code 7	Ledger > Edit procedure > **Medical Cross coding** > **AMA CPT**.	See Figure 13.
E116	HCPCS / CPT Code 8	Ledger > Edit procedure > **Medical Cross coding** > **AMA CPT**.	See Figure 13.
E117	HCPCS / CPT Code 9	Ledger > Edit procedure > **Medical Cross coding** > **AMA CPT**.	See Figure 13.
E118	HCPCS / CPT Code 10	Ledger > Edit procedure > **Medical Cross coding** > **AMA CPT**.	See Figure 13.
E119	HCPCS / CPT Code 11	Ledger > Edit procedure > **Medical Cross coding** > **AMA CPT**.	See Figure 13.
E120	HCPCS / CPT Code 12	Ledger > Edit procedure > **Medical Cross coding** > **AMA CPT**.	See Figure 13.
E121	HCPCS / CPT Code 13	Ledger > Edit procedure > **Medical Cross coding** > **AMA CPT**.	See Figure 13.
E122	HCPCS / CPT Code 14	Ledger > Edit procedure > **Medical Cross coding** > **AMA CPT**.	See Figure 13.
E123	HCPCS / CPT Code 15	Ledger > Edit procedure > **Medical Cross coding** > **AMA CPT**.	See Figure 13.
E124	File Layout Version Number	Office Manager > **Data Extraction** > **National Patient Information Record System (NPIRS)** > **Setup** > **File Format Version**.	See Figure 18.

Registration Record Fields (#1–74)

Field #	Field Name	Field Value	
R1	Unique Registration Code	Office Manager > **Data Extraction** > **National Patient Information Record System (NPIRS)** > **Setup** > **Database ID (from NDW)** + Patient ID from the database (DDB_PAT_BASE.PATID). Notes: • The Unique Registration Code has 15 digits total. • If the PATID has fewer than 10 digits, additional zeros are included before the PATID. • If the PATID has more than 10 digits, only the last 10 are included.	See Figure 18.
R2	Registration Create Date	Create/entry date from the database (DDB_PAT_BASE.EntryDateTime) in a ccyymmdd format.	
R3	Registration Last Update	Last modified date from the database (DDB_PAT_BASE.DDB_LAST_MOD) in a ccyymmdd format.	
R4	Registration Status Code	Family File > **Patient Information** > **PatientStatus**: A (active); otherwise, I (inactive).	See Figure 1.

Field #	Field Name	Field Value	
R5	Chart Facility Code	Office Manager > **Data Extraction** > **National Patient Information Record System (NPIRS)** > **Create Extraction** > **Export Box ASUFAC**.	See Figure 17.
R6	Chart Number	Family File > **Patient Information** > **Chart #**. Notes: • If the Chart # has fewer than 10 digits , additional zeros are included before the Chart #. • If the Chart # has more than 10 digits, only the last 10 are included.	See Figure 1.
R7	Title	Family File > **Patient Information** > **Title**.	See Figure 1.
R8	First Name	Family File > **Patient Information** > **First** name.	See Figure 1.
R9	Middle Name	Family File > **Patient Information** > **Middle** name.	See Figure 1.
R10	Last Name	Family File > **Patient Information** > **Last** name.	See Figure 1.
R11	Name Suffix	Family File > **Patient Information** > **Suffix**.	See Figure 1.
R12	Date of Birth	FamilyFile > **Patient Information** > **Birthdate** in a ccyymmdd format.	See Figure 1.
R13	Date of Death	Family File > **Patient Information** > **Death Date** in a ccyymmdd format.	See Figure 1.
R14	Gender	Family File > **Patient Information** > **Sex**: M (male); F (female); otherwise, U.	See Figure 1.
R15	SSN	Family File >Patient Information > SS#. Note: Dashes (-) are not included.	See Figure 1.
R16	SSN Pseudo Flag	Empty	
R17	Beneficiary Classification Code	Family File > **Patient Information** > **Additional Info** > **Beneficiary Classification Code**.	See Figure 4.
R18	Tribe Code	Family File > **Patient Information** > **Additional Info** > **Tribe of Membership**: **Code**.	See Figure 4.
R19	Blood Quantum Code	Family File > **Patient Information** > **Additional Info** > **Indian Blood Quantum**.	See Figure 4.
R20	Community of Residence Code	Family File > **Patient Information** > **Additional Info** > **Current Community**.	See Figure 4.
R21	Date Moved To Community	Family File > **Patient Information** > **AdditionalInfo**>**CurrentResidence Date** in a ccyymmdd format.	See Figure 4.
R22	Street	FamilyFile>**PatientInformation**> **Address** > Add or edit > **Street 1**.	See Figure 2.
R23	City	FamilyFile>**PatientInformation**> **Address** > Add or edit > **City**.	See Figure 2.
R24	State Code	Family File > **Patient Information**> **Address** > Add or edit > **State**.	See Figure 2.
R25	ZIP Code	Family File > **Patient Information** > **Address** > Add or edit > **ZIP** (5digits).	See Figure 2.
R26	ZIP Code Extension	Family File > **Patient Information** > **Address** > Add or edit > **ZIP** (4-digit suffix).	See Figure 2.

Field #	Field Name	Field Value	
R27	Father's First Name	Family File > **Patient Information** > **Contact Info** > Add or edit > **First** name.	See Figure 3.
R28	Father's Middle Name	Family File > **Patient Information** > **Contact Info** > Add or edit > **Middle** name.	See Figure 3.
R29	Father's Last Name	Family File > **Patient Information** > **Contact Info** > Add or edit > **Last** name.	See Figure 3.
R30	Mother's First Name	Family File > **Patient Information** > **Mother's Maiden First Name**.	See Figure 1.
R31	Mother's Middle Name	Family File > **Patient Information** > **Mother's Maiden Middle**.	See Figure 1.
R32	Mother's Maiden Last Name	Family File > **Patient Information** > **Mother's Maiden Last Name**.	See Figure 1.
R33	Service Eligibility Code	Empty	
R34	Veteran Flag	Family File > **Patient Information** > **Veteran Status**: Y (yes) or empty.	See Figure 1.
R35	Primary Dental Insurance Category Code	If the plan's selected financial class type's description (Family File > **Insurance Information** > **Dental Insurance** > **Insurance Data** > **Financial Class Types**) matches an insurance category code definition's description (Office Manager > **Maintenance** > **Practice Setup** > **IHS Standard Codes Definitions** > **Insurance Category Codes**), use that definition's **Code**: • MCD (the financial class type contains "Medicaid"). • MCR (the financial class type contains "Medicare"). • PVT (the financial class type contains "Private"). • RRE (the financial class type contains "Railroad").	See Figure 6 and Figure 16.
R36	Primary Dental Coverage Type Code	Family File > **Insurance Information** > **Dental Insurance** > **Insurance Data** > **Financial Class Types** > Selected financial class type's description. Note: If the description exceeds 30 characters, only the first 30 characters are included.	See Figure 6.
R37	Primary Dental Eligibility Start Date	Family File > **Insurance Information** > **Dental Insurance** > **Eligibility Start** in a ccyymmdd format.	See Figure 5.
R38	Primary Dental Eligibility End Date	Family File > **Insurance Information** > **Dental Insurance** > **Eligibility End** in a ccyymmdd format.	See Figure 5.
R39	Primary Dental Policy Number	Family File > **Insurance Information** > **Dental Insurance** > **Subscriber Id #**.	See Figure 5.
R40	Primary Dental Insurer Name	Family File > **Insurance Information** > **Dental Insurance** > **Insurance Data** > **Carrier Name**.	See Figure 6.
R41	Primary Dental Insurer EIN	Empty	

Field #	Field Name	Field Value	
R42	Primary Dental Eligibility State Code	Family File > **Patient Information** > **Address** > Add or edit > **State**.	See Figure 2.
R43	Primary Dental PlanName	If the plan's selected financial class type's description (Family File > **Insurance Information** > **Dental Insurance** > **Insurance Data** > **Financial Class Types**) contains "Medicaid," use the plan's **Group Plan**; otherwise, the field is empty.	See Figure 6.
R44	Primary Dental Policy Holder's First Name	Family File > **Insurance Information** > **Dental Insurance** > **Subscriber** first name.	See Figure 5.
R45	Primary Dental Policy Holder's Middle Name	Family File > **Insurance Information**> **Dental Insurance** > **Subscriber** middle name.	See Figure 5.
R46	Primary Dental Policy Holder's Last Name	Family File > **Insurance Information** > **Dental Insurance** > **Subscriber** last name.	See Figure 5.
R47	Relationship to Primary Dental Insured	Family File > **Insurance Information** > **Dental Insurance** > **Relation to Subscriber**.	See Figure 5.
R48	Primary Medical Insurance Category Code	If the plan's selected financial class type's description (Family File > **Insurance Information** > **Medical Insurance** > **Insurance Data** > **Financial Class Types**) matches an insurance category code definition's description (Office Manager > **Maintenance** > **Practice Setup** > **IHS Standard Codes Definitions** > **Insurance Category Codes**), use that definition's **Code**: • MCD (the financial class type contains "Medicaid"). • MCR (the financial class type contains "Medicare"). • PVT (the financial class type contains "Private"). • RRE (the financial class type contains "Railroad").	See Figure 8 and Figure 16.
R49	Primary Medical Coverage Type Code	Family File > **Insurance Information** > **Medical Insurance** > **Insurance Data** > **Financial Class Types** > Selected financial class type's description. Note: If the description exceeds 30 characters, only the first 30 characters are included.	See Figure 8.
R50	Primary Medical Eligibility Start Date	Family File > **Insurance Information** > **Medical Insurance** > **Eligibility Start** in a ccyymmdd format.	See Figure 7.
R51	Primary Medical Eligibility End Date	Family File > **Insurance Information** > **Medical Insurance** > **Eligibility End** in a ccyymmdd format.	See Figure 7.
R52	Primary Medical Policy Number	Family File > **Insurance Information** > **Medical Insurance** > **Subscriber Id #**.	See Figure 7.
R53	Primary Medical Insurer Name	Family File > **Insurance Information** > **Medical Insurance** > **Insurance Data** > **Carrier Name**.	See Figure 8.
R54	Primary Medical Insurer EIN	Empty	

Field #	Field Name	Field Value	
R55	Primary Medical Eligibility State Code	Family File > **Patient Information** > **Address** > Add or edit > **State**.	See Figure 2.
R56	Primary Medical Plan Name	If the plan's selected financial class type's description (Family File > **Insurance Information** > **Medical Insurance** > **Insurance Data** > **Financial Class Types**) contains "Medicaid," use the plan's **Group Plan**; otherwise, the field is empty.	See Figure 8.
R57	Primary Medical Policy Holder's First Name	Family File > **Insurance Information** > **Medical Insurance** > **Subscriber** first name.	See Figure 7.
R58	Primary Medical Policy Holder's Middle Name	Family File > **Insurance Information** > **Medical Insurance** > **Subscriber** middle name.	See Figure 7.
R59	Primary Medical Policy Holder's Last Name	Family File > **Insurance Information** > **Medical Insurance** > **Subscriber** last name.	See Figure 7.
R60	Relationship to Primary Medical Insured	Family File > **Insurance Information** > **Medical Insurance** > **Relation to Subscriber**.	See Figure 7.
R61	Secondary Dental Insurance Category Code	If the plan's selected financial class type's description (Family File > **Insurance Information** > **Dental Insurance** > **Insurance Data** >**Financial Class Types**) matches an insurance category code definition's description (Office Manager > **Maintenance** > **Practice Setup** > **IHS Standard Codes Definitions** > **Insurance Category Codes**), use that definition's **Code**: • MCD (the financial class type contains "Medicaid"). • MCR (the financial class type contains "Medicare"). • PVT (the financial class type contains "Private"). • RRE (the financial class type contains "Railroad").	See Figure 10 and Figure 16.
R62	Secondary Dental Coverage Type Code	Family File > **Insurance Information** > **Dental Insurance** > **Insurance Data** > **Financial Class Types** > Selected financial class type's description. Note: If the description exceeds 30 characters, only the first 30 characters are included.	See Figure 10.
R63	Secondary Dental Eligibility Start Date	Family File > **Insurance Information** > **Dental Insurance** > **Eligibility Start** in a ccyymmdd format.	See Figure 9.
R64	Secondary Dental Eligibility End Date	Family File > **Insurance Information** > **Dental Insurance** > **Eligibility End** in a ccyymmdd format.	See Figure 9.
R65	Secondary Dental Policy Number	Family File > **Insurance Information** > **Dental Insurance** > **Subscriber Id #**.	See Figure 9.
R66	Secondary Dental Insurer Name	Family File > **Insurance Information** > **Dental Insurance** > **Insurance Data** > **Carrier Name**.	See Figure 10.
R67	Secondary Dental Insurer EIN	Empty	

Field #	Field Name	Field Value	
R68	Secondary Dental Eligibility State Code	Family File>**Patient Information** > **Address** > Add or edit > **State**.	See Figure 2.
R69	Secondary Dental Plan Name	If the plan's selected financial class type's description (Family File > **Insurance Information** > **Dental Insurance** > **Insurance Data** > **Financial Class Types**) contains "Medicaid," use the plan's **Group Plan**; otherwise, the field is empty.	See Figure 10.
R70	Secondary Dental Policy Holder's First Name	Family File > **Insurance Information** > **Dental Insurance** > **Subscriber** first name.	See Figure 9.
R71	Secondary Dental Policy Holder's Middle Name	Family File > **Insurance Information** > **Dental Insurance** > **Subscriber** middle name.	See Figure 9.
R72	Secondary Dental Policy Holder's Last Name	Family File > **Insurance Information** > **Dental Insurance** > **Subscriber** last name.	See Figure 9.
R73	Relationship to Secondary Dental Insured	Family File > **Insurance Information** > **Dental Insurance** > **Relation to Subscriber**.	See Figure 9.
R74	File Format Version	Office Manager > **Data Extraction** > **National Patient Information Record System (NPIRS)** > **Setup** > **File Format Version**.	See Figure 18.

Trailer Record Fields (#1–13)

Field #	Field Name	Field Value	
T1	Trailer Record Code	Office Manager > **Data Extraction** > **National Patient Information Record System (NPIRS)** > **Setup** > **Trailer Record Code**.	See Figure 18.
T2	Process Code	Empty	
T3	Export ID	Empty	
T4	IHS Area Code	Office Manager > **Data Extraction** > **National Patient Information Record System (NPIRS)** > **Create Extraction** > **IHS Area Code**.	See Figure 17.
T5	Source File Name	Depends on the file type. See "File Naming Convention."	
T6	Source File Record Quantity	Number of records, including the header and trailer records, in the file.	
T7	IE File Name	Empty	
T8	IE Record Count	Empty	
T9	IE File Creation Date	Empty	
T10	Number of PCC Visits	Empty	
T11	PCC Visits Skipped	Empty	
T12	PCC Visit Errors	Empty	
T13	Skipped Demo Patients	Empty	

Figures Referenced in Tables

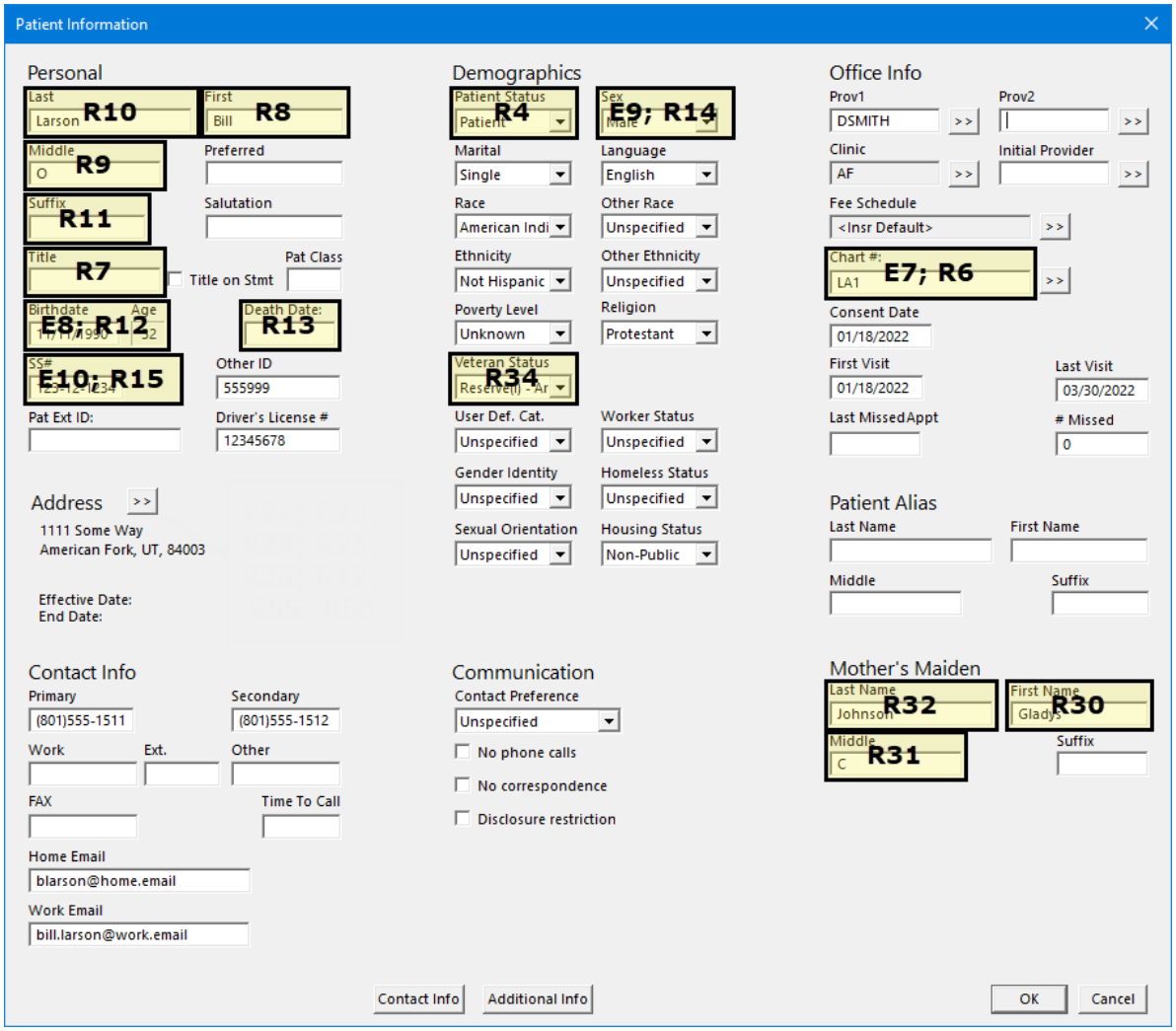


Figure 1: (Family File) Patient Information dialog box.

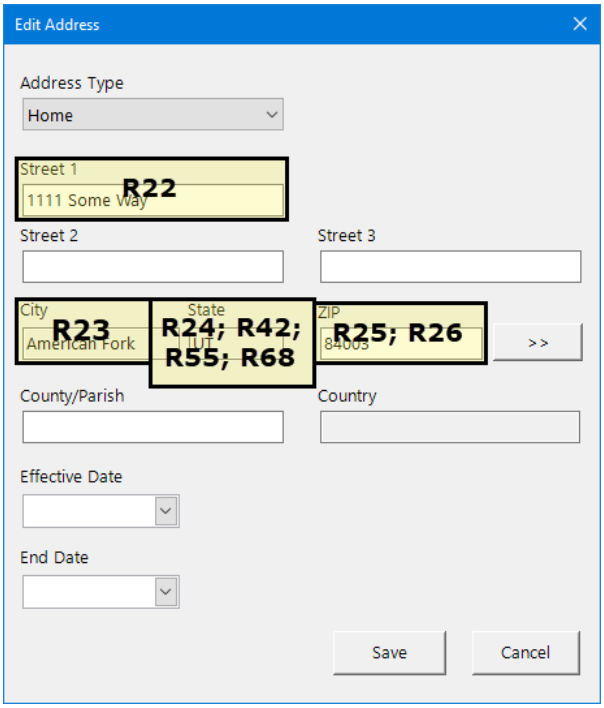


Figure 2: (Family File) Edit Address dialog box.

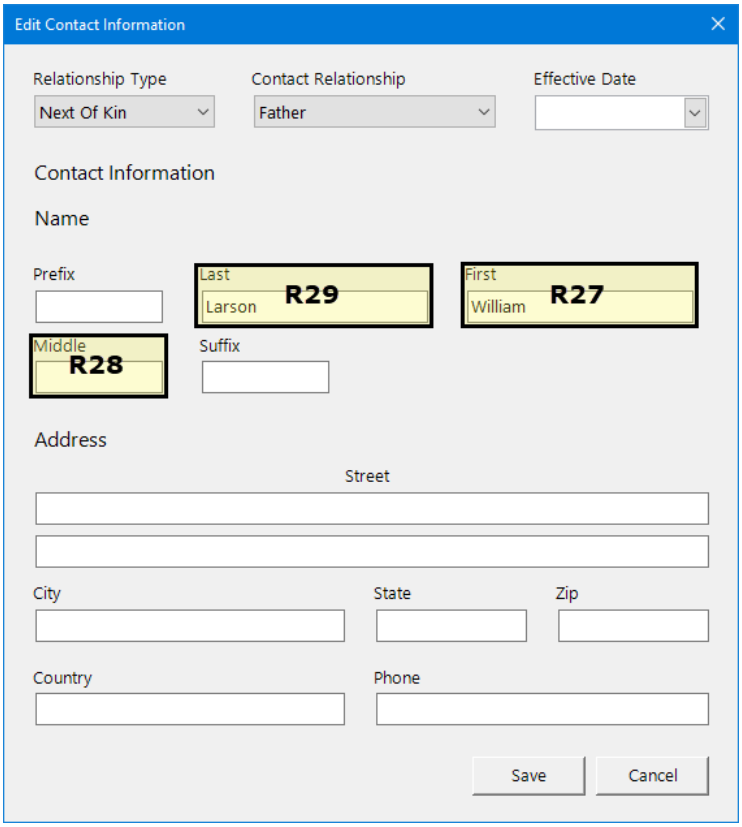


Figure 3: (Family File) Edit Contact Information dialog box.

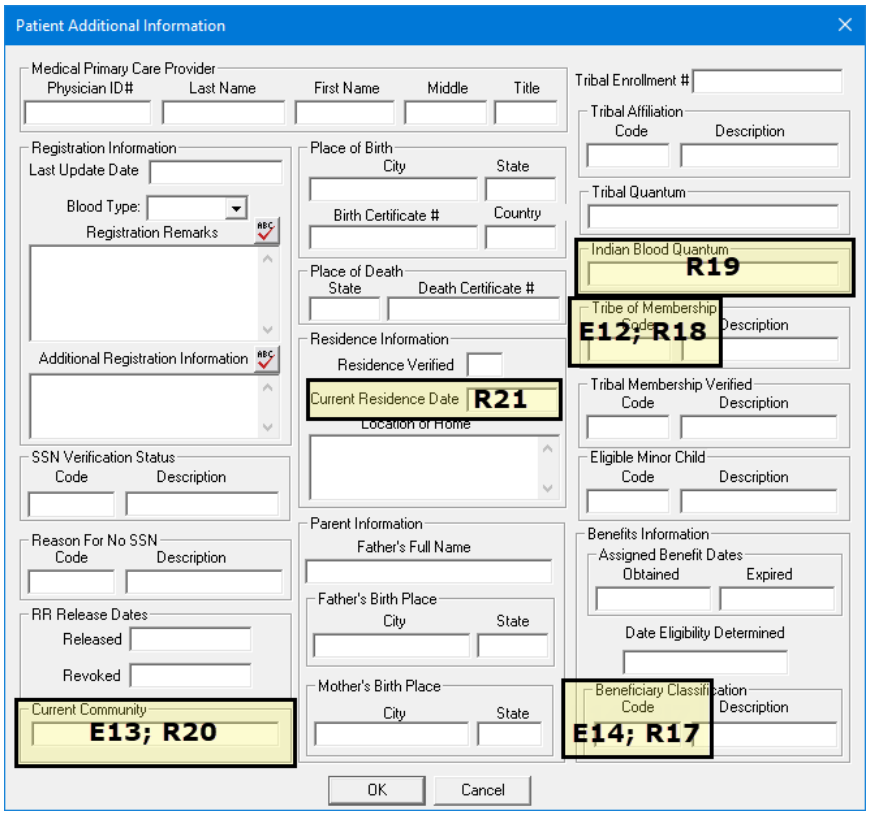


Figure 4: (Family File) Patient Additional Information dialog box.

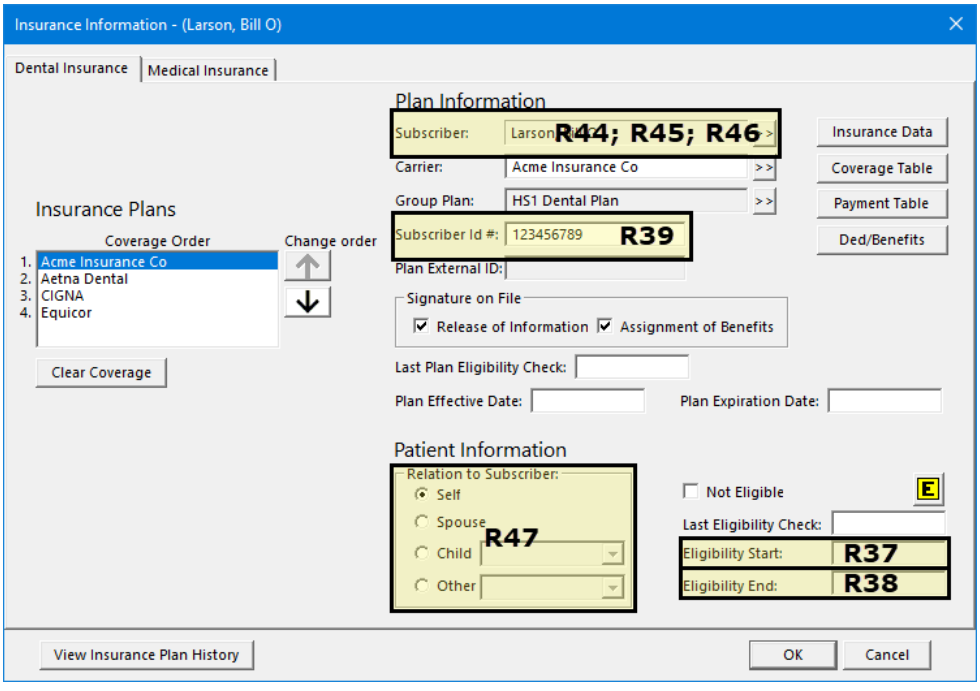


Figure 5: (Family File) Insurance Information dialog box. Primary dental insurance plan selected.

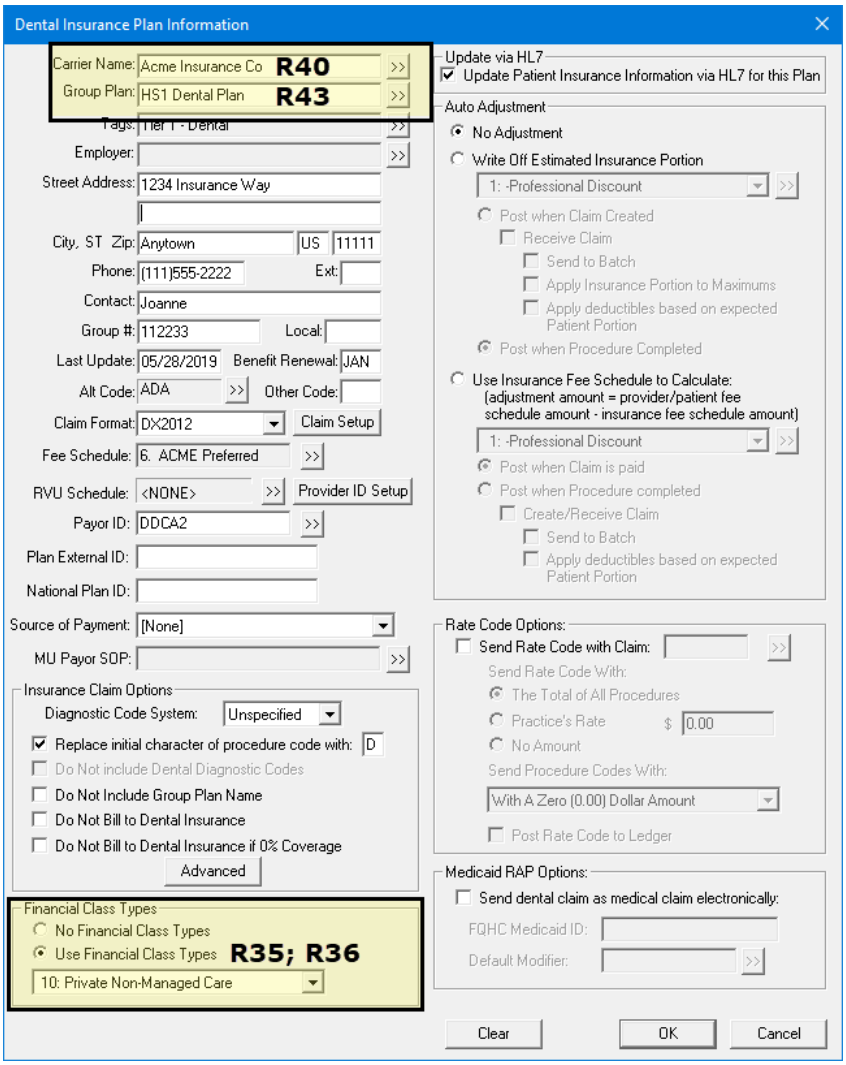


Figure 6: (Family File) Dental Insurance Plan Information dialog box for primary dental insurance plan.

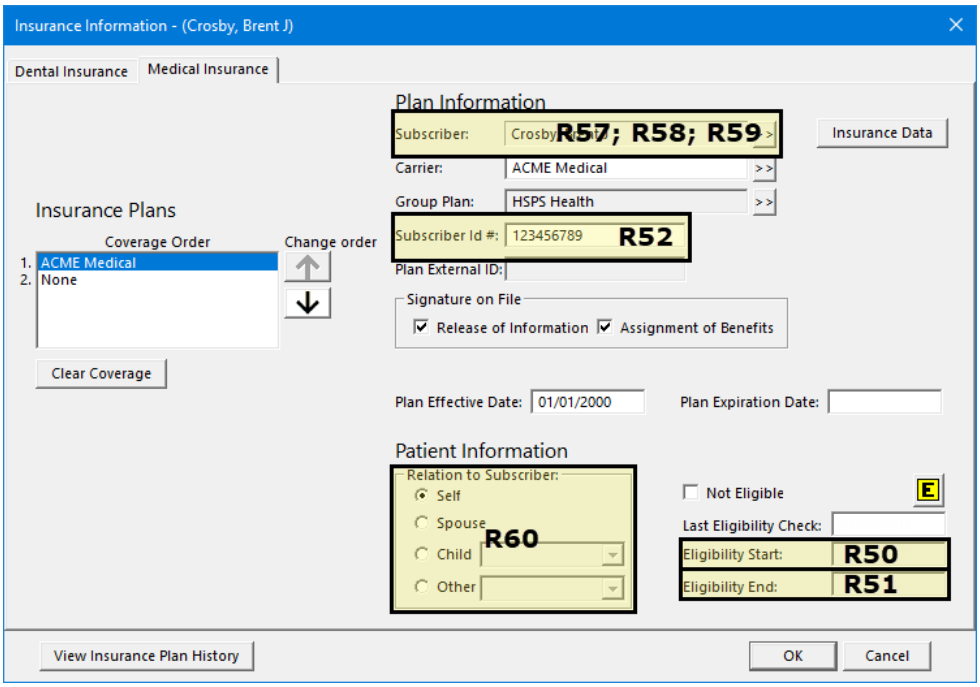


Figure 7: (Family File) Insurance Information dialog box. Primary medical insurance plan selected.

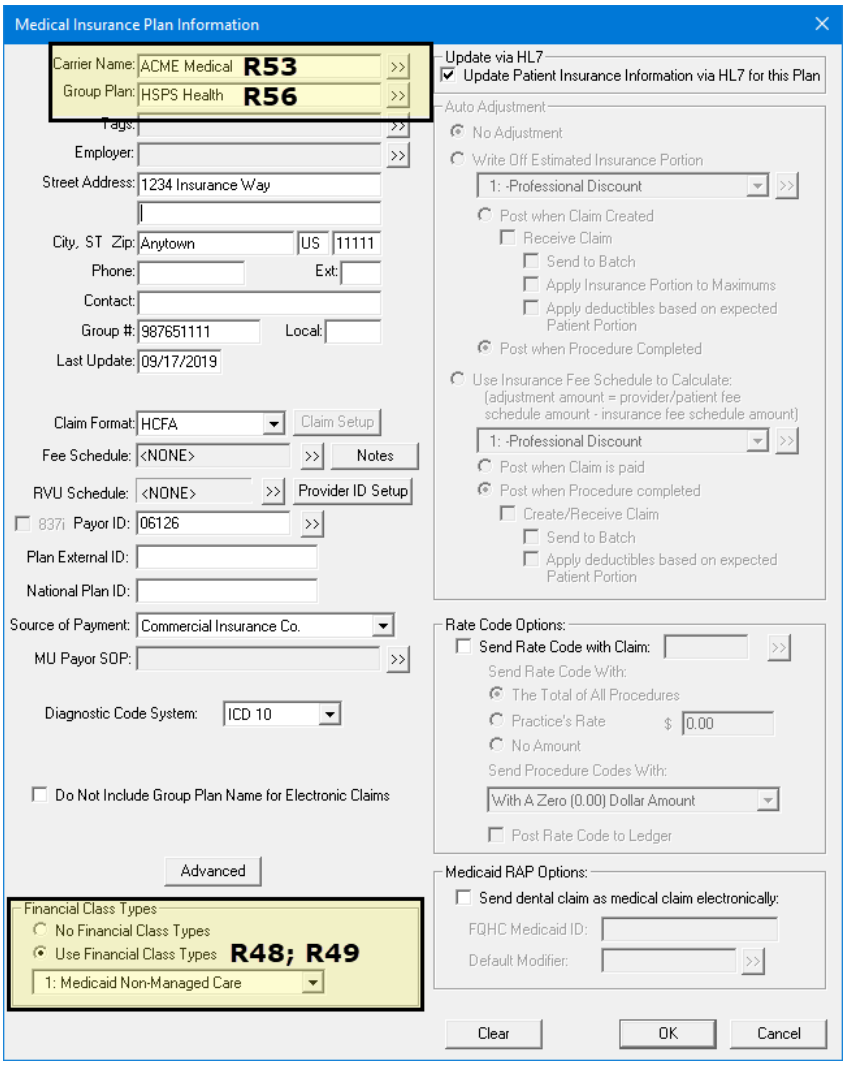


Figure 8: (Family File) Medical Insurance Plan Information dialog box for primary medical insurance plan.

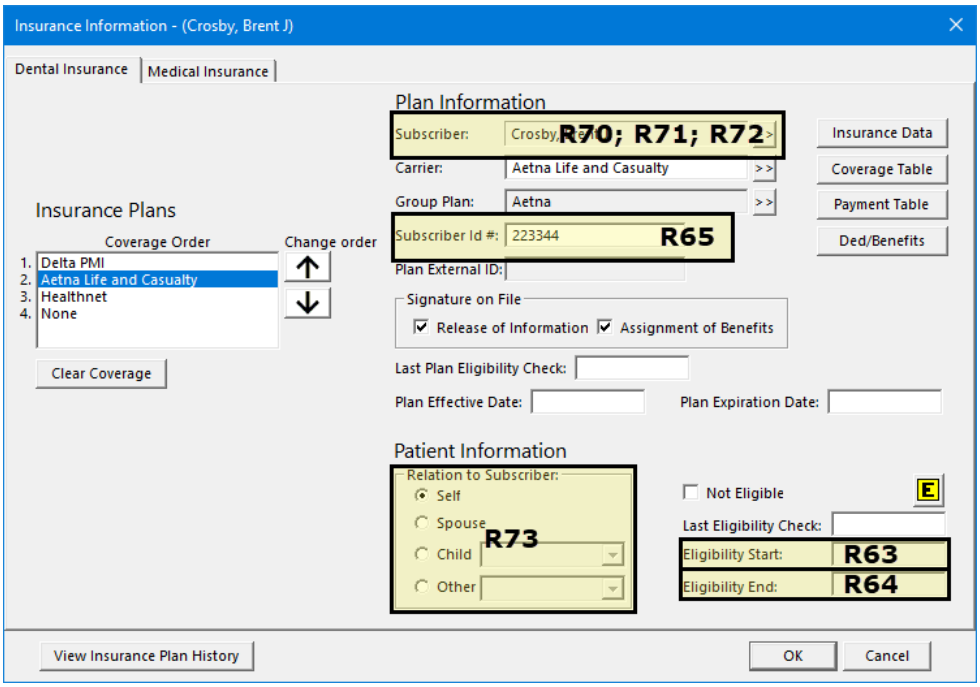


Figure 9: (Family File) Insurance Information dialog box. Secondary dental insurance plan selected.

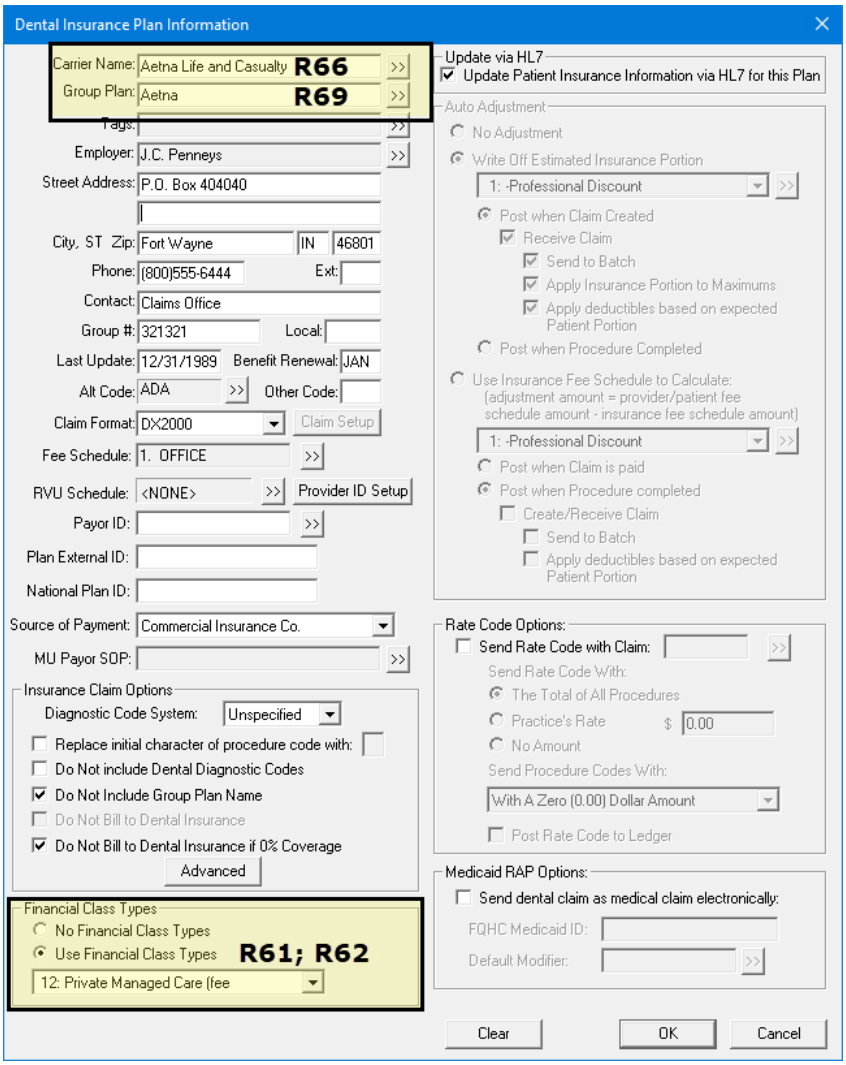


Figure 10: (Family File) Dental Insurance Plan Information dialog box for secondary dental insurance plan.

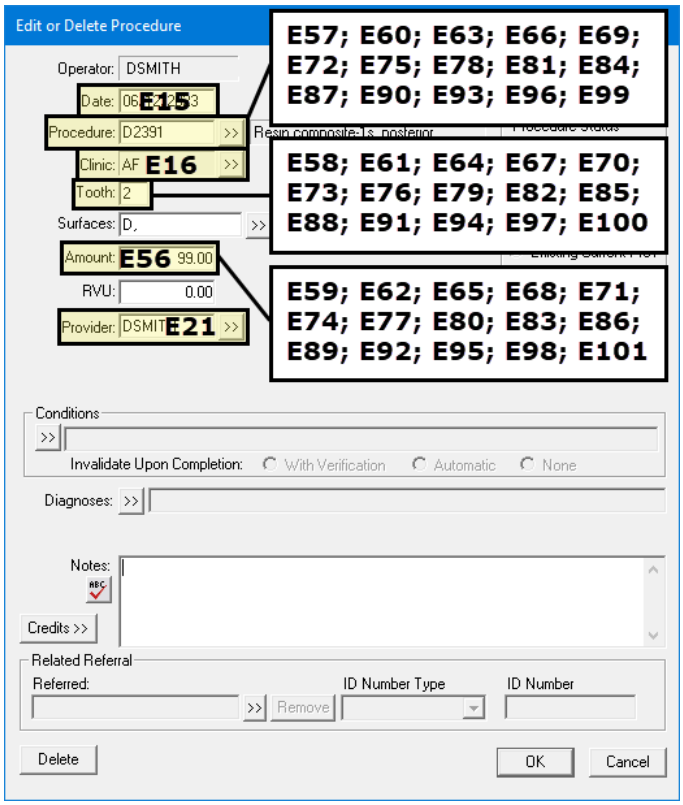


Figure 11: (Ledger) Edit or Delete Procedure dialog box.

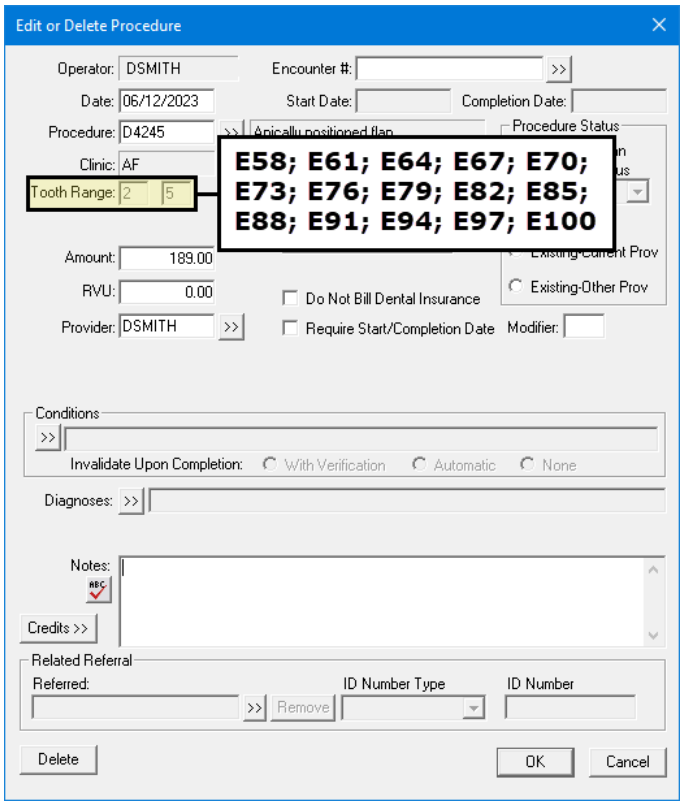


Figure 12: (Ledger) Tooth Range in Edit or Delete Procedure dialog box.

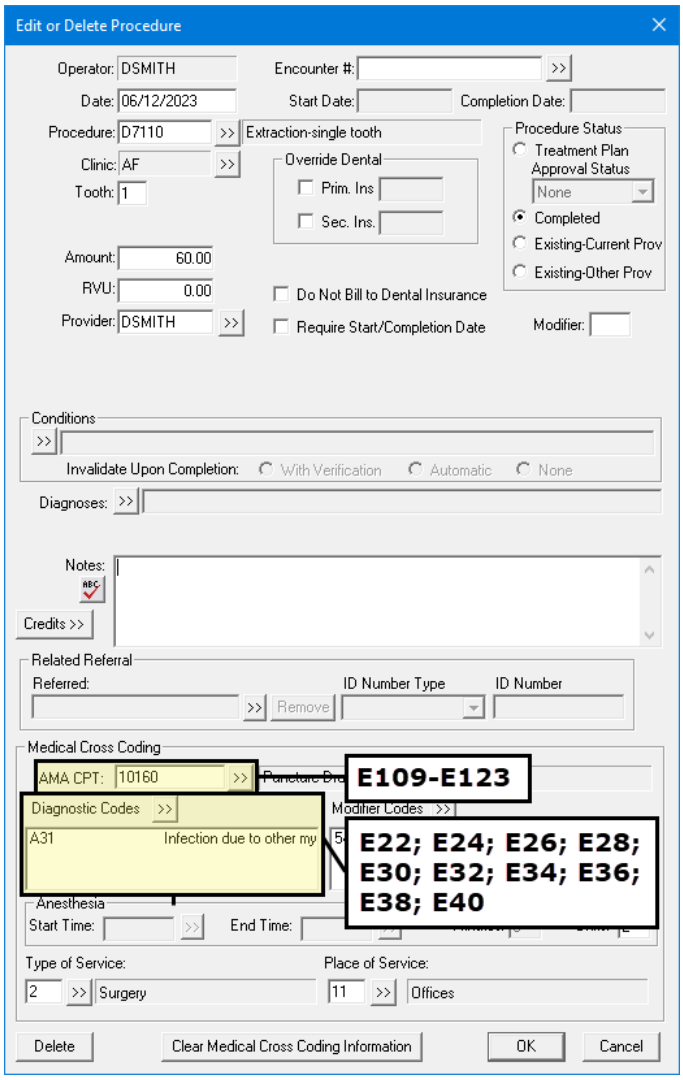


Figure 13: (Ledger) Medical Cross Coding in Edit or Delete Procedure dialog box.

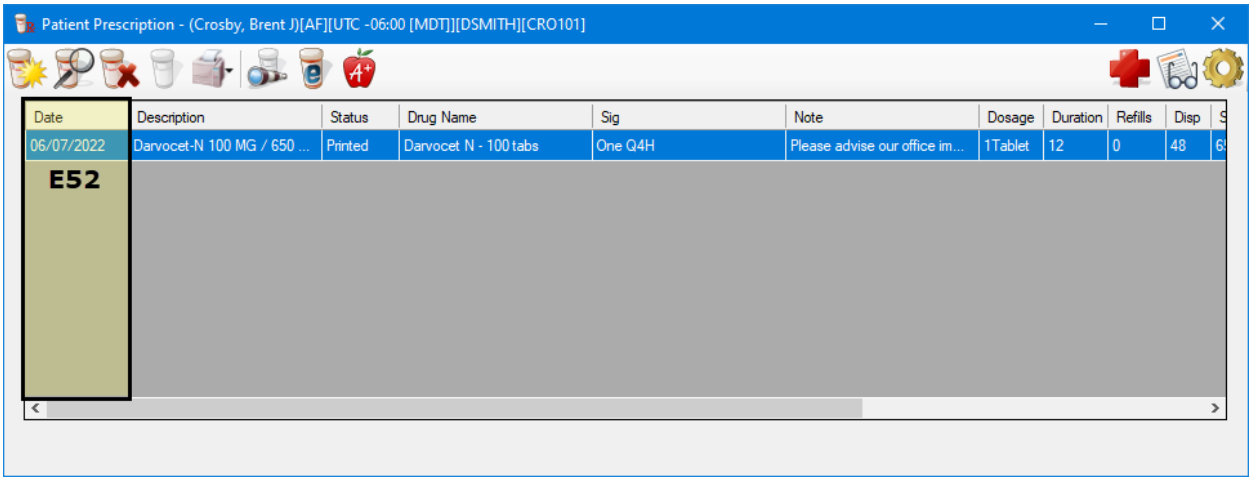


Figure 14: (Patient Prescription) Date column in list of prescriptions.

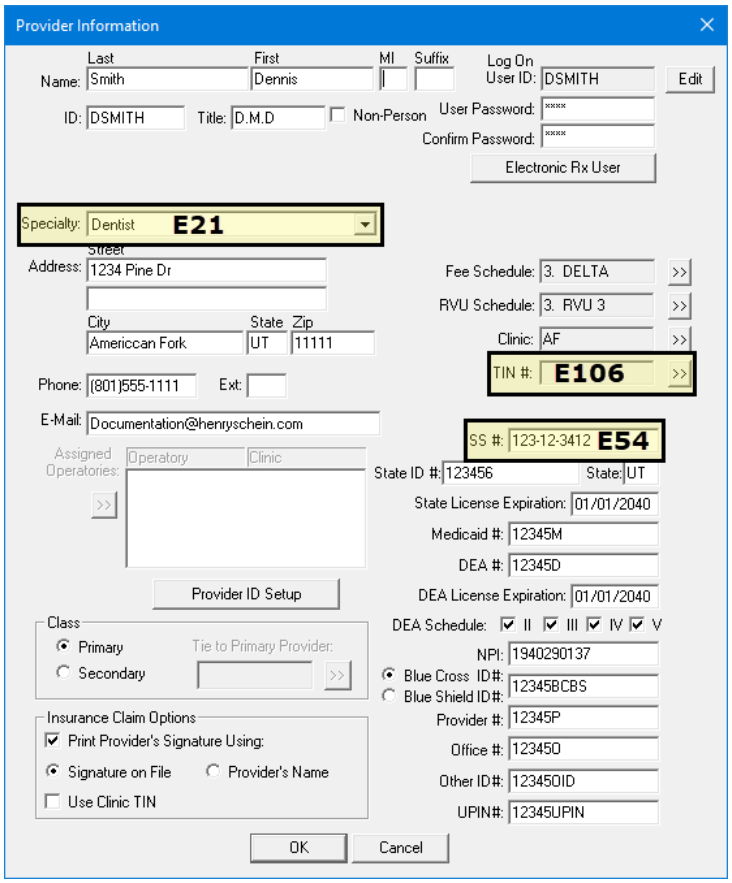


Figure 15: (Office Manager) Provider Information dialog box.

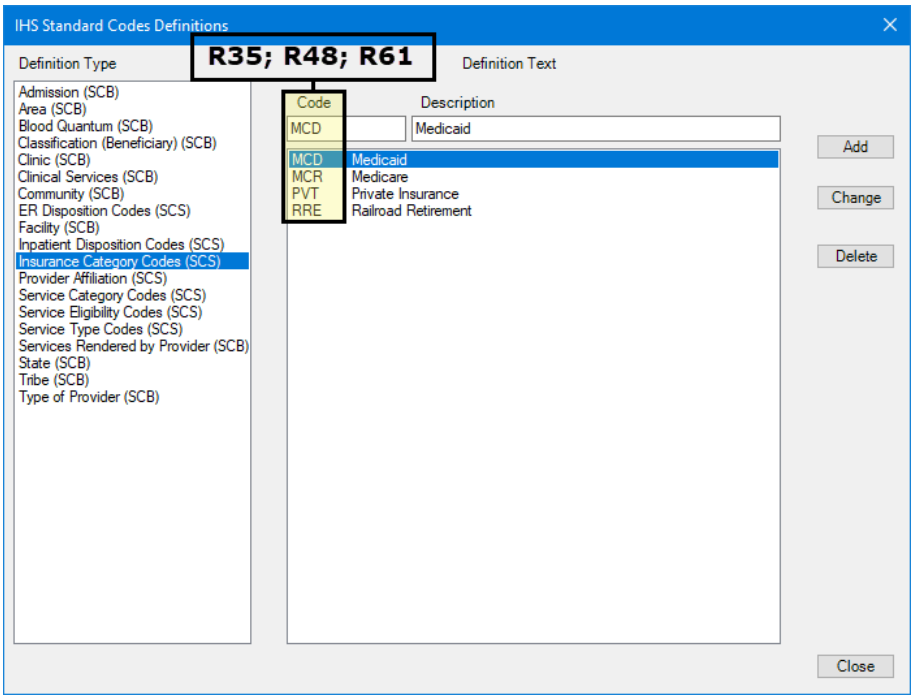


Figure 16: (Office Manager) IHS Standard Codes Definitions dialog box. Insurance Category Codes selected.

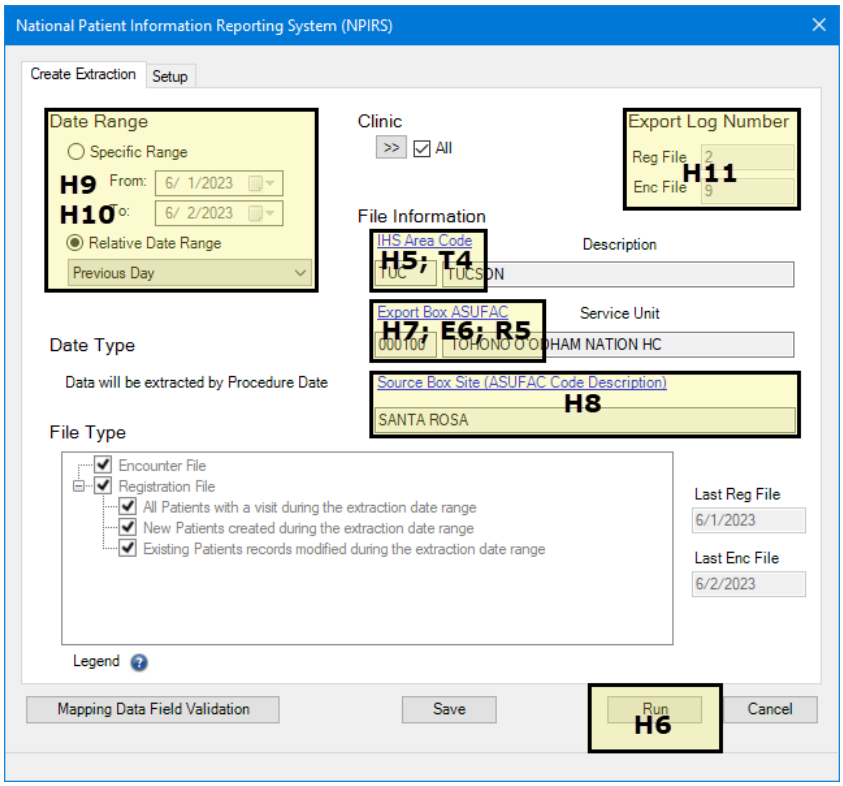


Figure 17: (Office Manager) NPIRS dialog box. Create Extraction tab selected.

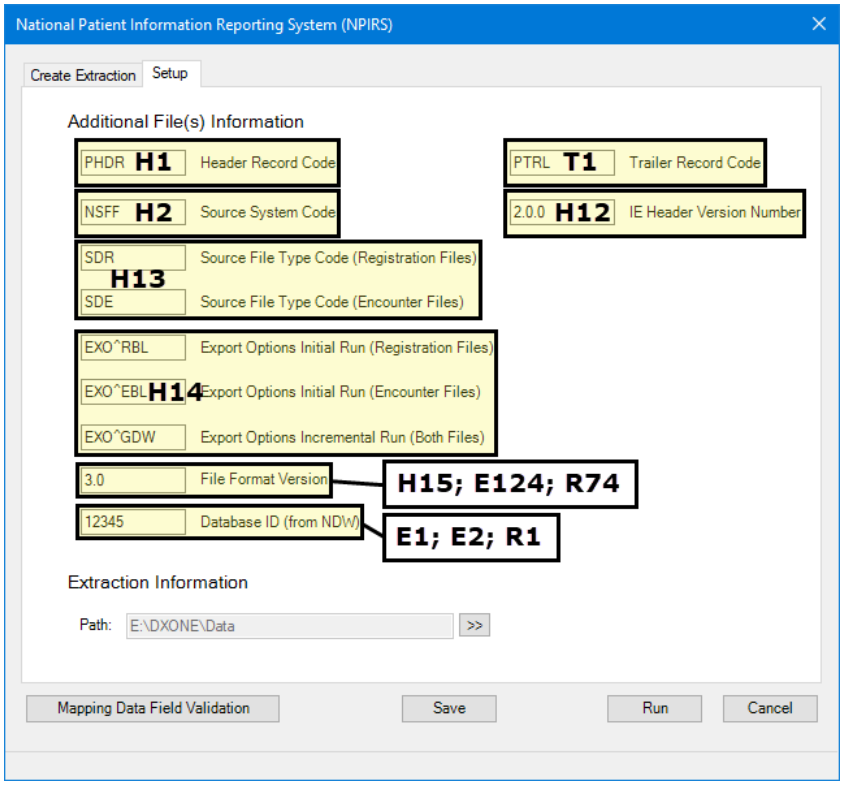


Figure 18: (Office Manager) NPIRS dialog box. Setup tab selected.

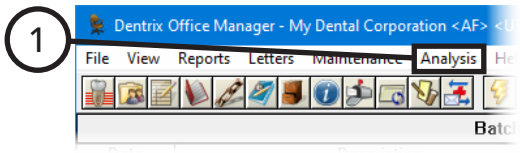
Using the Document Center Audit Documents Utility

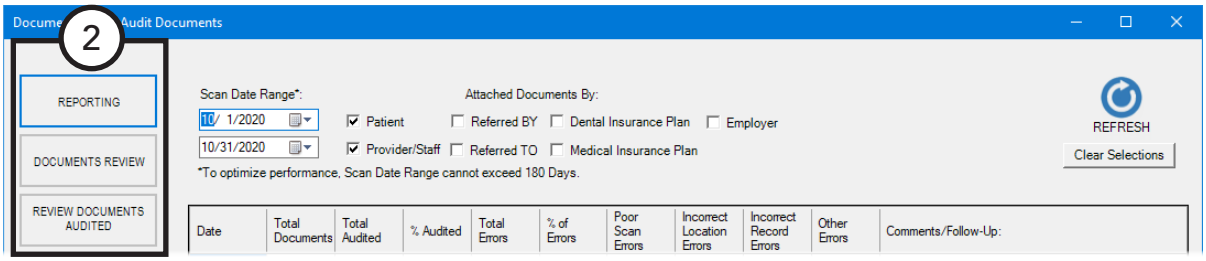
With the Document Center Audit Documents utility, you can identify audited documents and documents that have not been audited yet. From the utility, you can also access any document's information to make changes or audit the document as needed.

To view documents in the Document Center Audit Documents utility

1. In Office Manager, on the **Analysis** menu, click **Document Center Audit Documents**.

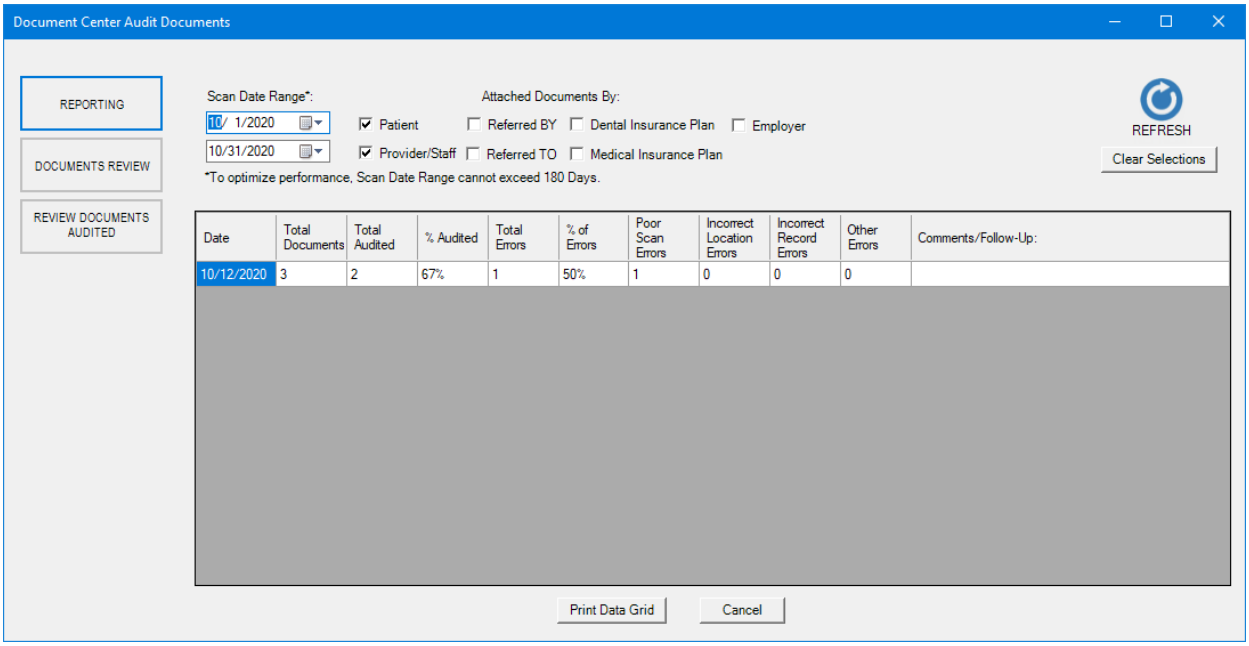
   The **Document Center Audit Documents** window appears.





2. Apply filters, and view the resulting data on any of the following tabs.

Reporting Tab



On the **Reporting** tab, do the following:

a. Set up the following filters:

- **Scan Date Range** – Specify a date range to include documents that were acquired on those dates. The current month is specified by default.

  Note: The date range cannot exceed 180 days.

- **Attached Documents By** – Select any of the following types of entities to include documents that are associated with those types of entities: **Patient**, **Provider/Staff**, **Referred BY**, **Referred TO**, **Dental Insurance Plan**, **Medical Insurance Plan**, and **Employer**.

b. Click the **Refresh** button  .

The data grid is updated according to the specified criteria.

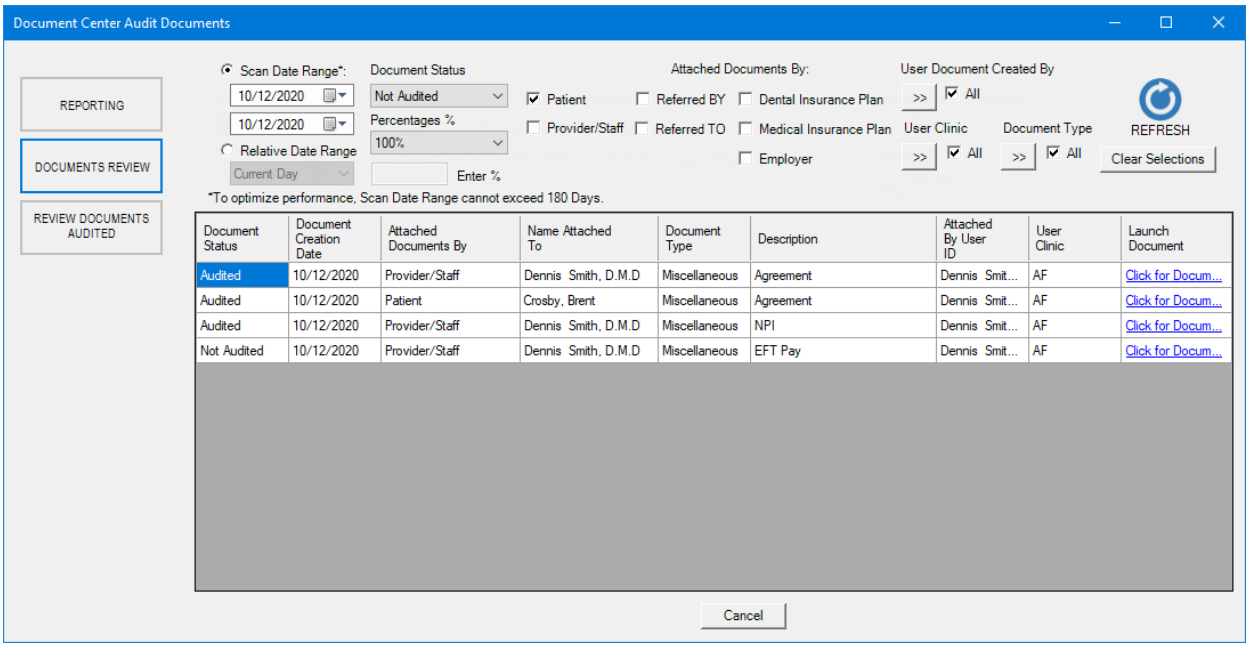
For each date that documents were acquired on, the data grid displays the following information:

- **Date** – The acquisition date.
- **Total Documents** – The total number of documents in the **Scan Date Range**. A document is counted once, regardless of the number of associated entities.
- **Total Audited** – Of the documents included in the **Total Documents** count, the total number that have been audited (documents with an Audited status).
- **% Audited** – Of the documents included in the **Total Documents** count, the percentage that have been audited (documents with an Audited status). This is calculated by dividing **Total Audited** by **Total Documents**.
- **Total Errors** – Of the documents included in the **Total Audited** count, the total number that have been marked as having an error (Poor Scan, Incorrect Location, Incorrect Record, or any user-defined error type).
- **% of Errors** – Of the documents included in the **Total Audited** count, the percentage that have been marked as having an error (**Poor Scan**, **Incorrect Location**, **Incorrect Record**, or any user-defined error type). This is calculated by dividing **Total Errors** by **Total Audited**.
- **Poor Scan Errors** – Of the documents included in the **Total Errors** count, the total number that have been marked with the Poor Scan error type.
- **Incorrect Location Errors** – Of the documents included in the **Total Errors** count, the total number that have been marked with the Incorrect Location error type.
- **Incorrect Record Errors** – Of the documents included in the **Total Errors** count, the total number that have been marked with the Incorrect Record error type.
- **Other Errors** – Of the documents included in the **Total Errors** count, the total number that have been marked with any user-defined error type.
- **Comments/Follow-Up** – In the box, enter any comments regarding that line of the data grid. The comments appear on the report but are not saved anywhere in Dentrix Enterprise.

  Note: To return the filters to their default states and clear the data grid, click **Clear Selections**.

c. Click **Print Data Grid** to preview the report. Then, you can print or save the report.

Documents Review tab



On the **Documents Review** tab, do the following:

a. Set up the following filters:

- **Scan creation date** – Select one of the following options:
  - **Scan Date Range** – To include documents that were acquired on a specific date or in a specific date range, enter the date or range in the two date boxes. The current date is entered by default.
  - **Relative Date Range** – To include documents that were acquired relative to the current date, select the desired relative date or date range: **Current Day**, **Current Week**, **Current MTD**, **Previous Day**, **Previous Week**, or **Previous Month**.
- **Document Status** – Select one of the following options:
  - **All** – To include all documents (audited and unaudited).
  - **Audited** – To include audited documents only.
  - **Not Audited** – To include unaudited documents only. This option is selected by default.
- **Percentages %** – To show all documents that meet the filter criteria. To show a specific percentage of documents (selected randomly) that meet the filter criteria, select **25%**, **50%**, or **Custom %**. If **Custom %** is selected, enter the desired percentage (as a whole number) in the **Enter %** box.
- **Attached Documents By** – Select any of the following types of entities to include documents that are associated with those types of entities: **Patient**, **Provider/Staff**, **Referred BY**, **Referred TO**, **Dental Insurance Plan**, **Medical Insurance Plan**, and **Employer**.
- **User Document Created By** – Click the search button >> to select the users who acquired documents that you want to include, or select the **All** check box to include documents that were acquired by any user. The **All** check box is selected by default.

  Note: Which users are available depends on the following security rights: under Central Clinic Only, the "View All Providers" right; and under Practice/Clinic Setup, the "My Clinics, Select Provider" right.

- **User Clinic** – Click the search button >> to select the clinics where users acquired documents that you want to include, or select the **All** check box to include documents that were acquired by users in any clinic. The **All** check box is selected by default.

  Note: Which clinics are available depends on the following security rights: under Central Clinic Only, the "View All Providers" right; and under Practice/Clinic Setup, the "My Clinics, View" right.

- **Document Type** – To include documents of any type, select the **All** check box. To include documents of only specific types, click the search button >> to select those types.

b. Click the **Refresh** button .

The data grid is updated according to the specified criteria.

Note: A document may appear more than once in the data grid, depending on the number of attachments and the specified filters.

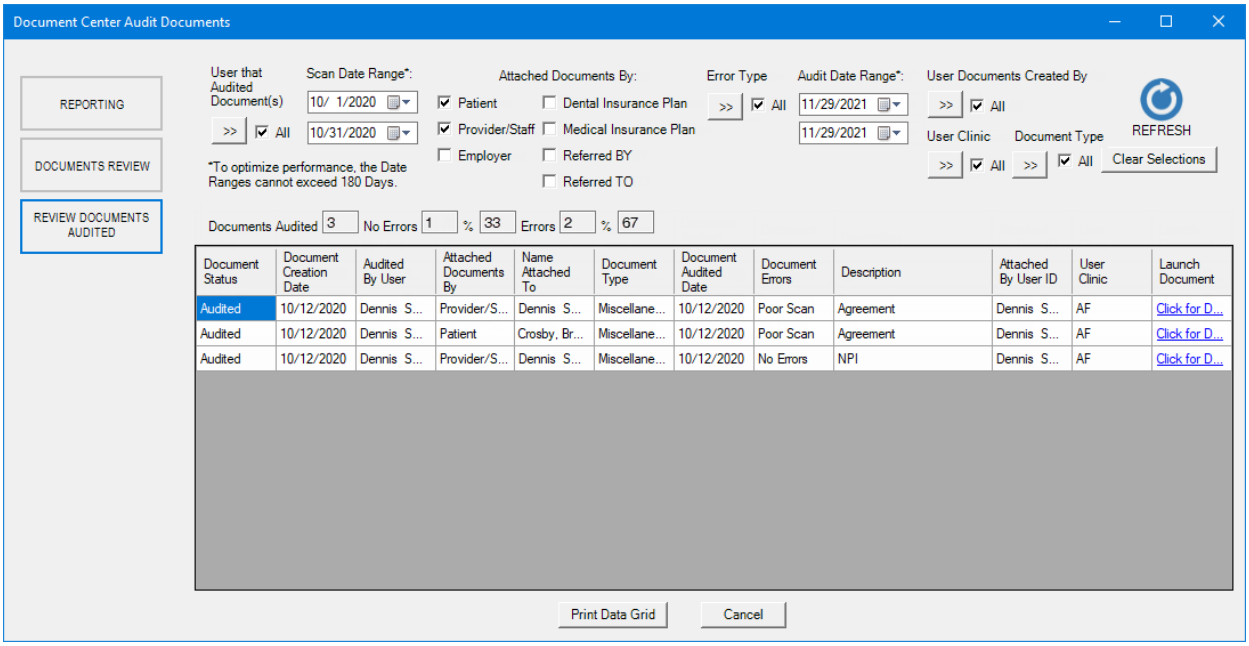
For each document, the data grid displays the following information:

- **Document Status** – The document's audit status: **Audited** or **Not Audited**.
- **Document Creation Date** – The document's acquisition date.
- **Attached Documents By** – The type of entity that the document is associated with: **Patient**, **Provider/Staff**, **Referred BY**, **Referred TO**, **Dental Insurance Plan**, **Medical Insurance Plan**, or **Employer**.
- **Name Attached To** – The name of the entity that the document is associated with.
- **Document Type** – The document's type (the folder name in the document tree).
- **Description** – The document's description (the file name in the document tree).
- **Attached By User ID** – The name of the user who acquired the document.
- **User Clinic** – The clinic that the user who acquired the document was logged in to when he or she acquired the document.
- **Launch Document** – Click the link to open the **Document Information** dialog box for the document. Then, you can review or edit the document information and audit the document as needed.

  Note: The corresponding entity's Document Center is open behind the **Document Information** dialog box, and the corresponding document is selected.

Note: To return the filters to their default states and clear the data grid, click **Clear Selections**.

Review Documents Audited tab



Note: To access the **Review Documents Audited** tab, your user account must have the "Document Center, Review Documents Audited" security right enabled.

On the **Review Documents Audited** tab, do the following:

a. Set up the following filters:

- **User that Audited Document(s)** – Click the search button [>>] to select the users who audited documents that you want to include, or select the **All** check box to include documents that were audited by any user. The **All** check box is selected by default.

  Note: Which users are available depends on the following security rights: under Central Clinic Only, the "View All Providers" right; and under Practice/Clinic Setup, the "My Clinics, Select Provider" right.

- **Scan Date Range** – Specify a date range to include documents that were acquired on those dates. The current month is specified by default.

  Note: The date range cannot exceed 180 days.

- **Attached Documents By** – Select any of the following types of entities to include documents that are associated with those types of entities: **Patient**, **Provider/Staff**, **Referred BY**, **Referred TO**, **Dental Insurance Plan**, **Medical Insurance Plan**, and **Employer**.
- **Error Type** – Click the search button [>>] to select the error types that are associated with documents that you want to include, or select the **All** check box to include documents with any error type. The **All** check box is selected by default. The default error types (**No Errors**, **Poor Scan**, **Incorrect Location**, and **Incorrect Record**) and any user-defined error types are available.
- **Audit Date Range** – Specify a date range to include documents that were audited on those dates. The current date is specified by default.

  Note: The date range cannot exceed 180 days.

- **User Documents Created By** – Click the search button >> to select the users who acquired documents that you want to include, or select the **All** check box to include documents that were acquired by any user. The **All** checkbox is selected by default.

  Note: Which users are available depends on the following security rights: under Central Clinic Only, the "View All Providers" right; and under Practice/Clinic Setup, the "My Clinics, Select Provider" right.

- **User Clinic** – Click the search button >> to select the clinics where users acquired documents that you want to include, or select the **All** check box to include documents that were acquired by users in any clinic. The **All** check box is selected by default.

  Note: Which clinics are available depends on the following security rights: under Central Clinic Only, the "View All Providers" right; and under Practice/Clinic Setup, the "My Clinics, View" right.

b. Click the **Refresh** button .

The data grid is updated according to the specified criteria.

Also, the following statistics appear above the data grid:

- **Documents Audited** – The total number of documents audited.
- **No Errors** – The total number of documents that were reviewed and had no errors.
- **%** – The percentage of documents that were reviewed and had no errors.
- **Errors** – The total number of documents that were reviewed and had errors.
- **%** – The percentage of document that were reviewedand had errors.

Note: A document may appear more than once in the data grid, depending on the number of attachments, the number of associated error types, the number of auditors, and the specified filters.

For each document, the data grid displays the following information:

- **Document Status** – The document's audit status: **Audited** or **Not Audited**.
- **Document Creation Date** – The document's acquisition date.
- **Audited By User** – The name of the user who audited the document.
- **Attached Documents By** – The type of entity that the document is associated with: **Patient**, **Provider/Staff**, **Referred BY**, **Referred TO**, **Dental Insurance Plan**, **Medical Insurance Plan**, or **Employer**.
- **Name Attached To** – The name of the entity that the document is associated with.
- **Document Type** – The document's type (the folder name in the document tree).
- **Document Audited Date** – The date when the document was audited.
- **Document Errors** – The error type that is associated with the document (**No Errors**, **Poor Scan**, **Incorrect Location**, **Incorrect Record**, or a user-defined error type).
- **Description** – The document's description (the file name in the document tree).
- **Attached By User ID** – The name of the user who acquired the document.
- **User Clinic** – The clinic that the user who acquired the document was logged in to when he or she acquired the document.

- **Launch Document** – Click the link to open the **Document Information** dialog box for the document. Then, you can review or edit the document information and audit the document as needed.

  Note: The corresponding entity's Document Center is open behind the **Document Information** dialog box, and the corresponding document is selected.

Note: To return the filters to their default states and clear the data grid, click **Clear Selections**.

c. Click **Print Data Grid** to preview the report. Then, you can print or save the report.

Using the Clinical Note Review Dashboard

The Clinical Note Review Dashboard helps automate the process of reviewing clinical notes. The review process includes review criteria and a score sheet. Also, there are new security rights for the dashboard.

To review clinical notes

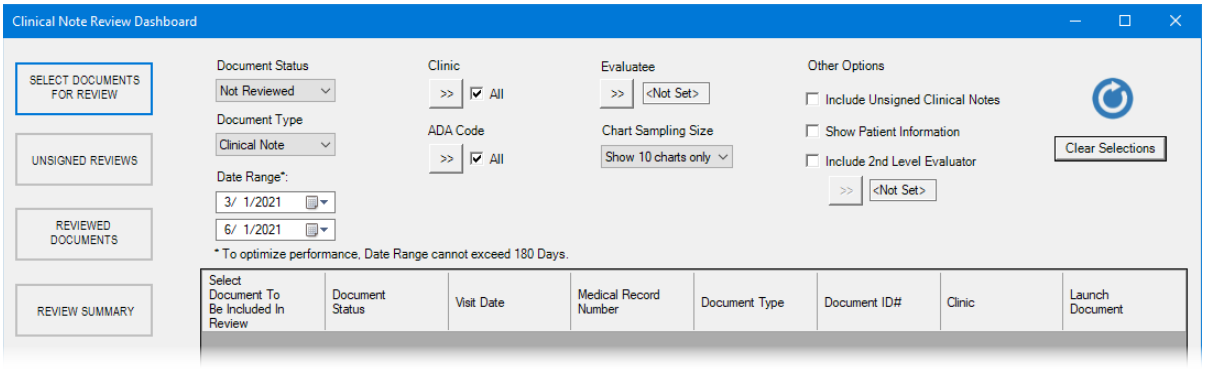
1. In Office Manager, from the **Analysis** menu, click **Clinical Note Review Dashboard**.

   The **Clinical Note Review Dashboard** window appears.

2. Apply filters, view the resulting data, and perform actions on the following tabs:
   a. **Select Documents for Review** (this tab is selected by default)
   b. **Unsigned Reviews**
   c. **Reviewed Documents**
   d. **Review Summary**

Select Documents for Review Tab

The evaluator compiles clinical notes and begins the review process.



On the **Select Documents for Review** tab, do the following as the evaluator:

1. Set up the following filters:
   - **Document Status** – To include clinical notes regardless of the status, select **All**; otherwise, select **In Progress**, **Reviewed**, or **Not Reviewed** (which is selected by default) to include documents with only that status.
   - **Document Type** – Currently, **Clinical Note** is the only type.

- **Date Range** – By default, the date range is the past three months, but you can change the date range as needed. To include clinical notes on a different date or within a different date range, enter the desired date or date range in the two boxes.

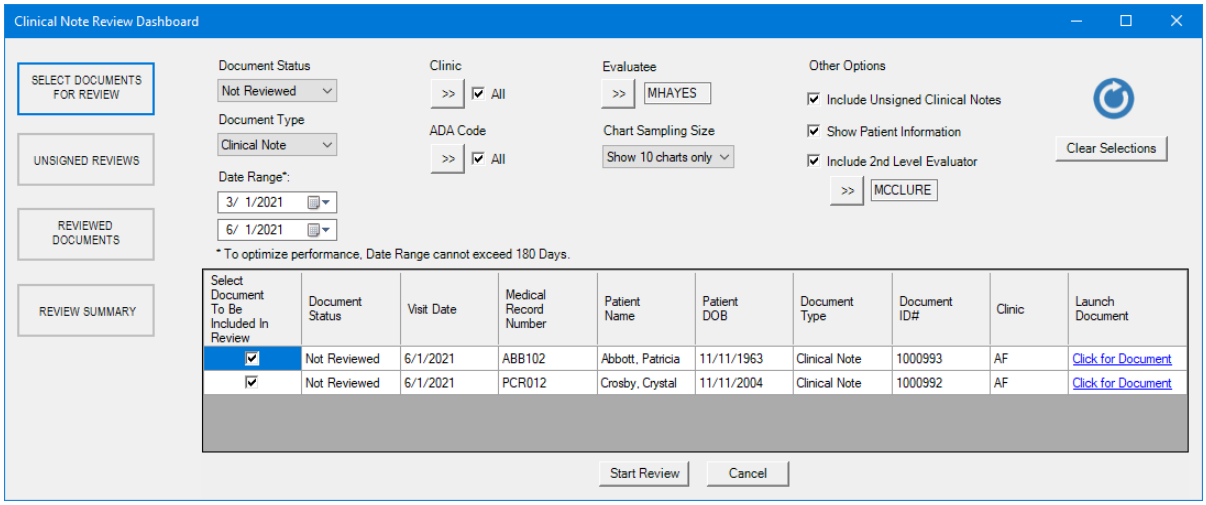
  Note: The date range cannot exceed 180 days.

- **Clinic** – To include clinical notes from any clinic, select the **All** check box. To include clinical notes from only specific clinics, click the search button [>>] to select the desired clinics.
- **ADA Code** – To include clinical notes for any procedure, select the **All** check box. To include clinical notes for only specific procedures, click the search button [>>] to select the desired procedures.
- **Evaluatee** – Click the search button [>>] to select the provider whose clinical notes you want to evaluate. You cannot select yourself. The evaluatee of an unsigned clinical note is the provider who is attached to the clinical note. The evaluatee of a signed clinical note is the provider who signed the clinical note.
- **Chart Sampling Size** – To show all clinical notes that meet the filter criteria, select **Show 100%**; otherwise, to show a specific number or percentage of clinical notes (selected randomly) that meet the filter criteria, select **Show 10 charts only** (which is selected by default), **Show 20 charts only**, **Show 5%**, **Show 10%**, **Show 20%**, **Show 30%**, **Show 40%**, **Show 50%**, **Show 60%**, **Show 70%**, **Show 80%**, or **Show 90%**.
- **Other Options**:
  - **Include Unsigned Clinical Notes** – To include signed and unsigned clinical notes, select this check box. With the check box clear, signed clinical notes are included, but unsigned clinical notes are not included.
  - **Show Patient Information** – To include additional columns for patient details in the data grid, select this check box.
  - **Include 2nd Level Evaluator** – To add a second-level evaluator, select this check box, and then click the search button [>>] to select that evaluator.

Note: To return the filters to their default states and clear the data grid, click **Clear Selections**.

2. Click the **Refresh** button.

The data grid is updated according to the specified criteria.



For each clinical note in the data grid, the following information appears:

- **Document Status** – The status of the review of the clinical note.
- **Visit Date** – The visit date associated with the clinical note.
- **Medical Record Number** – The patient's chart number.
- **Document Type** – Currently, the only type is **Clinical Note**.
- **Document ID#** – The unique ID number of the clinical note.
- **Clinic** – The clinic associated with the clinical note.

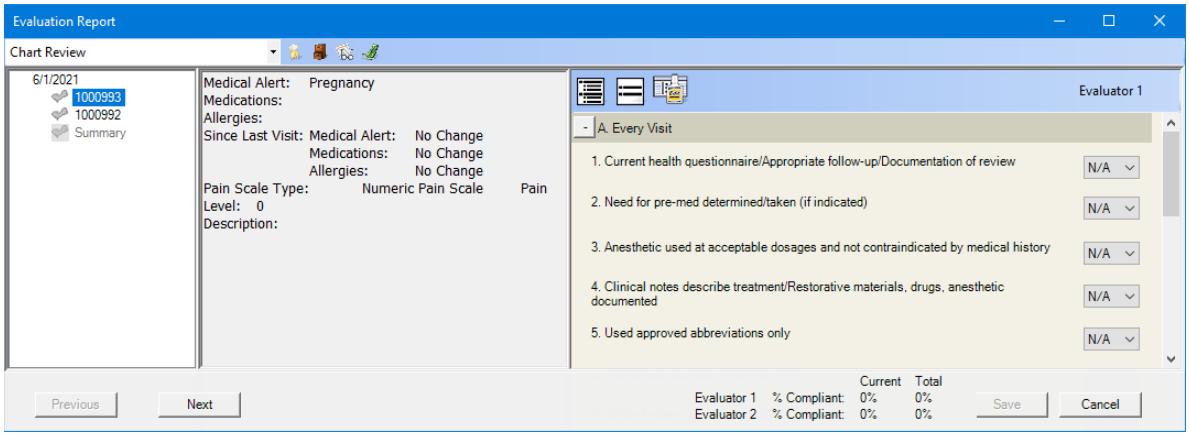
The following columns appear if the **Show Patient Information** check box is selected:

- **Patient Name** – The patient's first and last name (in a Last Name, First Name format).
- **Patient DOB** – The patient's birth date.

Note: To view the text of a clinical note, click the corresponding **Click for Document** link in the **Launch Document** column.

3. For each clinical note that you want to include in the review, select the check box in the **Document To Be Included In Review** column. You can select up to 10 clinical notes.
4. To start the review process for the selected clinical notes, click **Start Review**.

   The **Evaluation Report** dialog box appears.

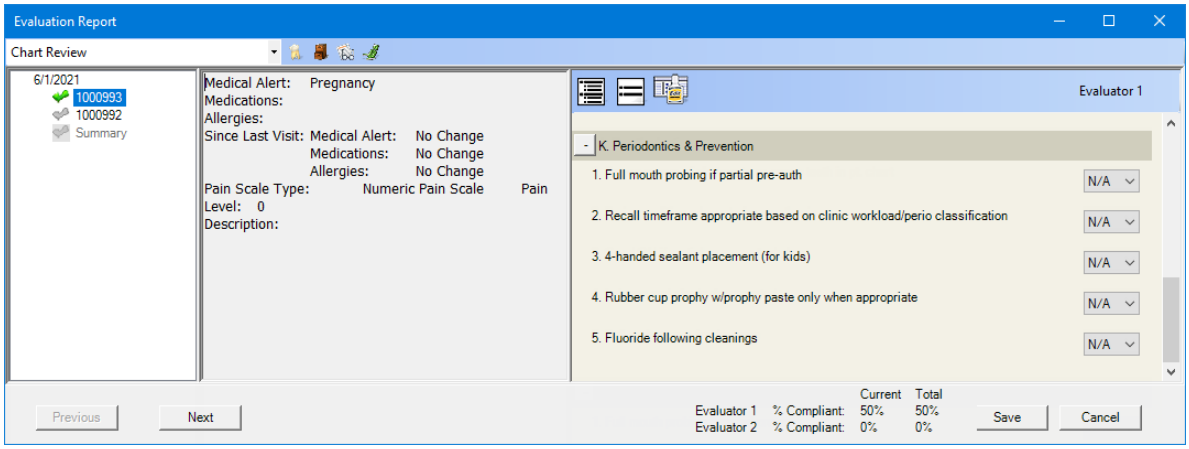


5. From the list at the top, select a clinical note review template to use the corresponding evaluation criteria.

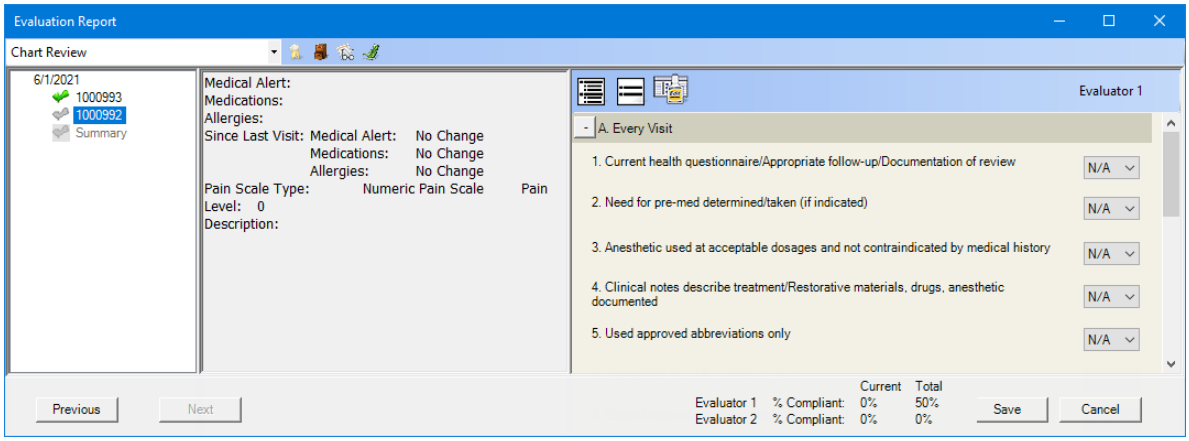
   Note: For information about managing clinical note review templates, see "Setting Up Clinical Note Review Templates."

6. For the first clinical note, select **Yes** or **No** for all applicable evaluation criteria. Leave **N/A** selected for the criteria that are not applicable.

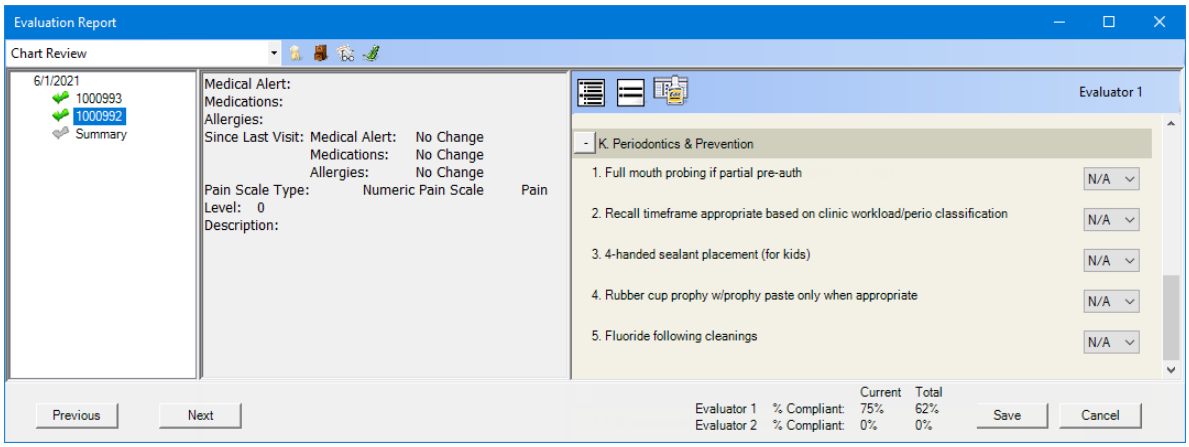
Note: If you have evaluated a clinical note, a green check mark appears next to its document ID on the left.



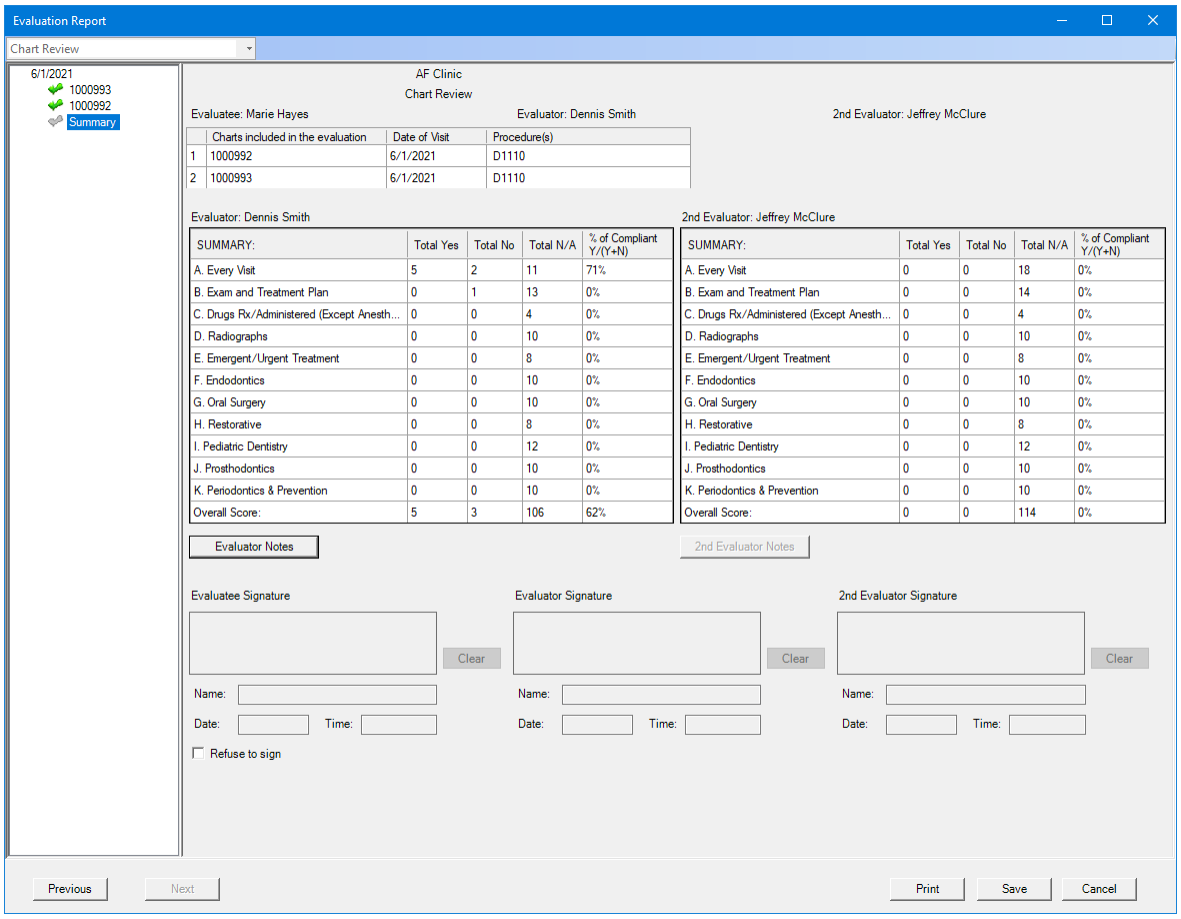
7. Click **Next**.



8. For each of the remaining clinical notes, select **Yes** or **No** for all applicable evaluation criteria, and then click **Next**.

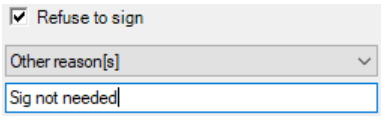


After you evaluate the last clinical note and click **Next**, the **Summary** page opens.



Note: The **Summary** page is available only if all clinical notes have been evaluated. A clinical note is considered to have been evaluated if there is at least one response to the evaluation criteria that is not **N/A**.

9. To add notes, click **Evaluator Notes**.
10. If the evaluatee will sign the review, the evaluatee will need to log in and sign the review after you save it. However, if the evaluatee will not or cannot sign the review, do the following:
    a. Under **Evaluatee Signature**, select the **Refuse to sign** check box.
    b. From the list that appears, select the reason why the evaluatee will not sign:
        - **Evaluatee is not present to sign the review**.
        - **Evaluatee no longer works at this clinic**.
        - **Evaluatee refuses to sign/acknowledge the evaluation**.
        - **Other reason(s)**. With this option selected, enter the reason in the box that appears.

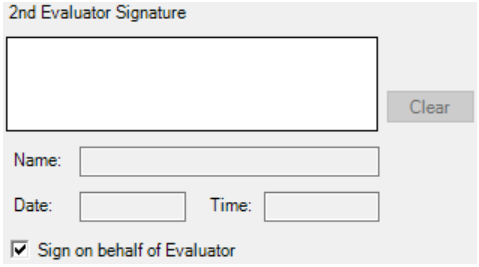


11. If the **Refuse to sign** check box is selected, to sign the review, sign in the **Evaluator Signature** box.

Note: If you need to remove the signature to re-sign, you can click the corresponding **Clear** button.

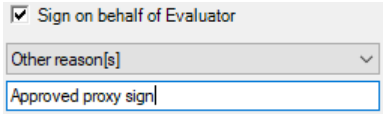
12. If there is a signature in the **Evaluator Signature** box, if a second-level evaluator is assigned to the review but will not or cannot sign, and if you are allowed to sign on behalf of evaluators, to sign as the second-level evaluator, do the following:

    a. Under **2nd Evaluator Signature**, select the **Sign on behalf of Evaluator** check box.



    b. From the list that appears, select the reason why you are signing on behalf of the second-level evaluator:

    - **Evaluator is not present to sign the review**.
    - **Evaluator no longer works at this clinic**.
    - **Evaluator refuses to sign/acknowledge the evaluation**.
    - **Other reason(s)**. With this option selected, enter the reason in the box that appears.



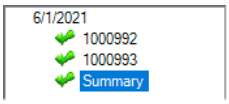
    c. Sign in the **2nd Evaluator Signature** box.

    Note: If you need to remove the signature to re-sign, you can click the corresponding **Clear** button.

13. Click **Save**.

    Note: You can save the review with or without evaluating all clinical notes or signing the review.

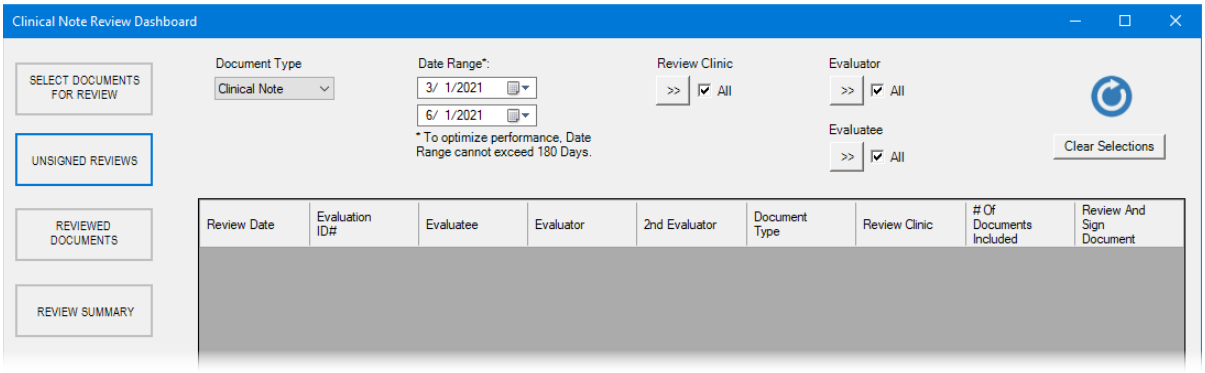
    - If you have not evaluated a clinical note, its status remains Not Reviewed.
    - If you have evaluated a clinical notes but not signed the review, the status of that evaluated clinical note changes to In Progress.
    - If you have evaluated all clinical notes and signed the review, the status of each evaluated clinical note changes to Reviewed, and a green check mark appears next to **Summary** on the left.



Unsigned Reviews Tab

Do one of the following:

- If the evaluator and second-level evaluator (if one is assigned) have both completed their reviews, the evaluatee looks over and then signs the review.
- If the review is not complete, the evaluator (or someone acting on his or her behalf) resumes his or her review.
- If the review is unsigned, and if a second-level evaluator is assigned to the review, the second-level evaluator (or someone acting on his or her behalf) starts or resumes his or her review.



On the **Unsigned Reviews** tab, do the following as the evaluatee, evaluator, or second-level evaluator:

1. Set up the following filters:
   - **Document Type** – Currently, **Clinical Note** is the only type.
   - **Date Range** – By default, the date range is the past three months, but you can change the date range as needed. To include reviews that were started on a different date or within a different date range, enter the desired date or date range in the two boxes.

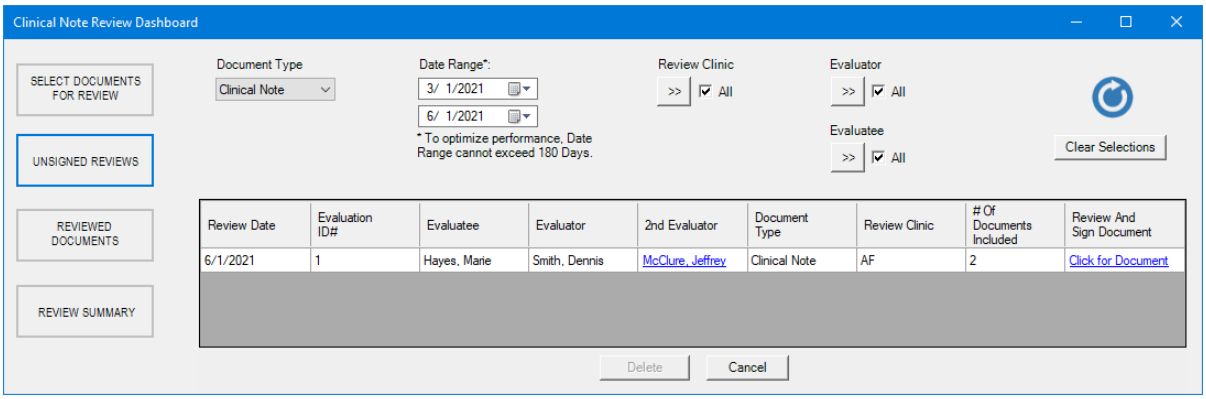
     Note: The date range cannot exceed 180 days.

   - **Review Clinic** – To include reviews that were started in any clinic, select the **All** check box. To include reviews that were started in only specific clinics, click the search button >> to select those clinics.
   - **Evaluator** – To include reviews that were started by any evaluator, select the **All** check box. To include reviews that were started by only specific evaluators, click the search button >> to select those evaluators.
   - **Evaluatee** – To include reviews for any evaluatee, select the **All** check box. To include reviews for only specific evaluatees, click the search button >> to select those evaluatees.

   Note: To return the filters to their default states and clear the data grid, click **Clear Selections**.

2. Click the **Refresh** button.

The data grid is updated according to the specified criteria.



For each review in the data grid, the following information appears:

- **Review Date** – That date when the review was started.
- **Evaluation ID#** – The review's unique ID number.
- **Evaluatee** – The person being evaluated.
- **Evaluator** – The person who started the review.
- **2nd Evaluator** – If applicable, the second-level evaluator assigned to the review.
- **Document Type** – Currently, the only type is **Clinical Note**.
- **Review Clinic** – The clinic where the review was started.
- **# Of Documents Included** – The number of clinical notes that are included in the review.

Note: To delete a review, select it, and then click **Delete**.

3. To resume, edit, or sign a review, click the corresponding **Click for Document** link in the **Review And Sign Document** column.

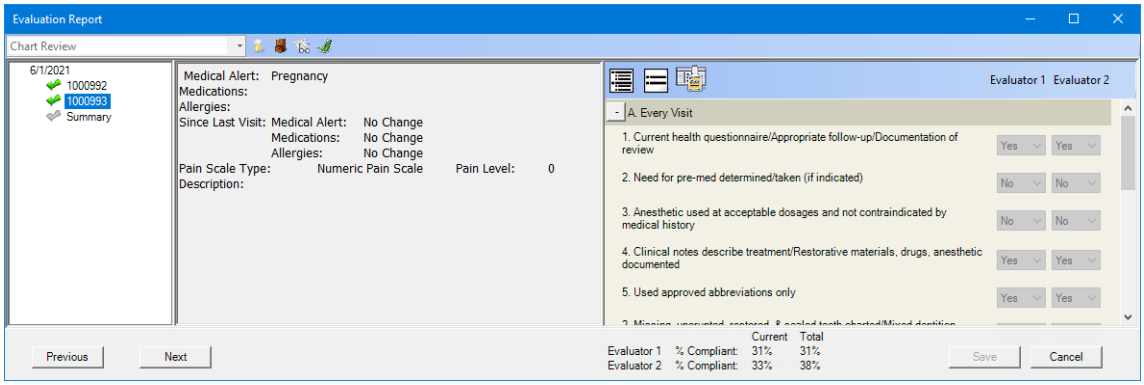
   The **Evaluation Report** dialog box appears.

4. Do one of the following:

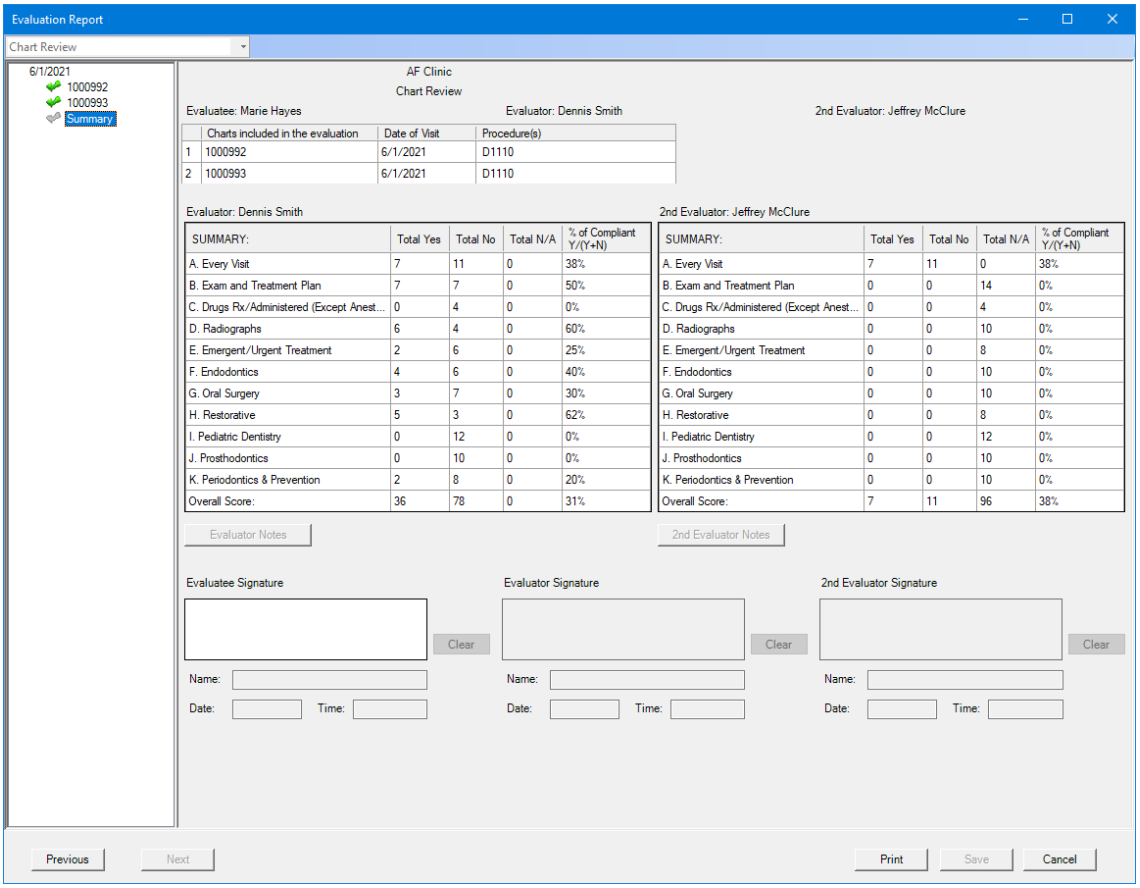
   Evaluatee

   As the evaluatee, to look over and sign the review, do the following:

   a. Select each clinical note's ID number on the left to view the corresponding responses to the evaluation criteria.



b. Select **Summary** on the left to view the summary.



c. Sign in the **Evaluatee Signature** box.

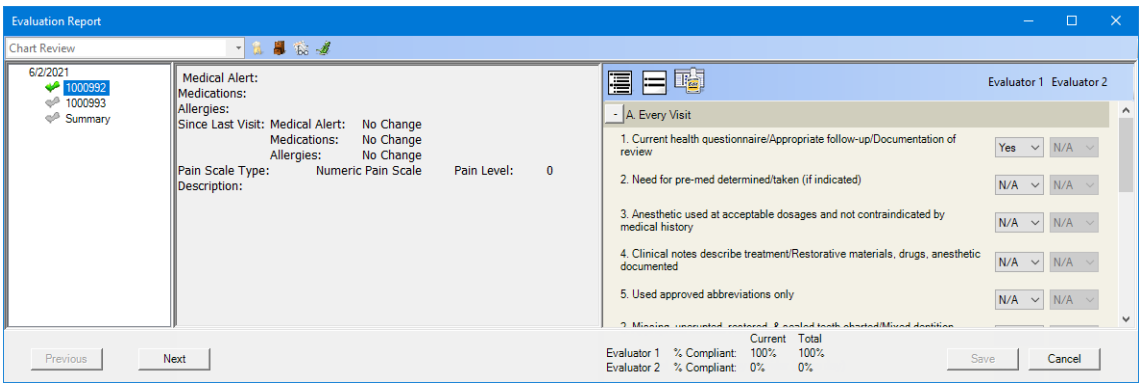
Note: If you need to remove the signature to re-sign, you can click the corresponding **Clear** button.

d. Click **Save**.

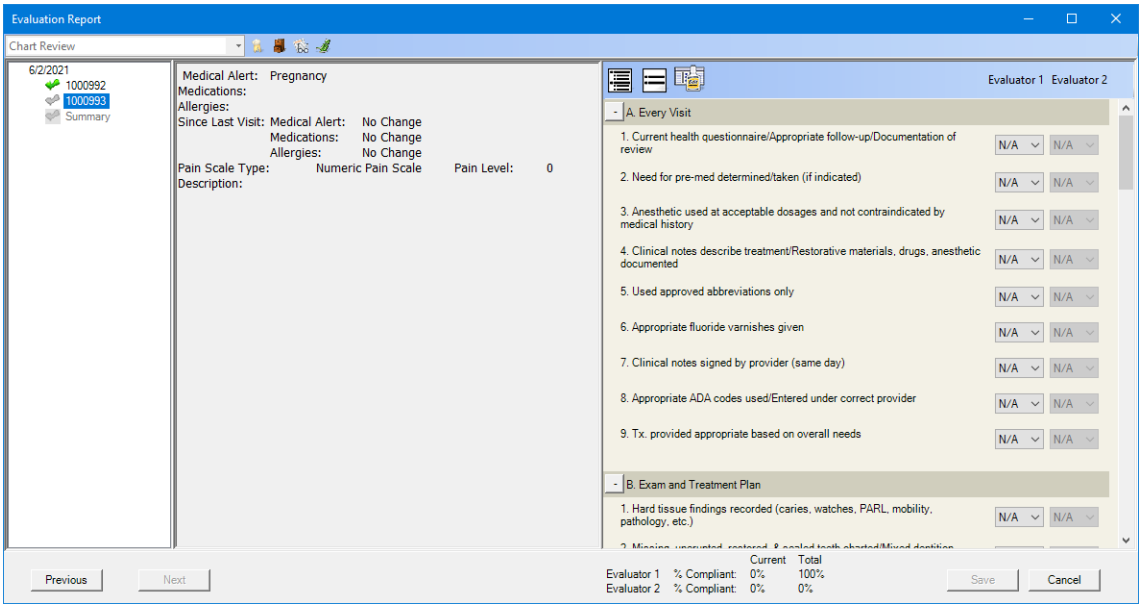
Evaluator

As the evaluator (or someone acting on his or her behalf), to resume your review, do the following:

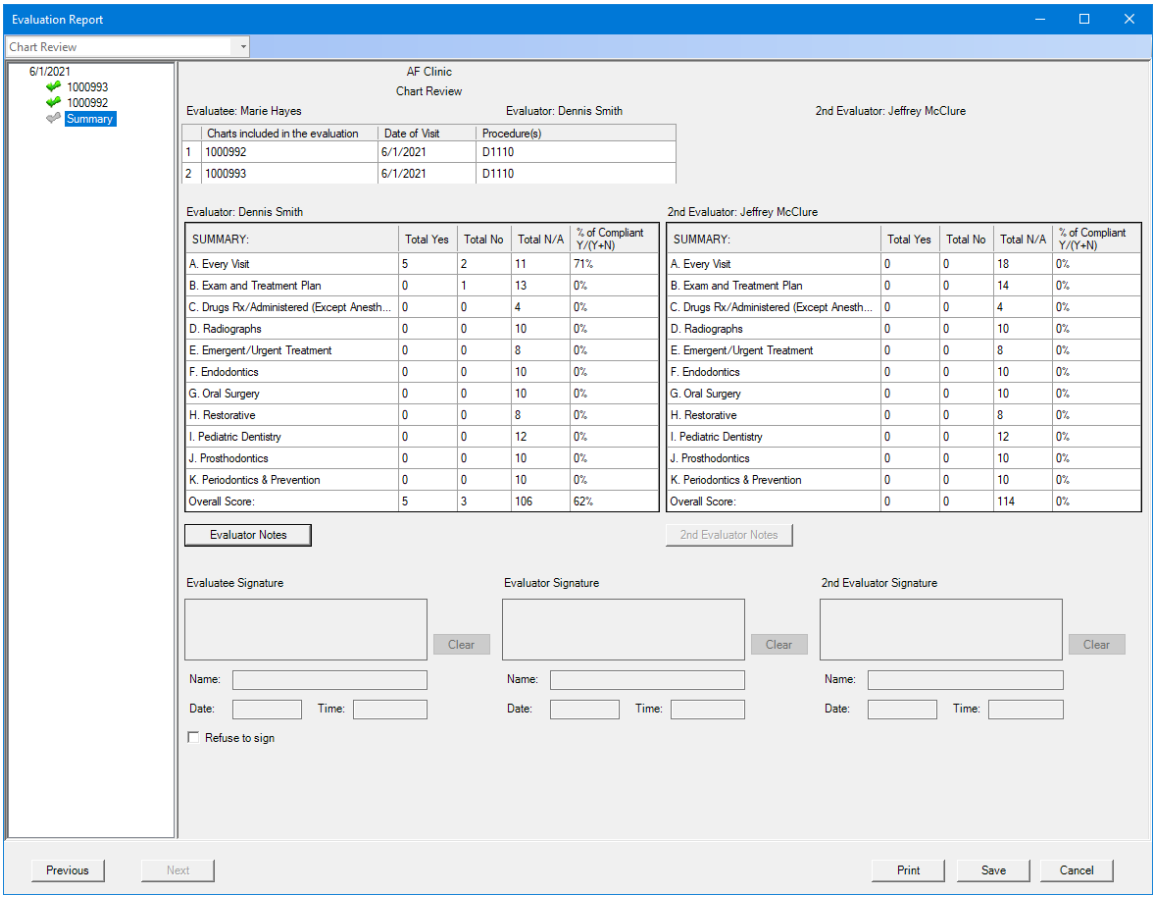
a. For each clinical note that you have evaluated (meaning it has at least one response that is not **N/A**), a green check mark appears next to its ID number on the left. To edit your responses for any of those clinical notes, select its ID on the left to view the corresponding evaluation criteria, and then change your responses in the **Evaluator 1** column by selecting **Yes** or **No** for all applicable evaluation criteria or **N/A** for the criteria that are not applicable.



b. For each clinical note that you have not evaluated (all its responses are **N/A**), select its ID on the left to view the corresponding evaluation criteria, and then select **Yes** or **No** for all applicable evaluation criteria in the **Evaluator 1** column. Leave **N/A** selected for the criteria that are not applicable.



c. If you have evaluated all clinical notes, select **Summary** on the left to view the summary.



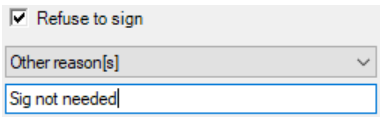
d. To add notes, click **Evaluator Notes**.

e. If the evaluatee will sign the review, the evaluatee will need to log in and sign the review after you save it. However, if the evaluatee will not or cannot sign the review, do the following:

1). Under **Evaluatee Signature**, select the **Refuse to sign** check box.

2). From the list that appears, select the reason why the evaluatee will not sign:

- **Evaluatee is not present to sign the review**.
- **Evaluatee no longer works at this clinic**.
- **Evaluatee refuses to sign/acknowledge the evaluation**.
- **Other reason(s)**. With this option selected, enter the reason in the box that appears.



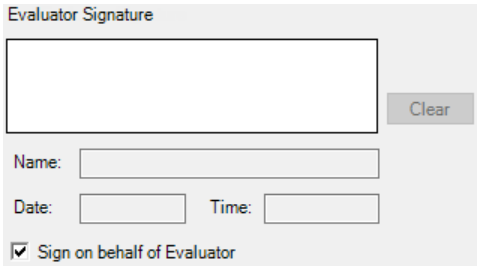
f. If the **Refuse to sign** check box is selected, do one of the following:

- If you are the evaluator (the person who created the review), to sign the review, sign in the **Evaluator Signature** box.

  Note: If you need to remove the signature to re-sign, you can click the corresponding **Clear** button.

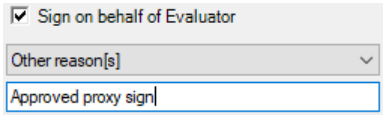
- If you are not the evaluator (the person who created the review) but are allowed to sign on behalf of evaluators, to sign as the evaluator, do the following:

  1). Under **Evaluator Signature**, select the **Sign on behalf of Evaluator** check box.



  2). From the list that appears, select the reason why you are signing on behalf of the evaluator:

  - **Evaluator is not present to sign the review**.
  - **Evaluator no longer works at this clinic**.
  - **Evaluator refuses to sign/acknowledge the evaluation**.
  - **Other reason(s)**. With this option selected, enter the reason in the box that appears.

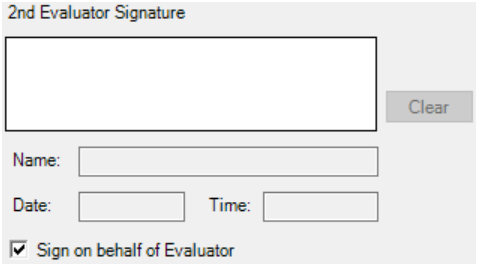


  3). Sign in the **Evaluator Signature** box.

  Note: If you need to remove the signature to re-sign, you can click the corresponding **Clear** button.

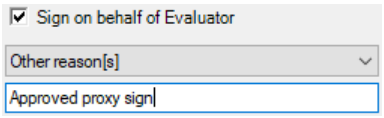
g. If there is a signature in the **Evaluator Signature** box, if a second-level evaluator is assigned to the review but will not or cannot sign, and if you are allowed to sign on behalf of evaluators, to sign as the second-level evaluator, do the following:

1). Under **2nd Evaluator Signature**, select the **Sign on behalf of Evaluator** check box.



2). From the list that appears, select the reason why you are signing on behalf of the second-level evaluator:

- **Evaluator is not present to sign the review**.
- **Evaluator no longer works at this clinic**.
- **Evaluator refuses to sign/acknowledge the evaluation**.
- **Other reason(s)**. With this option selected, enter the reason in the box that appears.



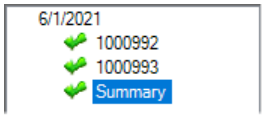
3). Sign in the **2nd Evaluator Signature** box.

Note: If you need to remove the signature to re-sign, you can click the corresponding **Clear** button.

h. Click **Save**.

Note: You can save the review with or without evaluating all clinical notes or signing the review.

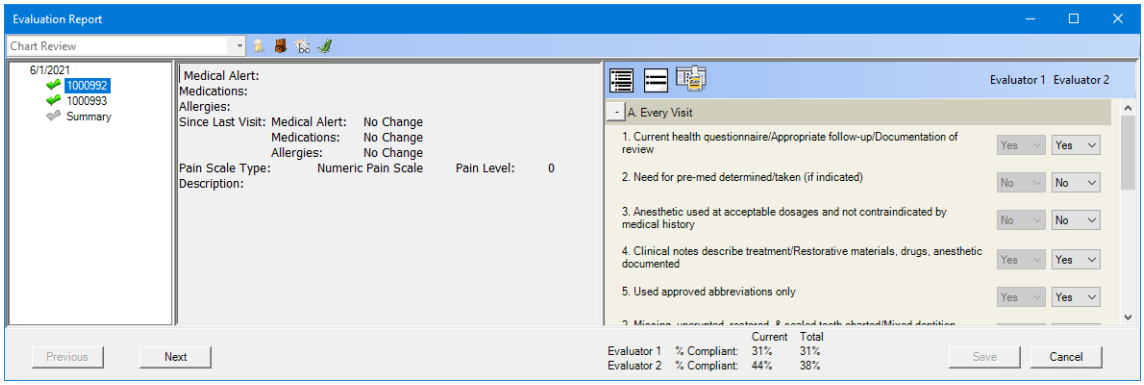
- If you have not evaluated a clinical note, its status remains Not Reviewed.
- If you have evaluated a clinical notes but not signed the review, the status of that evaluated clinical note changes to In Progress.
- If you have evaluated all clinical notes and signed the review, the status of each evaluated clinical note changes to Reviewed, and a green check mark appears next to **Summary** on the left.



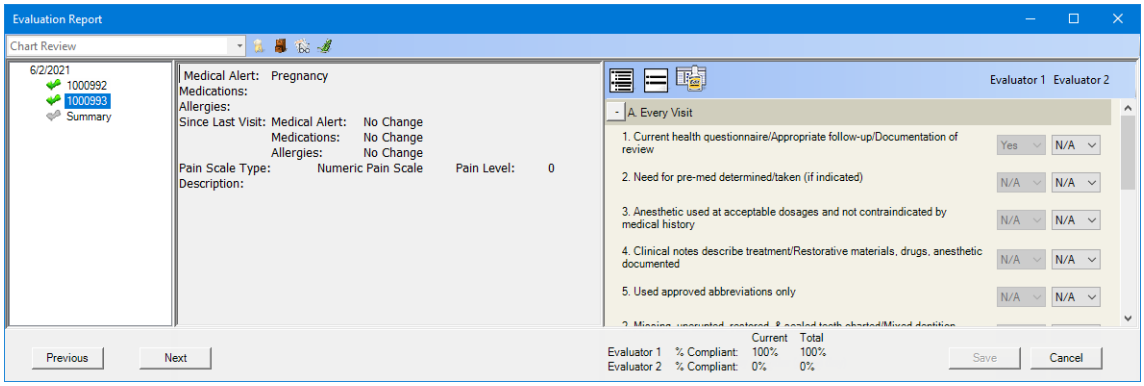
Second-level Evaluator

As the second-level evaluator (or someone acting on his or her behalf), to start or resume your review, do the following:

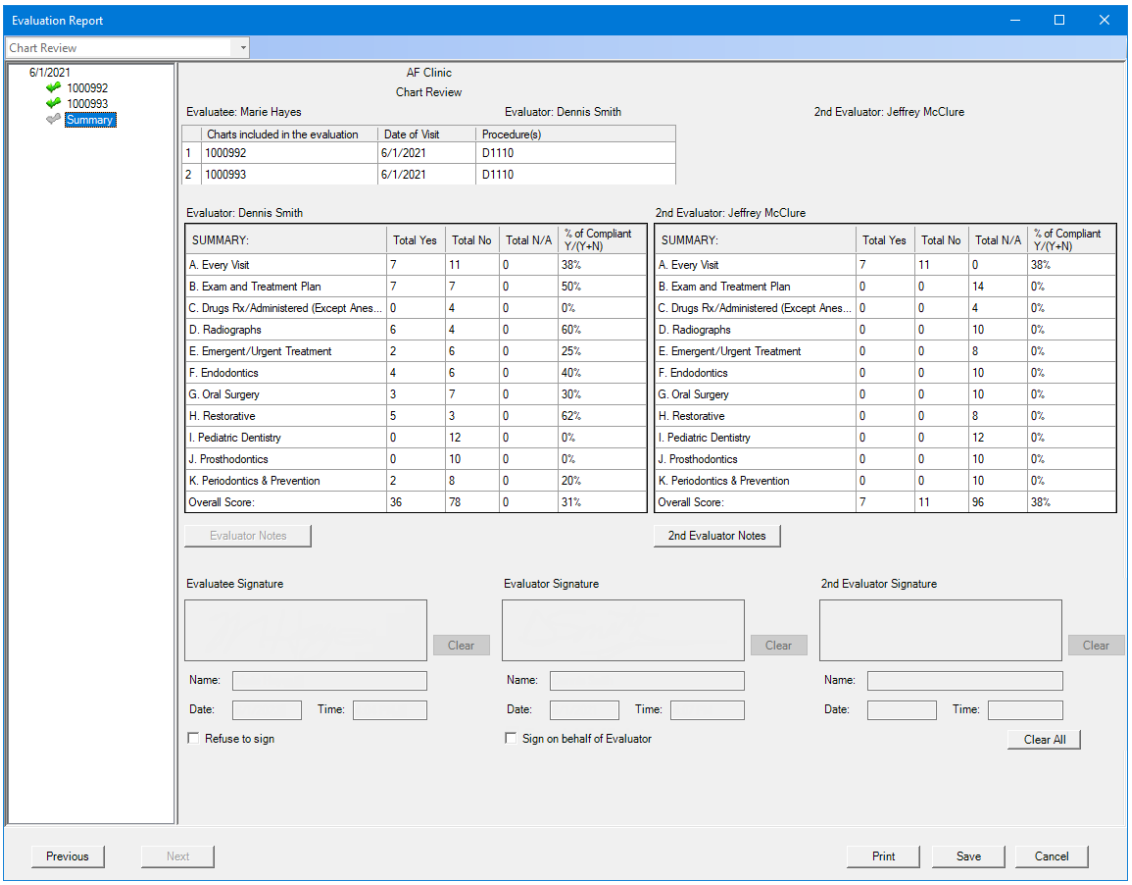
a. For each clinical note that you have evaluated, to edit your responses, select the clinical note's ID on the left to view the corresponding evaluation criteria, and then change your responses in the **Evaluator 2** column by selecting **Yes** or **No** for all applicable evaluation criteria or **N/A** for the criteria that are not applicable. Then, to navigate to the next clinical note, click **Next**.



b. For each clinical note that you have not evaluated, select its ID on the left to view the corresponding evaluation criteria, and then select **Yes** or **No** for all applicable evaluation criteria in the **Evaluator 2** column. Leave **N/A** selected for the criteria that are not applicable. Then, to navigate to the next clinical note, click **Next**.



c. If you have evaluated all clinical notes, select **Summary** on the left to view the summary.



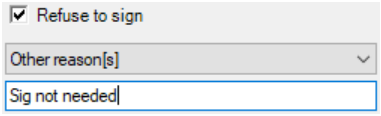
d. To add notes, click **2nd Evaluator Notes**.

e. If the evaluatee will sign the review, the evaluatee will need to log in and sign the review after you save it. However, if the evaluatee will not or cannot sign the review, do the following:

1). Under **Evaluatee Signature**, select the **Refuse to sign** check box.

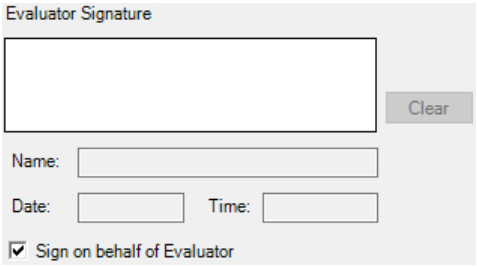
2). From the list that appears, select the reason why the evaluatee will not sign:

- **Evaluatee is not present to sign the review**.
- **Evaluatee no longer works at this clinic**.
- **Evaluatee refuses to sign/acknowledge the evaluation**.
- **Other reason(s)**. With this option selected, enter the reason in the box that appears.



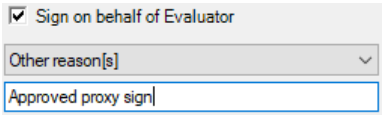
f. If the evaluator will not or cannot sign the review, and if you are allowed to sign on behalf of evaluators, to sign as the evaluator, do the following:

1). Under **Evaluator Signature**, select the **Sign on behalf of Evaluator** check box.



2). From the list that appears, select the reason why you are signing on behalf of the second-level evaluator:

- **Evaluator is not present to sign the review**.
- **Evaluator no longer works at this clinic**.
- **Evaluator refuses to sign/acknowledge the evaluation**.
- **Other reason(s)**. With this option selected, enter the reason in the box that appears.



3). Sign in the **Evaluator Signature** box.

Note: If you need to remove the signature to re-sign, you can click the corresponding **Clear** button.

g. If the **Refuse to sign** check box is selected under **Evaluatee Signature**, and if there is a signature in the **Evaluator Signature** box, to sign the review, sign in the **2nd Evaluator Signature** box.

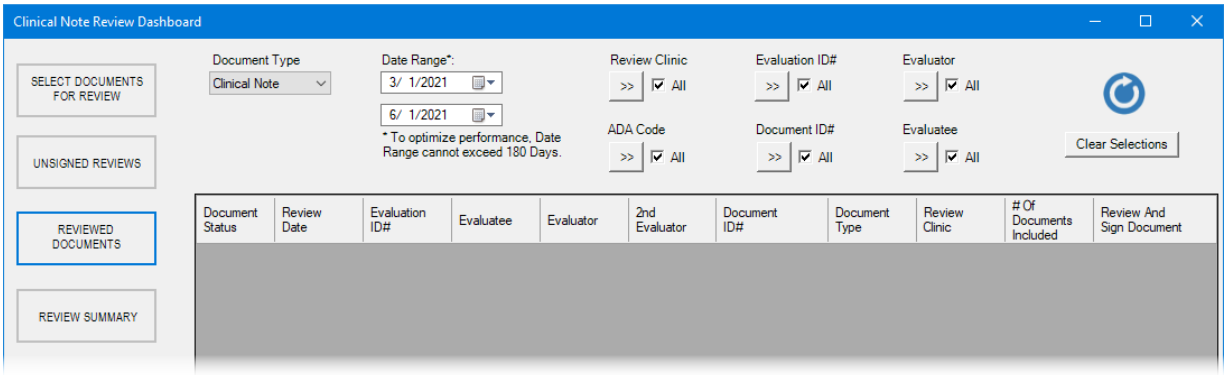
Note: If you need to remove the signature to re-sign, you can click the corresponding **Clear** button.

h. Click **Save**.

Reviewed Documents Tab

Do one of the following:

- If the evaluator and second-level evaluator (if one is assigned) have both completed their reviews, and if the evaluatee has signed the review, the evaluator (or someone acting on his or her behalf) signs the review.
- If either the evaluatee or evaluator have signed the review, and if a second-level evaluator is assigned to the review, the second-level evaluator (or someone acting on his or her behalf) signs the review.



On the **Reviewed Documents** tab, do the following as the evaluator or second-level evaluator:

1. Set up the following filters:
   - **Document Type** – Currently, **Clinical Note** is the only type.
   - **Date Range** – By default, the date range is the past three months, but you can change the date range as needed. To include reviews that were started on a different date or within a different date range, enter the desired date or date range in the two boxes.

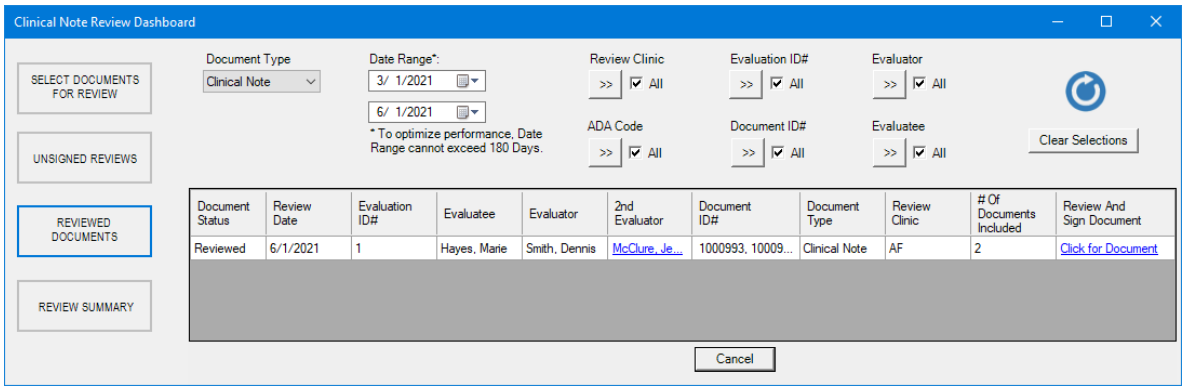
     Note: The date range cannot exceed 180 days.

   - **Review Clinic** – To include reviews that were started in any clinic, select the **All** check box. To include reviews that were started in only specific clinics, click the search button [>>] to select those clinics.
   - **ADA Code** – To include reviews with any procedure, select the **All** check box. To include reviews with only specific procedures, click the search button [>>] to select the desired procedures.
   - **Evaluation ID#** – To include reviews with any evaluation ID, select the **All** check box. To include reviews with only specific evaluation IDs, click the search button [>>] to select those IDs.
   - **Document ID#** – To include reviews of clinical notes with any ID number, select the **All** check box. To include reviews of clinical notes with only specific IDs, click the search button [>>] to select those IDs.
   - **Evaluator** – To include reviews that were started by any evaluator, select the **All** check box. To include reviews that were started by only specific evaluators, click the search button [>>] to select those evaluators.
   - **Evaluatee** – To include reviews for any evaluatee, select the **All** check box. To include reviews for only specific evaluatees, click the search button [>>] to select those evaluatees.

   Note: To return the filters to their default states and clear the data grid, click **Clear Selections**.

2. Click the **Refresh** button.

The data grid is updated according to the specified criteria.



For each review in the data grid, the following information appears:

- **Document Status** – The status of the review of the clinical note.
- **Review Date** – That date when the review was started.
- **Evaluation ID#** – The review's unique ID number.
- **Evaluatee** – The person being evaluated.
- **Evaluator** – The person who started the review.
- **2nd Evaluator** – If applicable, the second-level evaluator assigned to the review.
- **Document ID#** – The clinical note's unique ID number.
- **Document Type** – Currently, the only type is **Clinical Note**.
- **Review Clinic** – The clinic where the review was started.
- **# Of Documents Included** – The number of clinical notes that are included in the review.

3. To sign a review, click the corresponding **Click for Document** link in the **Review And Sign Document** column.

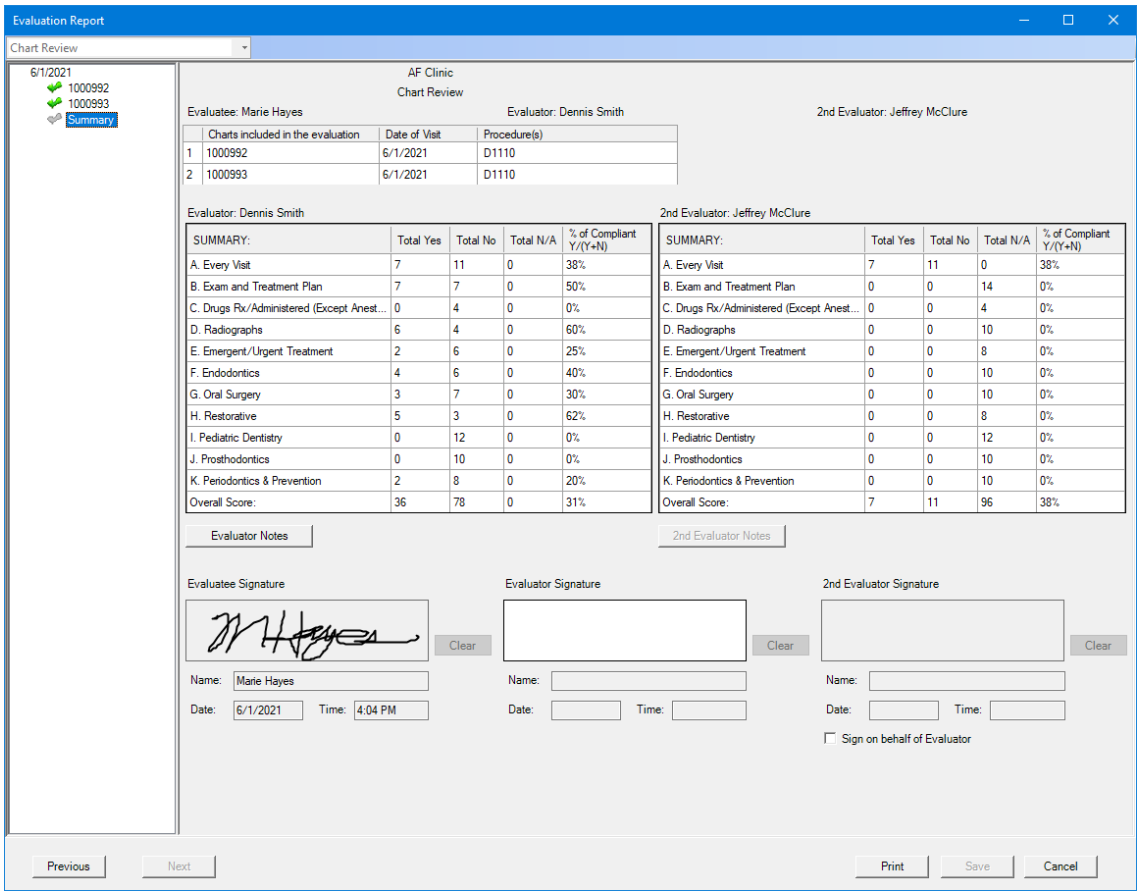
   The **Evaluation Report** dialog box appears.

4. Do one of the following:

Evaluator

As the evaluator, do the following:

a. Select **Summary** on the left to view the summary.



b. If you are the evaluator, to add notes, click **Evaluator Notes**.

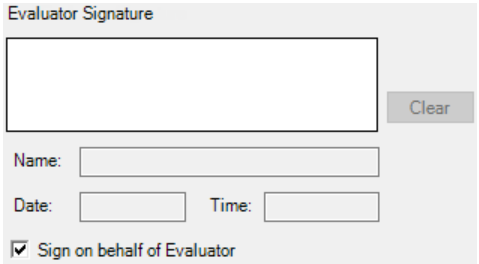
c. Do one of the following:

- If you are the evaluator, to sign the review, sign in the **Evaluator Signature** box.

  Note: If you need to remove the signature to re-sign, you can click the corresponding **Clear** button.

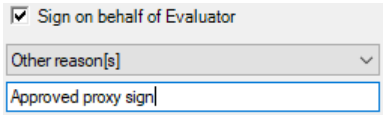
- If you are not the evaluator, and if you are allowed to sign on behalf of evaluators, to sign as the evaluator, do the following:

  1). Under **Evaluator Signature**, select the **Sign on behalf of Evaluator** check box.



2). From the list that appears, select the reason why you are signing on behalf of the evaluator:

- **Evaluator is not present to sign the review**.
- **Evaluator no longer works at this clinic**.
- **Evaluator refuses to sign/acknowledge the evaluation**.
- **Other reason(s)**. With this option selected, enter the reason in the box that appears.

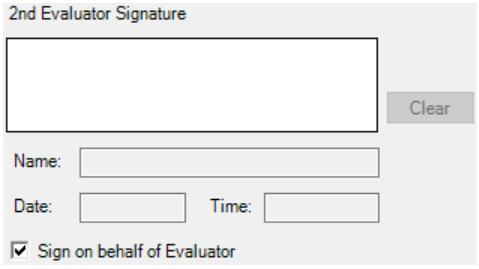


3). Sign in the **Evaluator Signature** box.

Note: If you need to remove the signature to re-sign, you can click the corresponding **Clear** button.

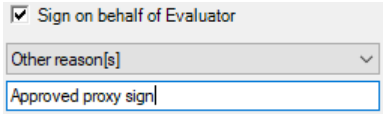
d. If the second-level evaluator will not or cannot sign the review, and if you are allowed to sign on behalf of evaluators, to sign as the second-level evaluator, do the following::

1). Under **2nd Evaluator Signature**, select the **Sign on behalf of Evaluator** check box.



2). From the list that appears, select the reason why you are signing on behalf of the second-level evaluator:

- **Evaluator is not present to sign the review**.
- **Evaluator no longer works at this clinic**.
- **Evaluator refuses to sign/acknowledge the evaluation**.
- **Other reason(s)**. With this option selected, enter the reason in the box that appears.

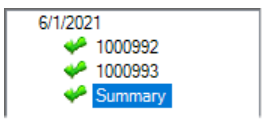


3). Sign in the **2nd Evaluator Signature** box.

Note: If you need to remove the signature to re-sign, you can click the corresponding **Clear** button.

e. Click **Save**.

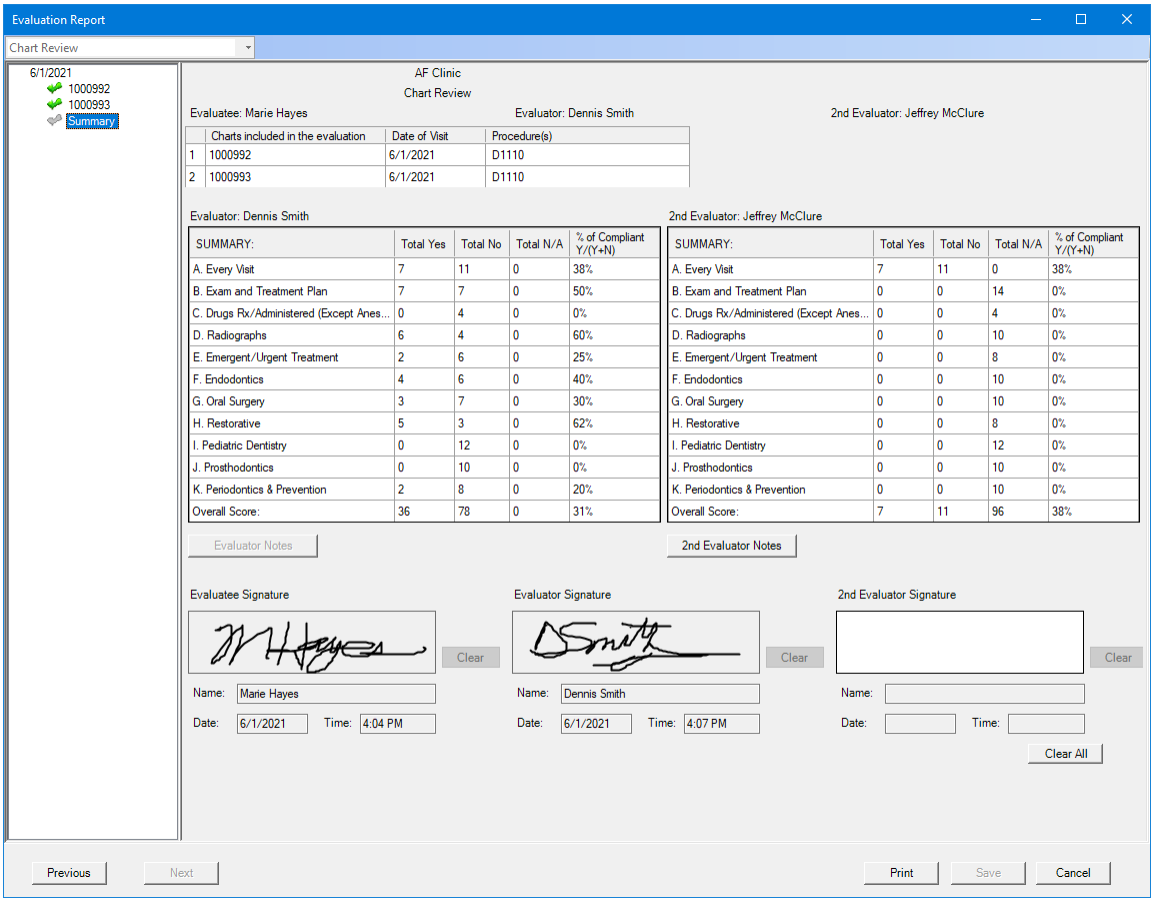
Note: If you have signed the review, a green check mark appears next to **Summary** on the left.



Second-level Evaluator

As the second-level evaluator, do the following:

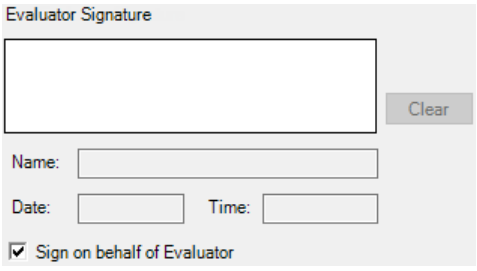
a. Select **Summary** on the left to view the summary.



b. If you are the second-level evaluator, to add notes, click **2nd Evaluator Notes**.

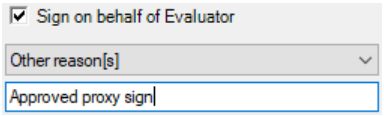
c. If the evaluator has not signed the review and will not or cannot sign the review, and if you are allowed to sign on behalf of evaluators, to sign as the evaluator, do the following:

1). Under **Evaluator Signature**, select the **Sign on behalf of Evaluator** check box.



2). From the list that appears, select the reason why you are signing on behalf of the evaluator:

- **Evaluator is not present to sign the review**.
- **Evaluator no longer works at this clinic**.
- **Evaluator refuses to sign/acknowledge the evaluation**.
- **Other reason(s)**. With this option selected, enter the reason in the box that appears.



3). Sign in the **Evaluator Signature** box.

Note: If you need to remove the signature to re-sign, you can click the corresponding **Clear** button.

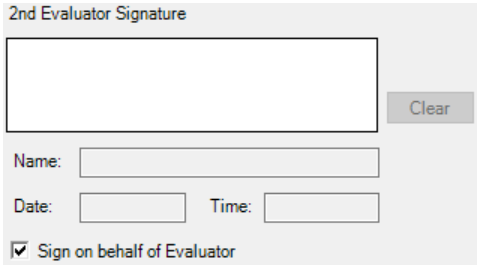
d. Do one of the following:

- If you are the second-level evaluator, to sign the review, sign in the **2nd Evaluator Signature** box.

  Note: If you need to remove the signature to re-sign, you can click the corresponding **Clear** button.

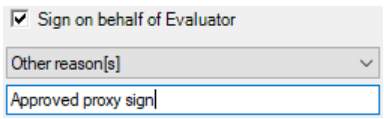
- If you are not the second-level evaluator, and if you are allowed to sign on behalf of evaluators, to sign as the second-level evaluator, do the following:

  1). Under **2nd Evaluator Signature**, select the **Sign on behalf of Evaluator** check box.



  2). From the list that appears, select the reason why you are signing on behalf of the second-level evaluator:

  - **Evaluator is not present to sign the review**.
  - **Evaluator no longer works at this clinic**.
  - **Evaluator refuses to sign/acknowledge the evaluation**.
  - **Other reason(s)**. With this option selected, enter the reason in the box that appears.



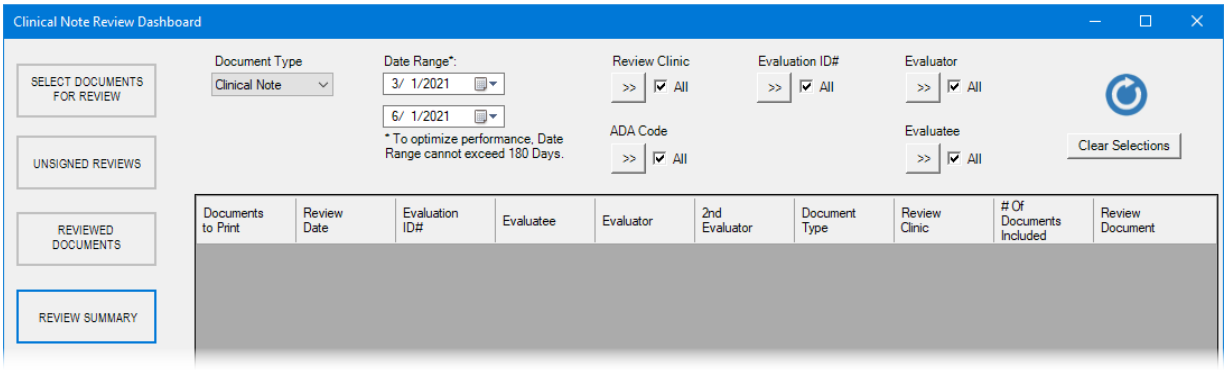
  3). Sign in the **2nd Evaluator Signature** box.

  Note: If you need to remove the signature to re-sign, you can click the corresponding **Clear** button.

e. Click **Save**.

Review Summary Tab

If the evaluator has signed the review, and if a second-level evaluator is assigned to the review, the second-level evaluator (or someone acting on his or her behalf) signs the review if he or she has not already done so. Also, you can print clinical note reviews on this tab.



On the **Review Summary** tab, do the following:

1. Set up the following filters:
   - **Document Type** – Currently, **Clinical Note** is the only type.
   - **Date Range** – By default, the date range is the past three months, but you can change the date range as needed. To include reviews that were started on a different date or within a different date range, enter the desired date or date range in the two boxes.

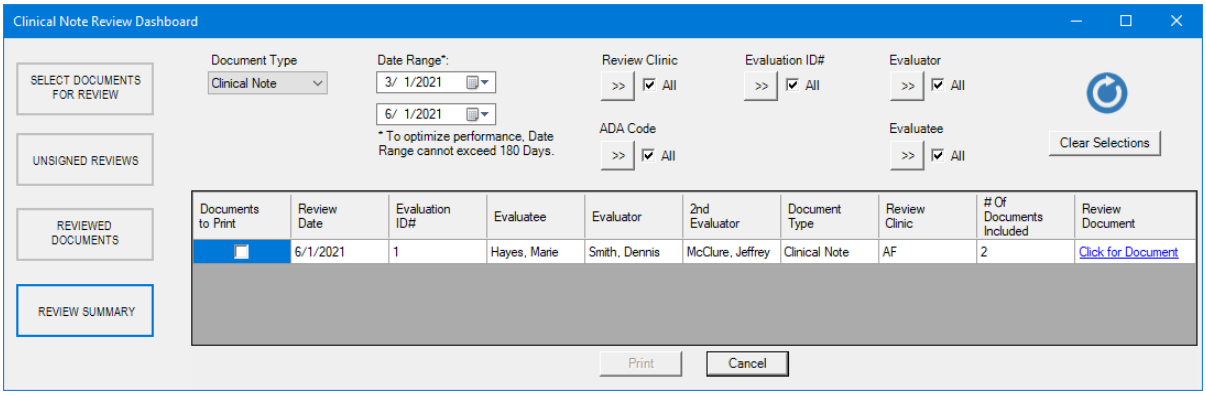
     Note: The date range cannot exceed 180 days.

   - **Review Clinic** – To include reviews that were started in any clinic, select the **All** check box. To include reviews that were started in only specific clinics, click the search button [>>] to select those clinics.
   - **ADA Code** – To include reviews with any procedure, select the **All** check box. To include reviews with only specific procedures, click the search button [>>] to select the desired procedures.
   - **Evaluation ID#** – To include reviews with any evaluation ID, select the **All** check box. To include reviews with only specific evaluation IDs, click the search button [>>] to select those IDs.
   - **Evaluator** – To include reviews that were started by any evaluator, select the **All** check box. To include reviews that were started by only specific evaluators, click the search button [>>] to select those evaluators.
   - **Evaluatee** – To include reviews for any evaluatee, select the **All** check box. To include reviews for only specific evaluatees, click the search button [>>] to select those evaluatees.

   Note: To return the filters to their default states and clear the data grid, click **Clear Selections**.

2. Click the **Refresh** button.

The data grid is updated according to the specified criteria.



For each review in the data grid, the following information appears:

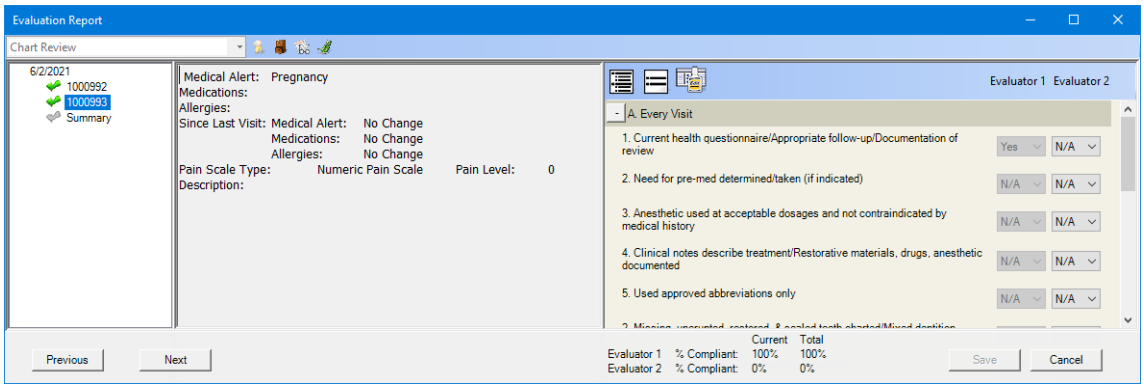
- **Review Date** – That date when the review was started.
- **Evaluation ID#** – The review's unique ID number.
- **Evaluatee** – The person being evaluated.
- **Evaluator** – The person who started the review.
- **2nd Evaluator** – If applicable, the second-level evaluator assigned to the review.
- **Document Type** – Currently, the only type is **Clinical Note**.
- **Review Clinic** – The clinic where the review was started.
- **# Of Documents Included** – The number of clinical notes that are included in the review.
- **Document ID#** – The clinical note's unique ID number.

3. To open or sign a review do the following:

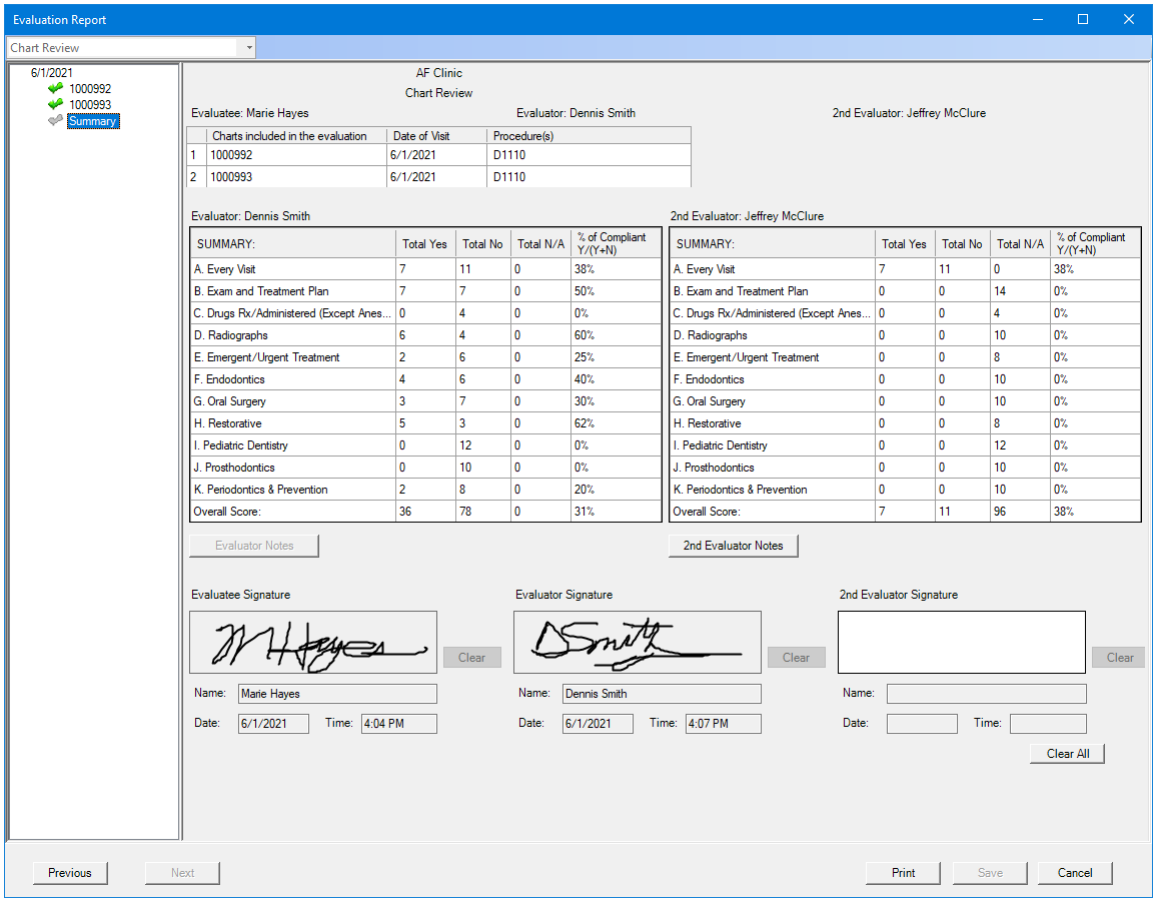
   a. Click the corresponding **Click for Document** link in the **Review Document** column.

   The **Evaluation Report** dialog box appears.

   b. Click each clinical notes ID number on the left to view the responses to the evaluation criteria.



c. Click **Summary** on the left to view the summary.



d. If you are the second-level evaluator, to add notes, click **2nd Evaluator Notes**.

e. As the second-level evaluator, do the following if a signature is needed:

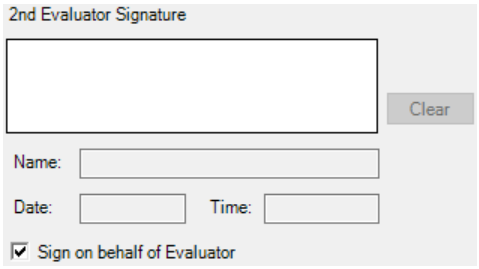
1). Do one of the following:

- If you are the second-level evaluator, to sign the review, sign in the **2nd Evaluator Signature** box.

  Note: If you need to remove the signature to re-sign, you can click the corresponding **Clear** button.

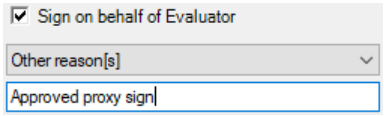
- If you are not the second-level evaluator, and if you are allowed to sign on behalf of evaluators, to sign as the second-level evaluator, do the following:

a). Under **2nd Evaluator Signature**, select the **Sign on behalf of Evaluator** check box.



b). From the list that appears, select the reason why you are signing on behalf of the second-level evaluator:

- **Evaluator is not present to sign the review**.
- **Evaluator no longer works at this clinic**.
- **Evaluator refuses to sign/acknowledge the evaluation**.
- **Other reason(s)**. With this option selected, enter the reason in the box that appears.

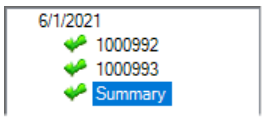


c). Sign in the **2nd Evaluator Signature** box.

Note: If you need to remove the signature to re-sign, you can click the corresponding **Clear** button.

2). Click **Save**.

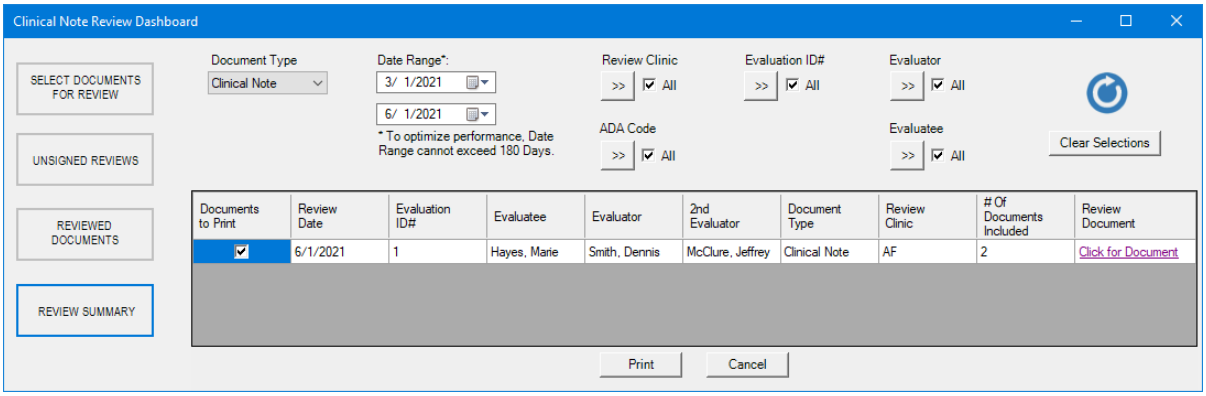
Note: If you have signed the review, a green check mark appears next to **Summary** on the left.



f. If you need to clear all the signatures for the review, click **Clear All**, and then click **Save** to save the change.

g. Click **Cancel** to return to the **Clinical Note Review Dashboard** window.

4. For each review that you want to include on a report, select the check box in the **Documents To Print** column.



5. To preview the selected reviews, click **Print**. Then, you can print or save the report.

Setting Up Clinical Note Review Templates

You can add clinical note review templates as needed. You can edit a template only if it is not associated with a saved review. You can delete a template only if it is not associated with a saved review and if it is not the only template.

Notes:

- Each question in an evaluation must be worded in a way that the response could be Yes, No, or N/A.
- The default template should be the template that you will use most often and will be the template that is selected by default when you open the **Evaluation Report** dialog box to start a review.

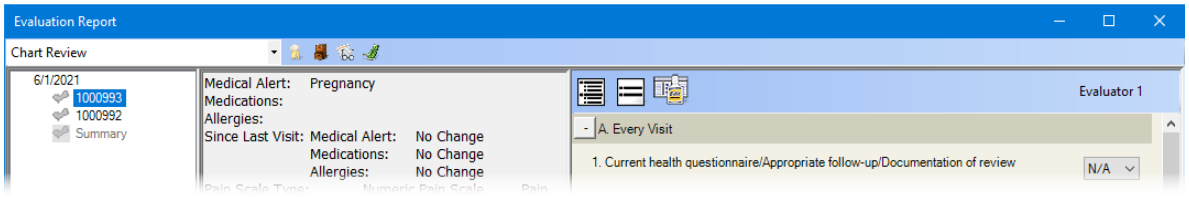
To set up clinical note review templates

1. In Office Manager, from the **Analysis** menu, click **Clinical Note Review Dashboard**.

   The **Clinical Note Review Dashboard** window appears.

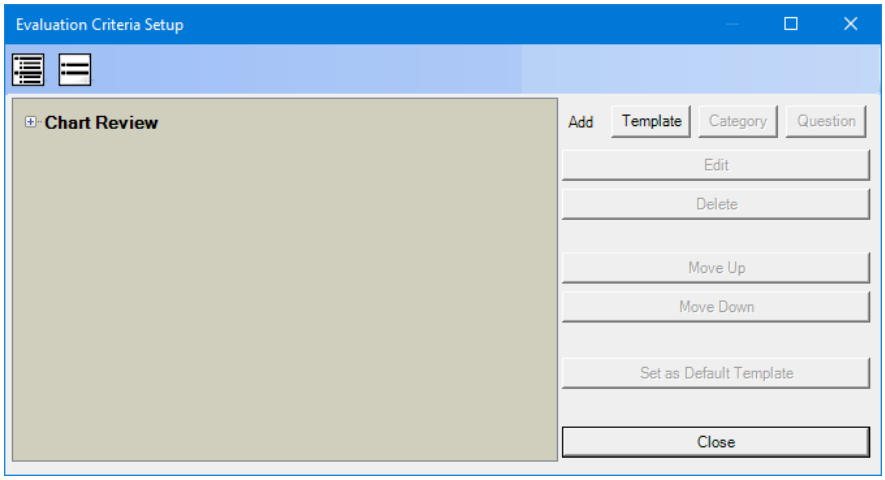
2. Select the **Select Documents for Review** tab.
3. Set up the filters, and then click the **Refresh** button .
4. With at least one check box selected in the **Document To Be Included In Review** column, click **Start Review**.

   The **Evaluation Report** dialog box appears.



5. Click the **Template Setup** button .

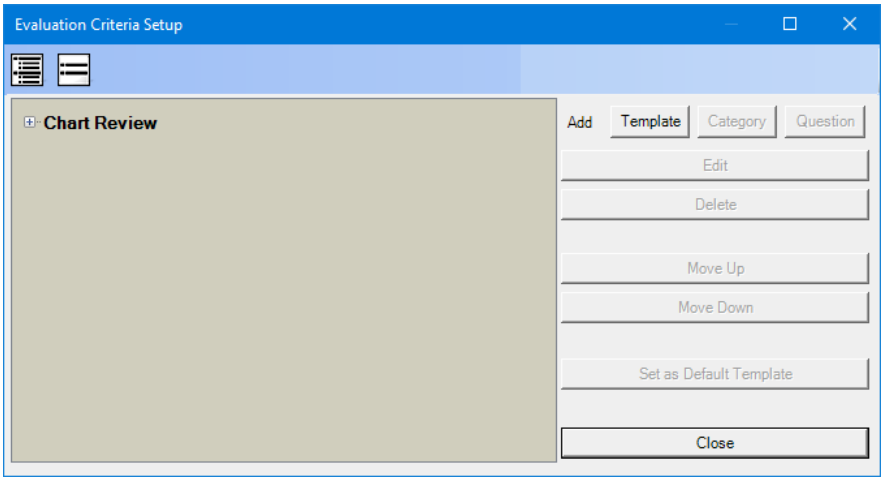
   The **Evaluation Criteria Setup** dialog box appears.



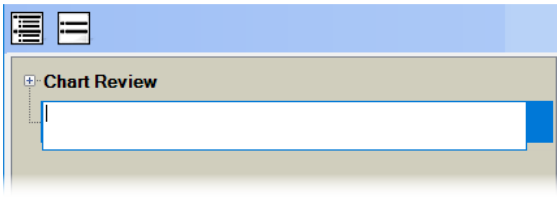
6. Do any of the following as needed:

Add a template:

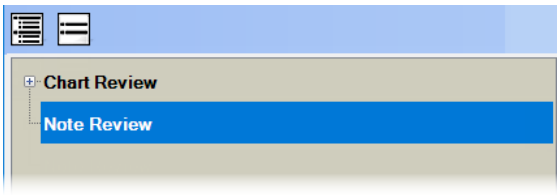
a. Next to **Add** on the right, click **Template**.



b. In the box that appears on the left, enter a name for the template, and then press Enter.

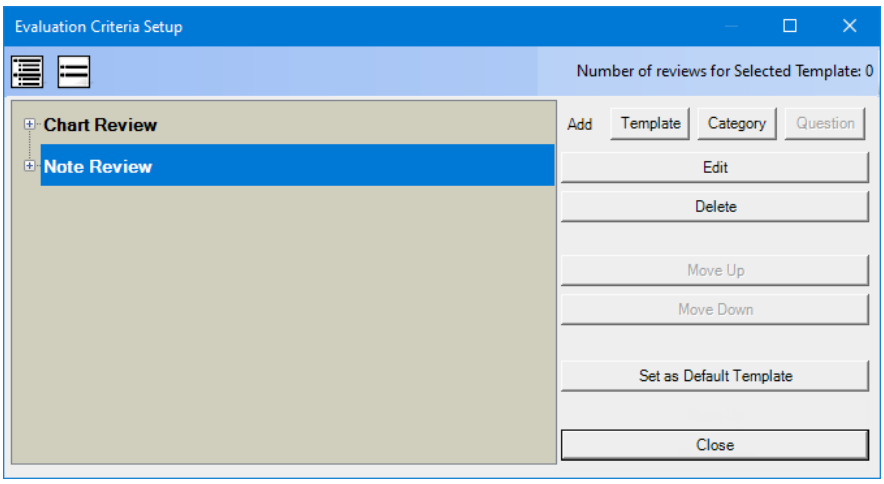


The new template is now selected, so you can add categories and questions to it.

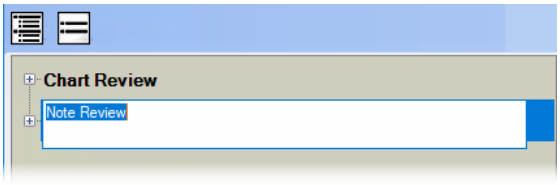


Rename a template:

a. On the left, select a template, and then click **Edit** on the right.

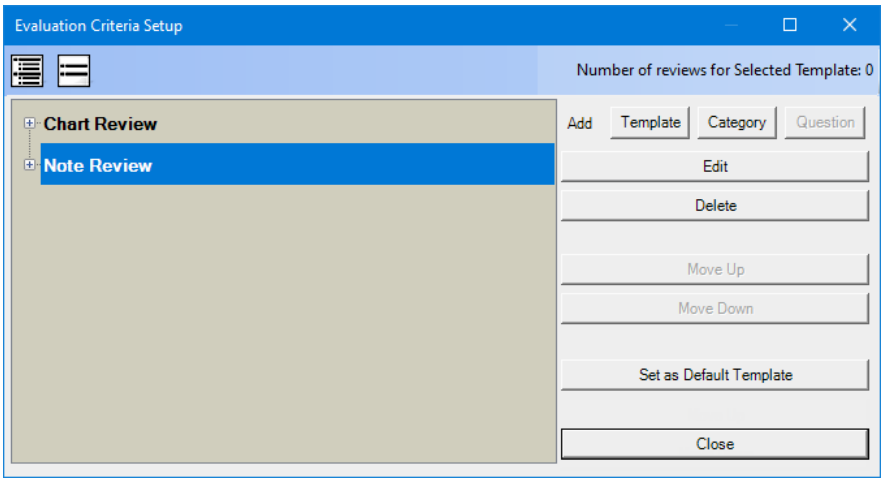


b. The template name becomes an editable box. Change the name, and then press Enter.



Delete a template:

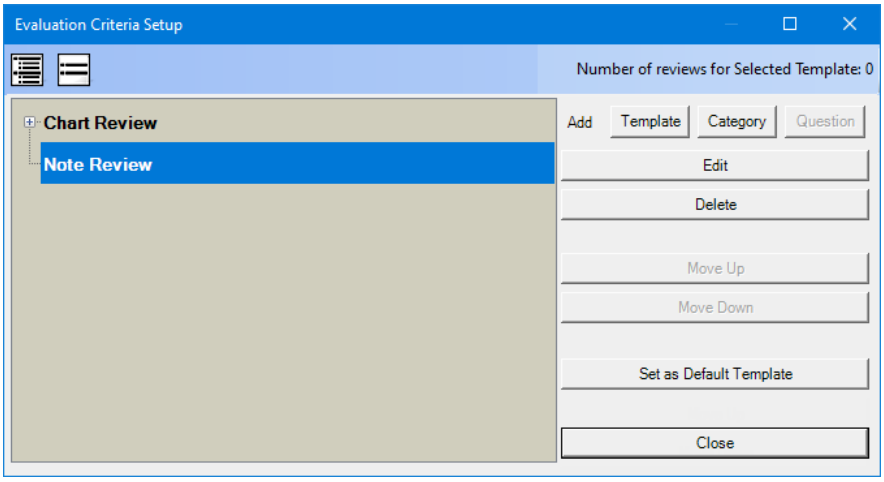
a. On the left, select a template, and then click **Delete** on the right.



b. On the confirmation messages that appear, click **Yes**.

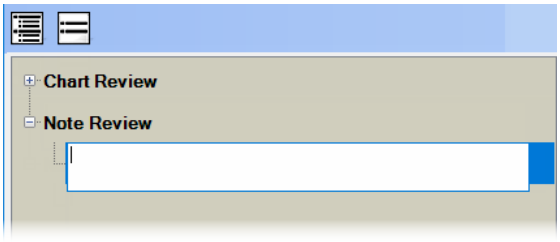
Add a category:

a. On the left, either select a template to add a category as the last one for that template, or select an existing category to add a new one after the selected one.

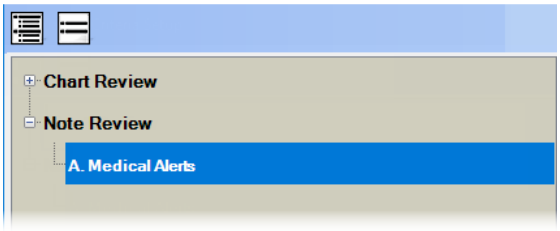


b. Next to **Add** on the right, click **Category**.

c. In the box that appears on the left, enter a name for the category, and then press Enter.

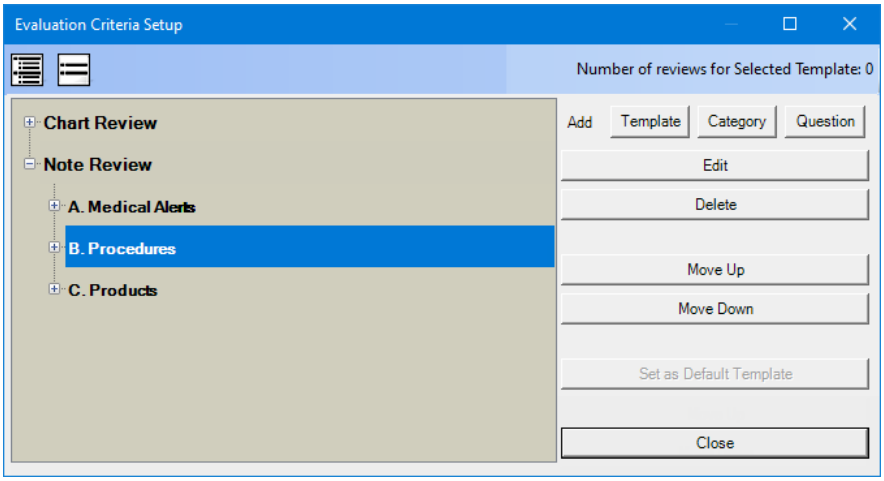


An uppercase letter, period, and space are added to the beginning of the name automatically. Also, the new category is now selected, so you can add questions to it.

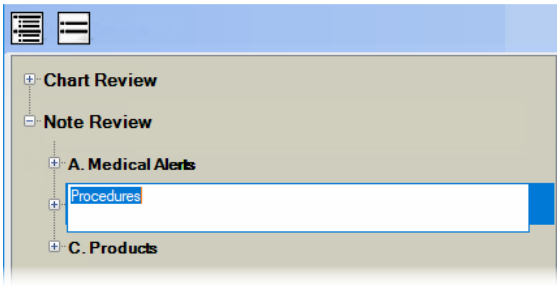


Rename a category:

a. On the left, select a category, and then click **Edit** on the right.

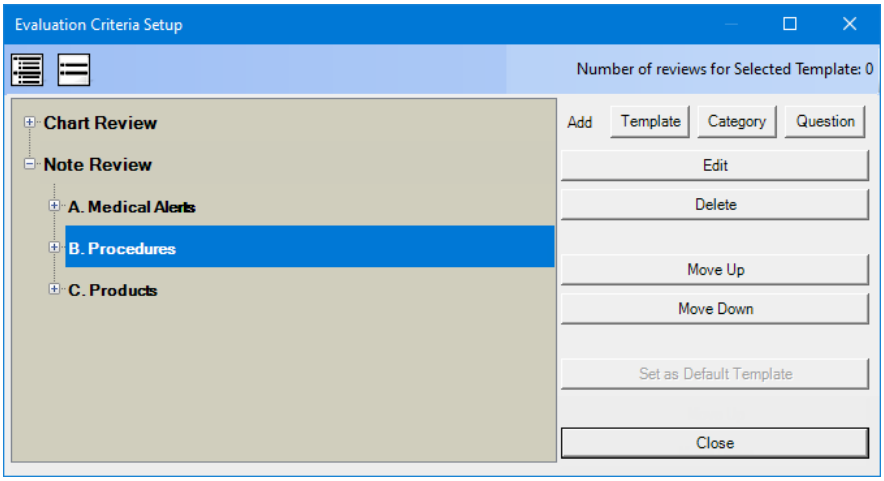


b. The category name becomes an editable box. Change the name, and then press Enter.



Delete a category:

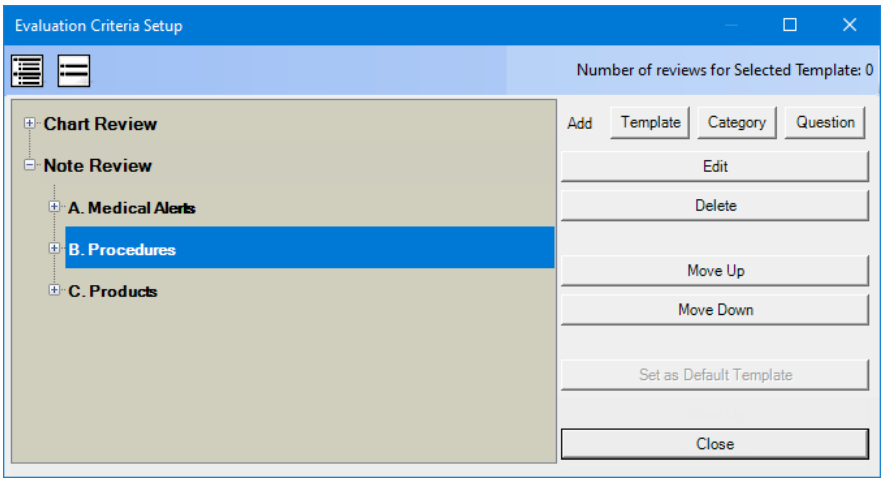
a. On the left, select a category, and then click **Delete** on the right.



b. On the confirmation message that appears, click **Yes**.

Reorder categories:

a. On the left, select a category.

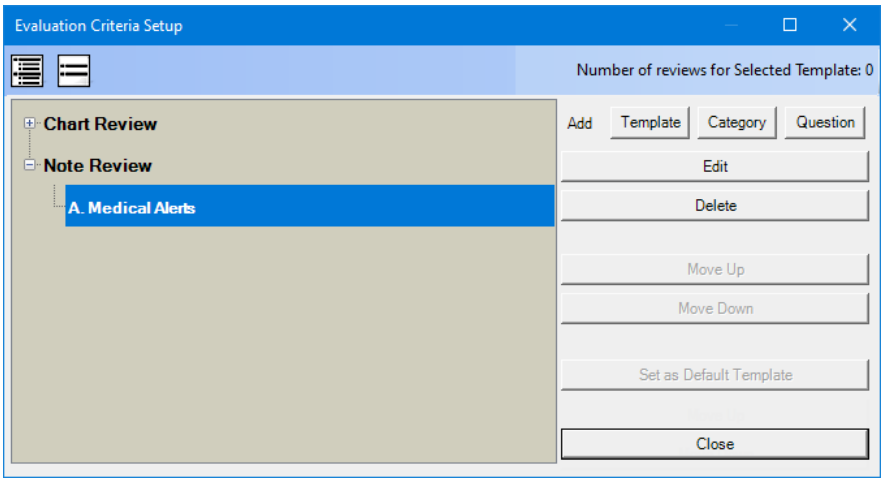


b. On the right, click **Move Up** or **Move Down** as needed to move the category to the desired position in the template.

c. Repeat these steps as needed for other categories to achieve the desired order.

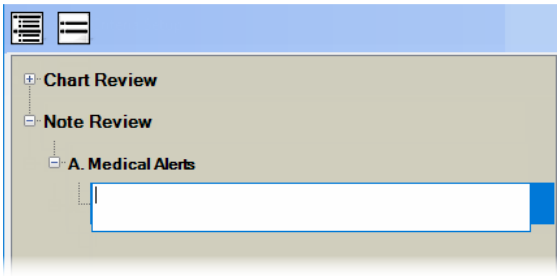
Add a question:

a. On the left, either select a category to add a question as the last one in that category, or select an existing question to add a new one after the selected one.

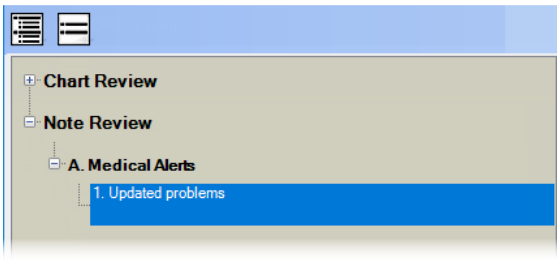


b. Next to **Add** on the right, click **Question**.

c. In the box that appears on the left, enter the text of the question, and then press Enter.

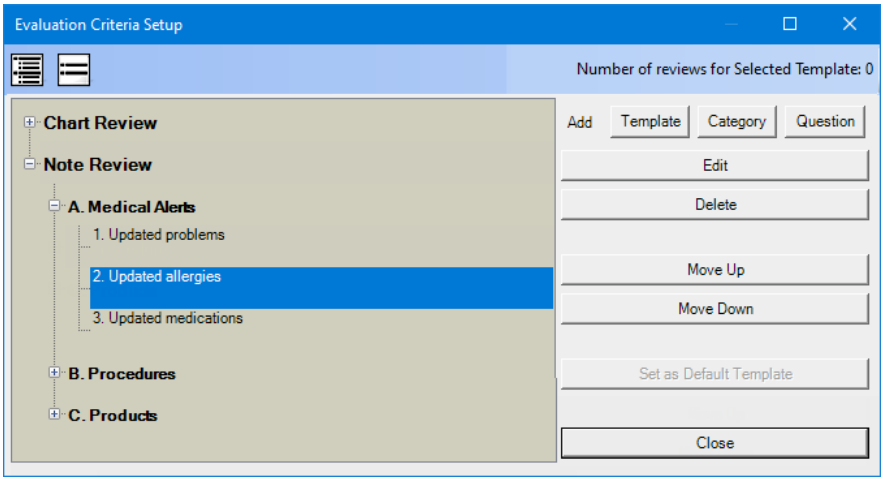


A number, period, and space are added to the beginning of the question automatically.

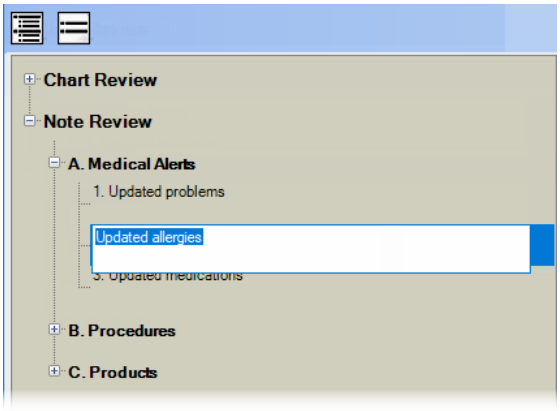


Edit a question:

a. On the left, select a question, and then click **Edit** on the right.

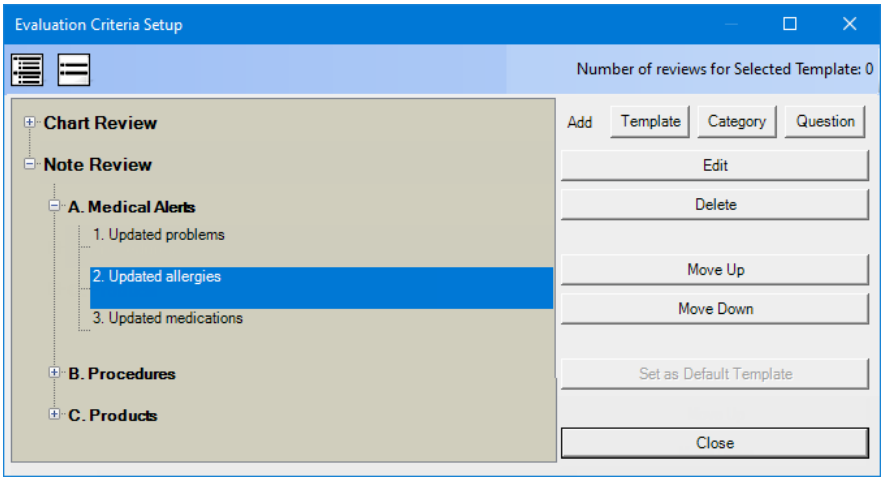


b. The question becomes an editable box. Change the text of the question, and then press Enter.



Delete a question:

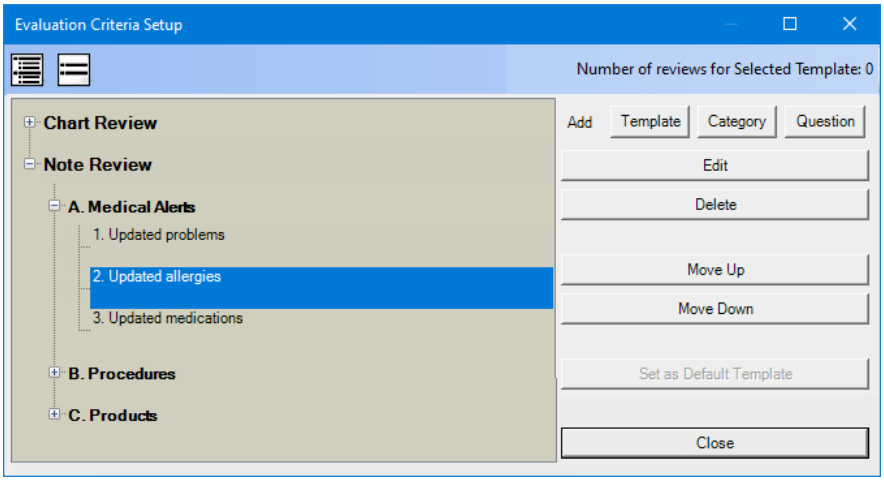
a. On the left, select a question, and then click **Delete** on the right.



b. On the confirmation message that appears, click **Yes**.

Reorder questions:

a. On the left, select a question.

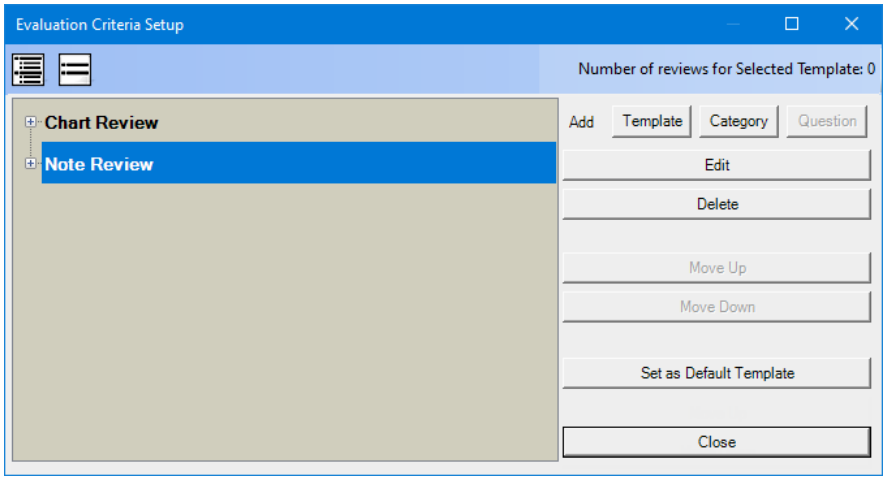


b. On the right, click **Move Up** or **Move Down** as needed to move the question to the desired position in the list.

c. Repeat these steps as needed for other questions to achieve the desired order.

Set the default template:

a. On the left, select a template.



b. On the right, click **Set as Default Template**. This button is available only if there is more than one template and if the selected template is not already the default template.

7. Click **Close**.

8. In the **Evaluation Report** dialog box, click **Cancel** because you are managing templates and not performing an evaluation. Then, on the confirmation message, click **Yes**.

Dynamic Reporting

A dynamic reporting dashboard is available.

Notes:

- A global setting controls the availability of Dynamic Reporting.
- Accessing Dynamic Reporting requires the "Dynamic Reporting Interface, Open" security right (in the "Office Manager" category).
- Exporting data from Dynamic Reporting requires the "Dynamic Reporting Interface, Export Report" security right.
- On each client computer that connects to the Dentrix Enterprise database, in the SQL Server Configuration Manager, **TCP/IP** must be enabled, and the alias for Dentrix must use that protocol.

Opening Dynamic Reporting

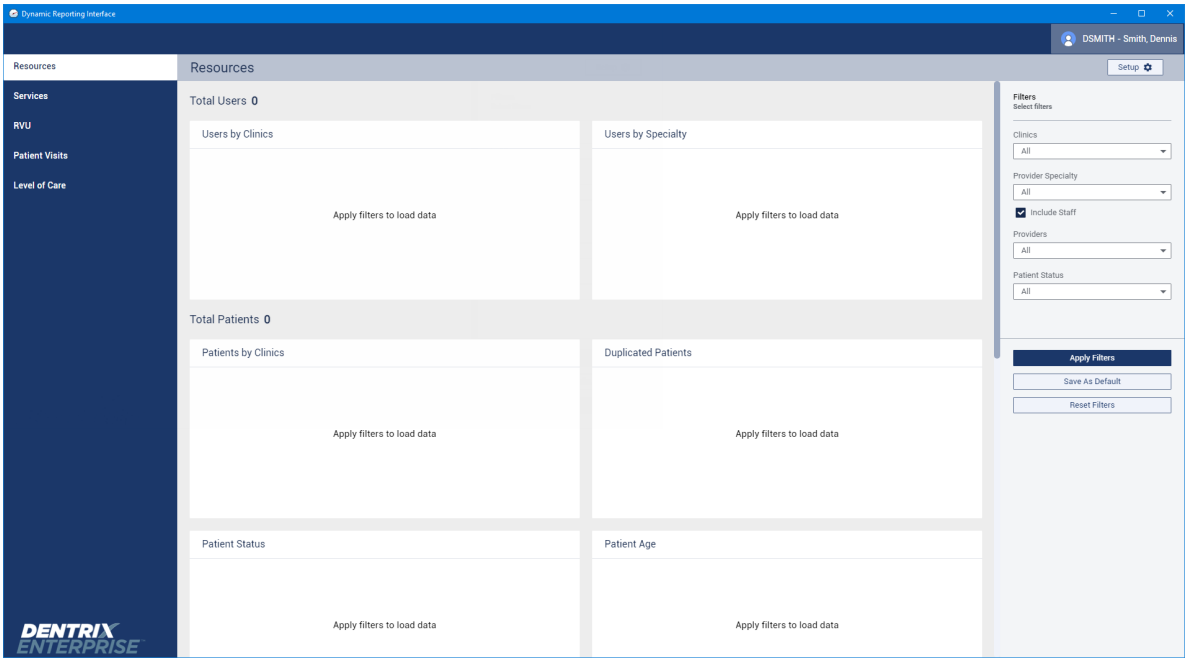
Dynamic Reporting is a dependent module, which means you can open it only from another module. If Dynamic Reporting is open when you close Office Manager, Dynamic Reporting closes also.

To open Dynamic Reporting

In Office Manager, do one of the following:

- Click the **Dynamic Reporting Interface** button on the toolbar .
- On the **File** menu, click the new **Dynamic Reporting Interface** option.

Dynamic Reporting opens.



In this window, you can do the following:

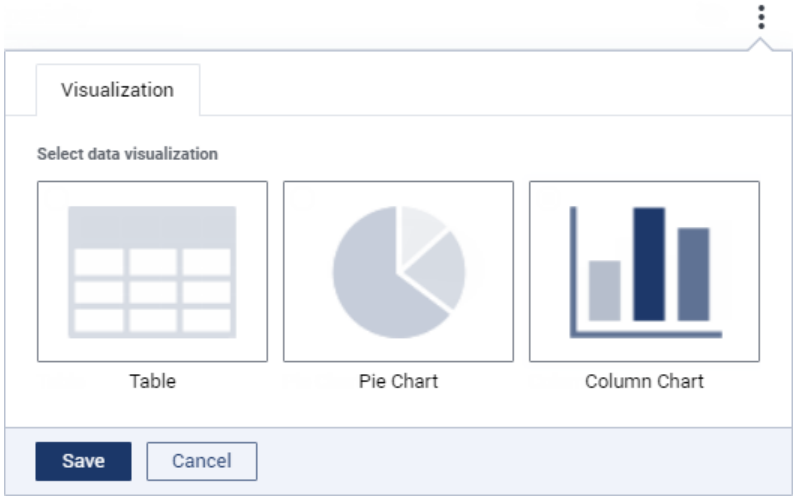
- Use the navigation bar on the left to navigate to each page of the dashboard: **Resources**, **Services**, **RVU**, **Patient Visits**, and **Level of Care**.
- Turn on setup mode to show, hide, resize, and arrange information on each page of the dashboard.
- In view mode, filter the information on each page of the dashboard.

Setting Up Dynamic Reporting

You can customize each page of the dashboard as needed.

To set up Dynamic Reporting

1. To turn on setup mode, click **Setup**.
2. Navigate to one of the following pages: **Resources**, **Services**, **RVU**, **Patient Visits**, or **Level of Care**.
3. Do any of the following as needed to customize the page:
   - To show a summary tile, totals strip, or ratio tile, do the following:
     a. Click the corresponding **Show Widget** button .
        The button changes to the **Hide Widget** button .
   - To resize a summary tile, do the following:
     a. Position your pointer over the corner of an item .
        The cursor turns into a two-way, diagonal arrow .
     b. Click and drag either diagonally down to the right to increase the size or diagonally up to the left to decrease the size.
   - To move a summary tile, totals strip, or ratio tile, do the following:
     a. Position your pointer over the item.
        The cursor turns into a four-direction arrow .
     b. Click and drag the item to the desired position. Other items automatically adjust their positions to accommodate.
   - To specify the format for a summary tile, do the following:
     a. Expand the corresponding **Visualization** menu.



     b. Select an option: **Table**, **Pie Chart**, or **Column Chart**.
     c. Click **Save**.
   - To hide a summary tile, totals strip, or ratio tile, do the following:
     a. Click the corresponding **Hide Widget** button .
        The button changes to the **Show Widget** button .

Note: To undo any changes that you have made to the current page and return to view mode, click **Reset to Default**, and then click **Yes** on the confirmation message that appears.

4. Click **Save**.
5. Repeat steps 2–4 as needed for any other pages that you want to customize.
6. To return to view mode, click **Back to Reporting Interface**.

Filtering Dynamic Reporting

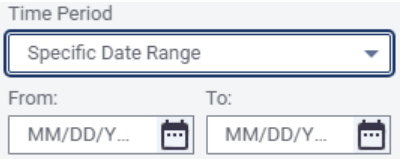
You can filter the data that appears on each page of the dashboard as needed.

Note: The available filters vary by page.

To filter Dynamic Reporting

1. Navigate to one of the following pages: **Resources**, **Services**, **RVU**, **Patient Visits**, or **Level of Care**.
2. Under **Filters**, change any of the following options that apply to the current page:
   - **Time Period** (Services, RVU, Patient Visits, and Level of Care pages only) – Do one of the following:
     - To specify a relative date range, select one of the following options:
       - Current Day
       - Current MTD
       - Current Fiscal YTD
       - Current Calendar YTD
       - Previous Day
       - Previous Week
       - Previous Month
       - Previous 3 Months
       - Previous 6 Months
       - Previous Fiscal Year
       - Previous Calendar Year
       - Specific Date Range
     - To specify an absolute date range, do the following:
       a. From the list, select **Specific Date Range**.

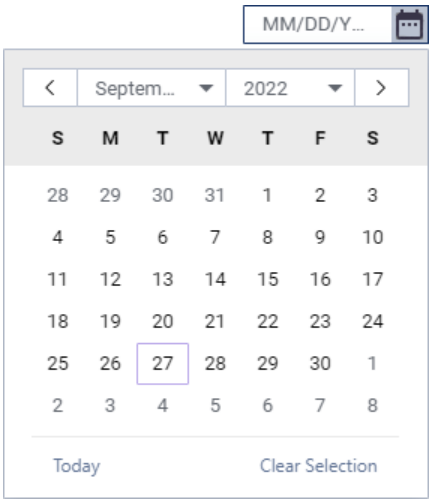
          The options to specify a date range become available.

       b. Do one of the following:
          - To include a specific date, enter (in a mm/dd/yyyy format) or select the same date for both **From** and **To**.
          - To include a specific date range, enter (in a mm/dd/yyyy format) or select the starting date of the range for **From** and the ending date of the range for **To**.

          To select a date for **From** or **To**, do the following:

i. Click the applicable calendar icon to view a month calendar.



Notes:

- To use today's date, click the Today link.
- To clear the date, click Clear Selection.

ii. Select the correct month and year from the lists at the top of the calendar, or click the left or right chevron as needed to navigate to a different month.

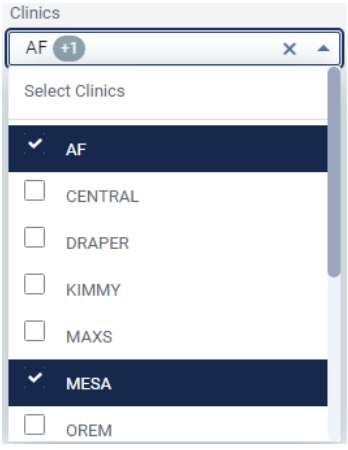
iii. Click the correct day.

- **Clinics** (All pages) – Do one of the following:
  - If specific clinics are currently selected (a clinic ID and possibly a counter appear in the box), to include all clinics, click the **X**.



The box then displays "All" to indicate that all clinics are included.

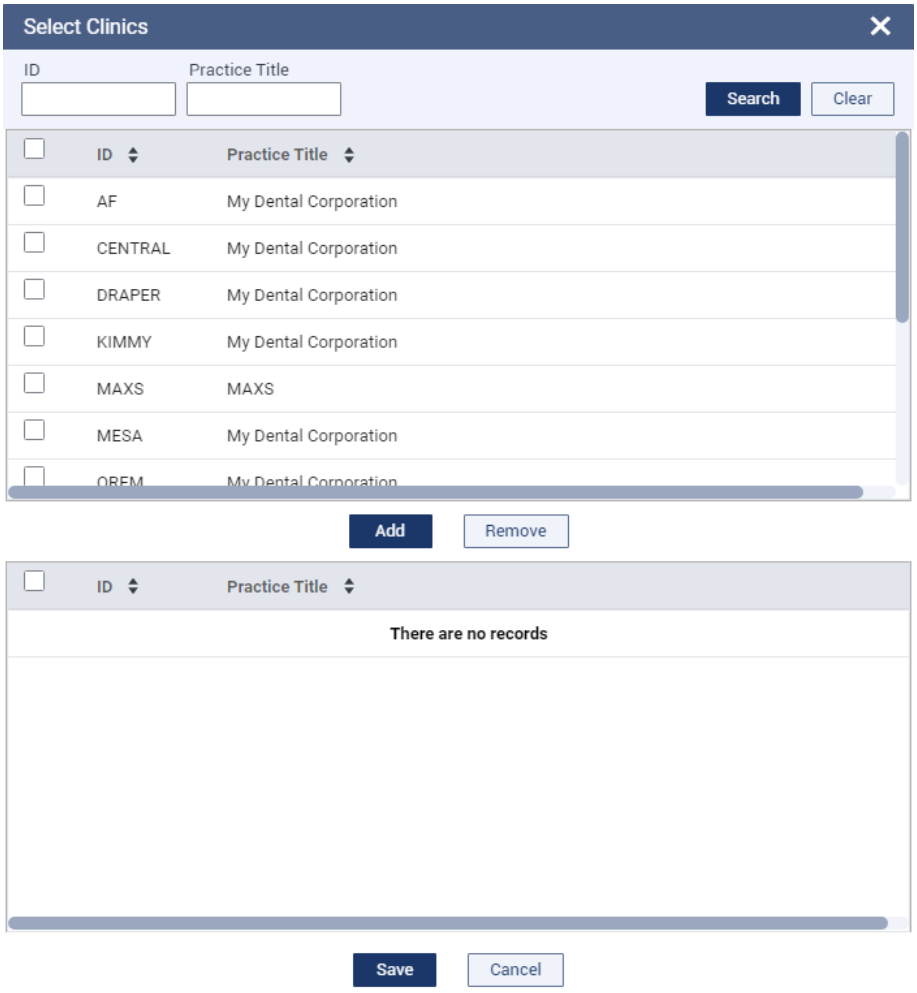
  - To quickly include or exclude clinics, expand the list, and then select or clear the check box of each clinic to include or exclude.



  - To specify which clinics to include, do the following:

a. From the list, select **Select Clinics**.

The **Select Clinics** dialog box appears.



Note: If your user account has been granted the "View All Patients" security right for the Central clinic, all clinics appear in the upper list; otherwise, the clinics for which your user account has been granted the "My Clinics, View" security right (in the "Practice/Clinic Setup" category) appear in the upper list; however, if your user account has not been granted that right to any clinic, only the clinic that you are currently logged in to appears in the upper list.

b. If the list is long, to search for a clinic, do the following:

i. Enter the first character or more of a clinic ID and/or title in the **ID** and/or **Practice Title** boxes.

ii. Click **Search**.

The matching clinics appear in the upper list.

Note: To return to viewing the list of all clinics, Clear.

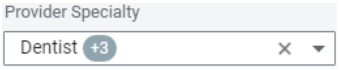
c. In the upper list, select the check box of each clinic to include, or select the check box at the top of the list to select all the check boxes.

d. Click **Add**.

Note: To remove a clinic that you have added, select its check box in the lower list, and then click Remove.

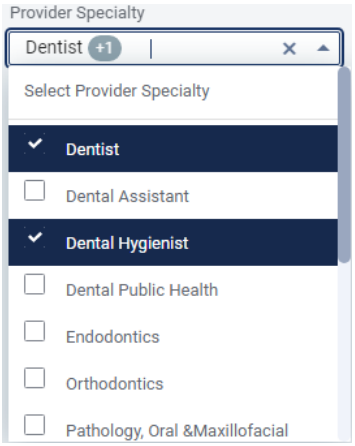
e. Click **OK**.

- **Provider Specialty** (All pages) – Do one of the following:
  - If specific specialties are currently selected (a specialty and possibly a counter appear in the box), to include all specialties, click the **X**.



The box then displays "All" to indicate that all specialties are included.

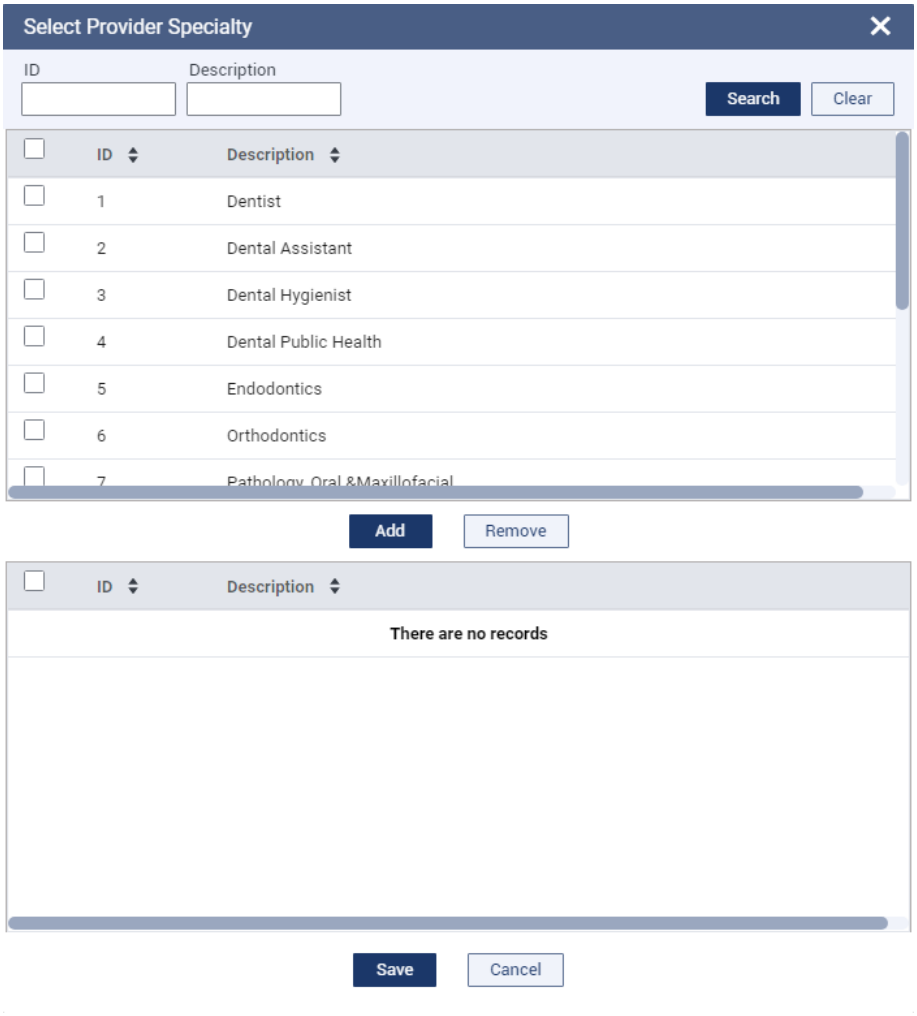
  - To quickly include or exclude specialties, expand the list, and then select or clear the check box of each specialty to include or exclude.



  - To specify which specialties to include, do the following:

a. From the list, select **Select Provider Specialty**.

The **Select Provider Specialty** dialog box appears.



Note: All specialties appear in the upper list.

b. To search for a specialty, do the following:

i. Enter the first character or more of a specialty ID and/or description in the **ID** and/or **Description** boxes.

ii. Click **Search**.

The matching specialties appear in the upper list.

Note: To return to viewing the list of all specialties, click **Clear**.

c. In the upper list, select the check box of each specialty to include, or select the check box at the top of the list to select all the check boxes.

d. Click **Add**.

Note: To remove a specialty that you have added, select its check box in the lower list, and then click **Remove**.

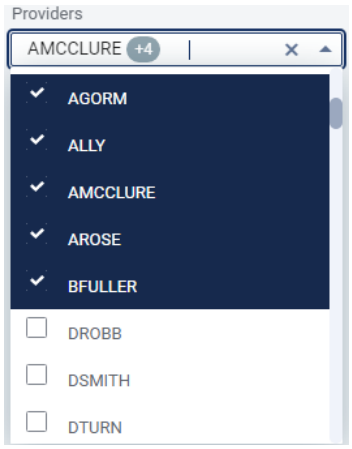
e. Click **OK**.

- **Include Staff** (Resources page only) – Select or clear this check box:
  - With this check box selected, the **Providers** filter can include providers and staff.
  - With this check box clear, the **Providers** filter can include only providers.

- **Providers** (All pages) – Do one of the following:
  - If specific providers and staff members (if applicable) are currently selected (a provider/staff ID and possibly a counter appear in the box), to include all providers and staff members (if applicable), click the **X**.



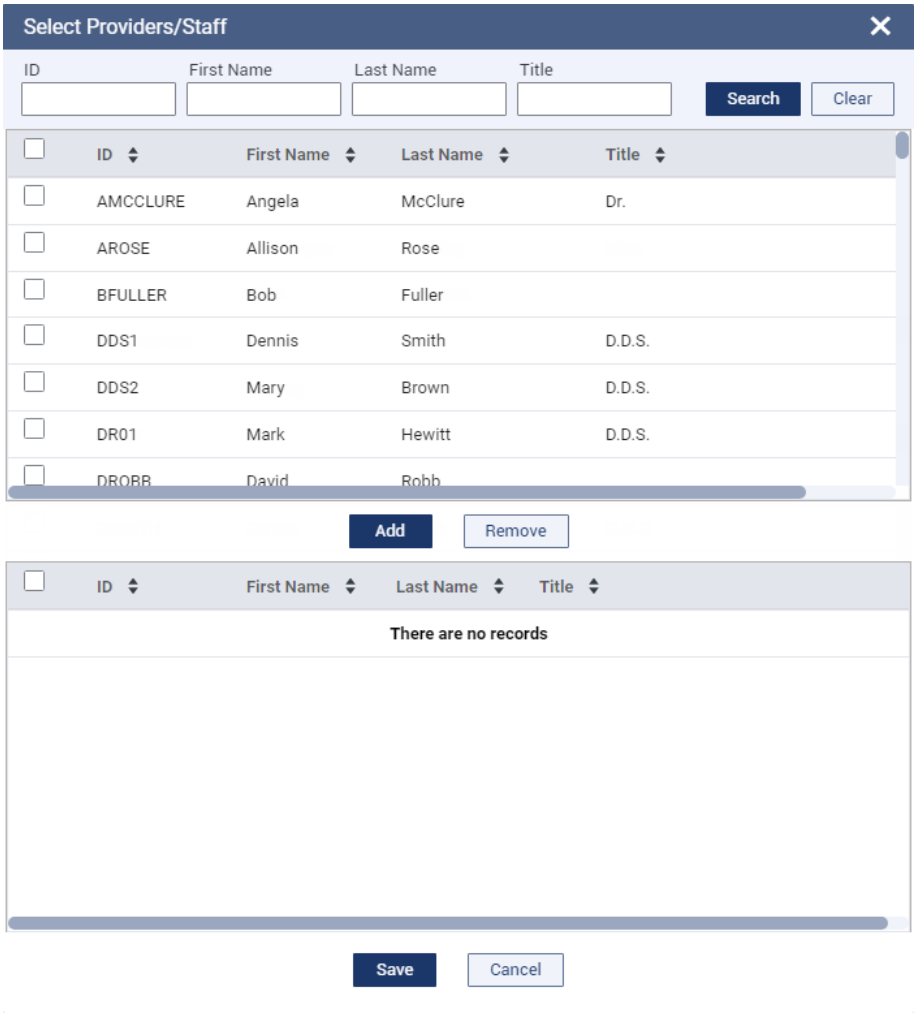
    The box then displays "All" to indicate that all providers and staff members (if applicable) are included.
  - To quickly include or exclude providers and staff members (if applicable), expand the list, and then select or clear the check box of each provider or staff member (if applicable) to include or exclude.



    To specify which providers and staff members (if applicable) to include, do the following:

    a. From the list, select **Select Providers/Staff**.

    The **Select Providers/Staff** dialog box appears.



Note: Only active providers and staff members appear in the upper list. Inactive providers and staff members are not available.

b. If the list is long, to search for a provider/staff member, do the following:

i. Enter the first character or more of a provider/staff ID, first name, last name, and/or title in the **ID**, **First Name**, **Last Name**, and/or **Title** boxes.

ii. Click **Search**.

The matching providers/staff members appear in the upper list.

Note: To return to viewing the list of all providers and staff members, click **Clear**.

c. In the upper list, select the check box of each provider/staff member to include, or select the check box at the top of the list to select all the check boxes.

d. Click **Add**.

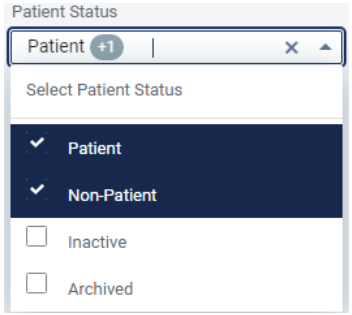
Note: To remove a provider/staff member that you have added, select its check box in the lower list, and then click **Remove**.

e. Click **OK**.

- **Patient Status** (Resources page only) – Do one of the following:
  - If specific patient statuses are currently selected (a status and possibly a counter appear in the box), to include all patient statuses, click the **X**.



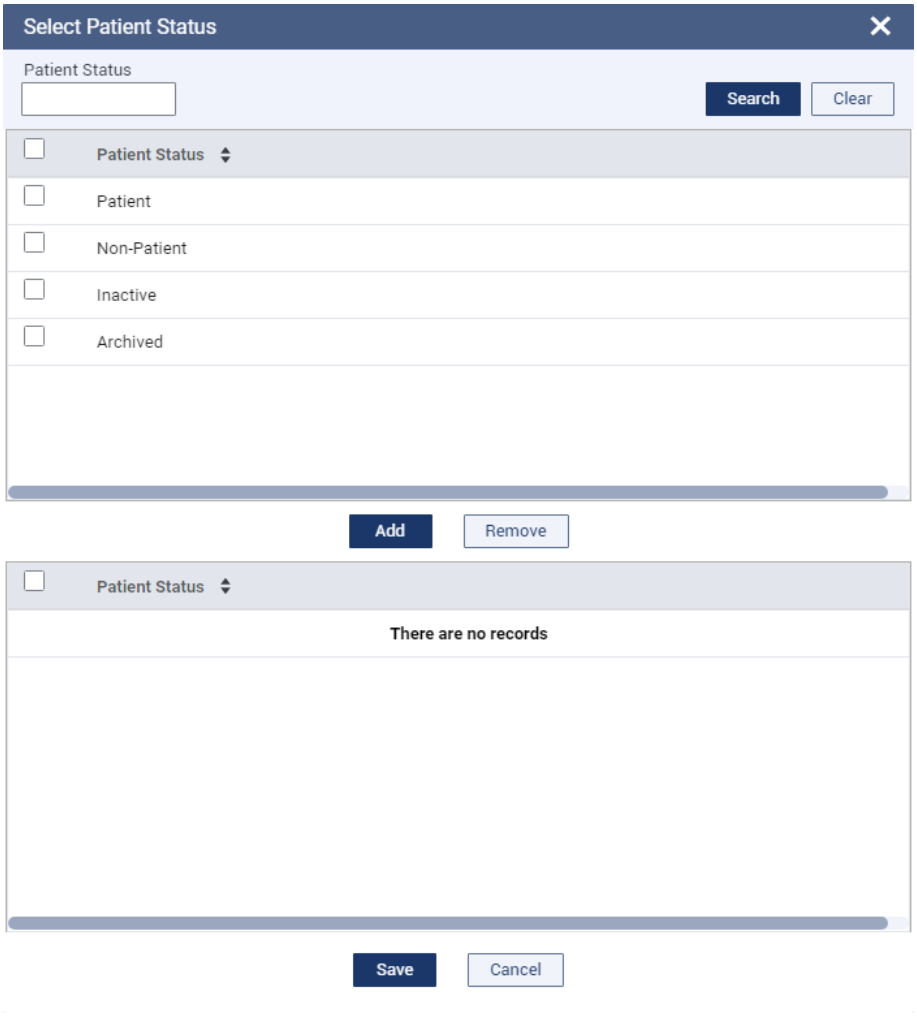
    The box then displays "All" to indicate that all patient statuses are included.
  - To quickly include or exclude patient statuses, expand the list, and then select or clear the check box of each status to include or exclude.



    To specify which patient statuses to include, do the following:

    a. From the list, select **Select Patient Status**.

    The **Select Patient Status** dialog appears.



Note: All patient statuses appear in the upper list.

b. To search for a patient status, do the following:

i. Enter the first character or more of a patient status in the **Patient Status** box.

ii. Click **Search**.

The matching patient statuses appear in the upper list.

Note: To return to viewing the list of all patient statuses, click **Clear**.

c. In the upper list, select the check box of each patient status to include, or select the check box at the top of the list to select all the check boxes.

d. Click **Add**.

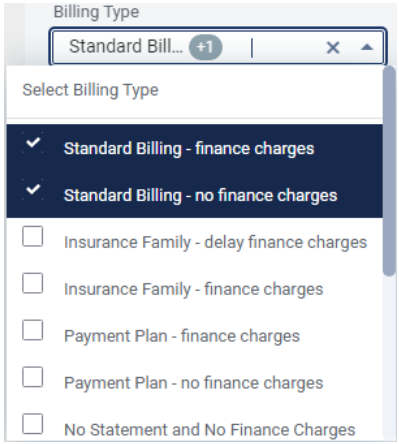
Note: To remove a patient status that you have added, select its check box in the lower list, and then click **Remove**.

e. Click **OK**.

- **Billing Type** (Services, RVU, and Patient Visits pages only) – Do one of the following:
  - If specific billing types are currently selected (a type and possibly a counter appear in the box), to include all billing types, click the **X**.



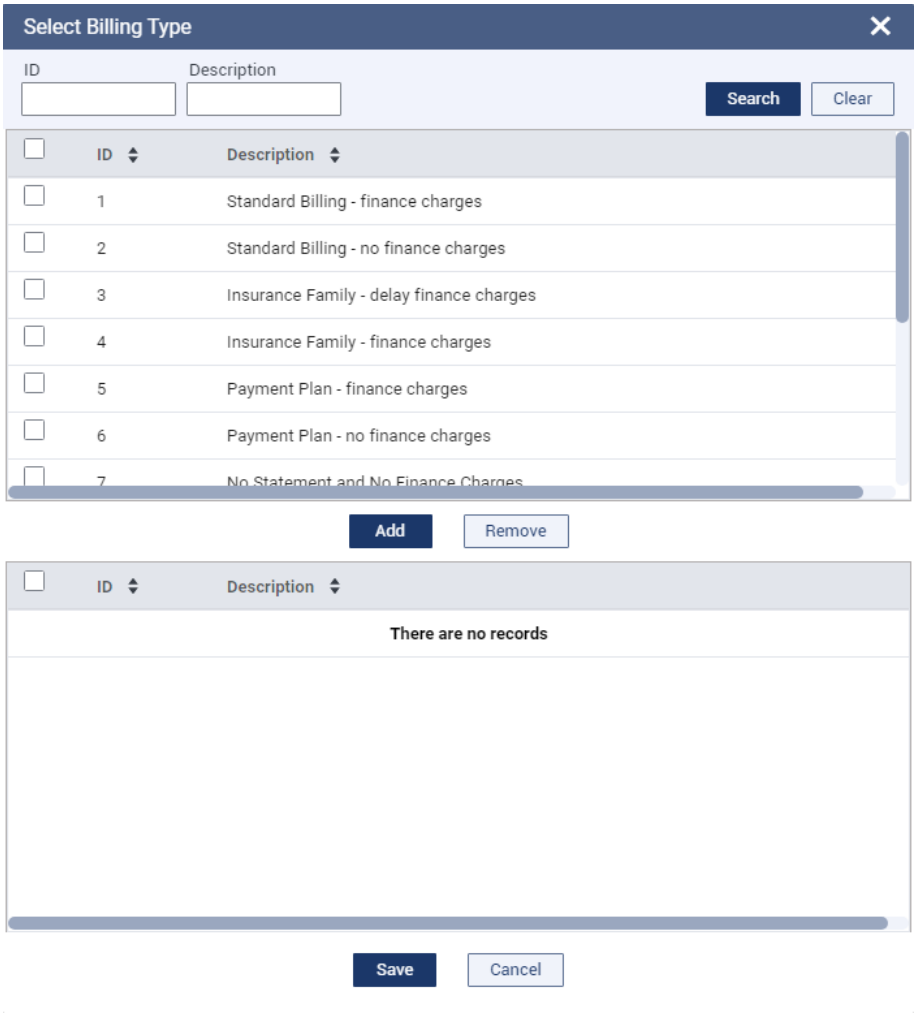
    The box then displays "All" to indicate that all billing types are included.
  - To quickly include or exclude billing types, expand the list, and then select or clear the check box of each billing type to include or exclude.



    To specify which billing types to include, do the following:

    a. From the list, select **Select Billing Type**.

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



Note: All billing types appear in the upper list.

b. If the list is long, to search for a billing type, do the following:

i. Enter the first character or more of a billing type ID and/or description in the **ID** and/or **Description** boxes.

ii. Click **Search**.

The matching billing types appear in the upper list.

Note: To return to viewing the list of all billing types, **Clear**.

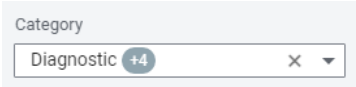
c. In the upper list, select the check box of each billing type to include, or select the check box at the top of the list to select all the check boxes.

d. Click **Add**.

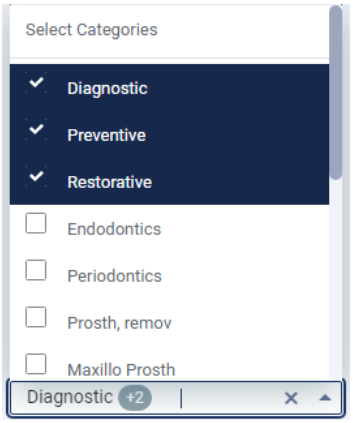
Note: To remove a billing type that you have added, select its check box in the lower list, and then click **Remove**.

e. Click **OK**.

- **Category** (Services, RVU, and Patient Visits pages only) – Do one of the following:
  - If specific procedure code categories are currently selected (a category and possibly a counter appear in the box), to include all procedure code categories, click the **X**.



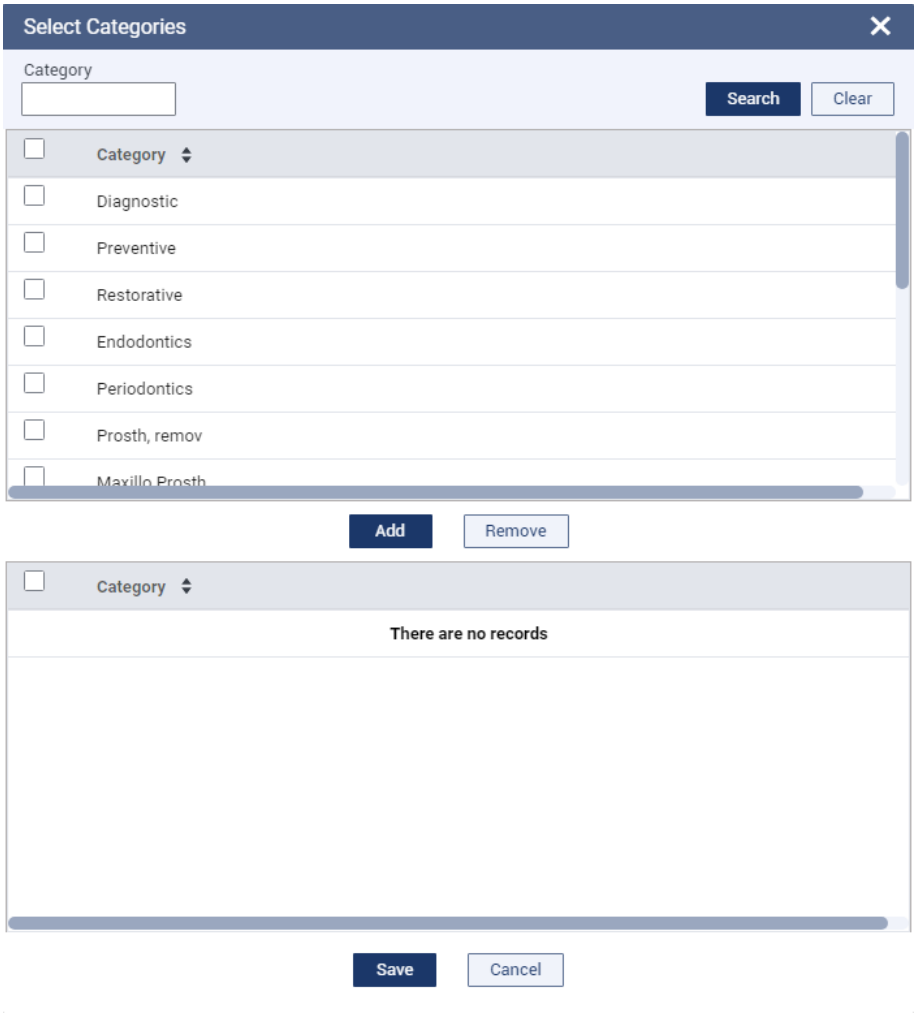
    The box then displays "All" to indicate that all procedure code categories are included.
  - To quickly include or exclude procedure code categories, expand the list, and then select or clear the check box of each procedure code category to include or exclude.



    To specify which procedure code categories to include, do the following:

    a. From the list, select **Select Categories**.

    The **Select Categories** dialog box appears.



Note: All procedure code categories appear in the upper list.

b. To search for a category, do the following:

i. Enter the first character or more of a procedure code category name in the **Category** box.

ii. Click **Search**.

The matching procedure code categories appear in the upper list.

Note: To return to viewing the list of all categories, click **Clear**.

c. In the upper list, select the check box of each procedure code category to include, or select the check box at the top of the list to select all the check boxes.

d. Click **Add**.

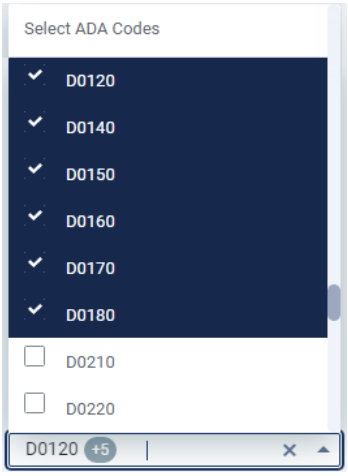
Note: To remove a procedure code category that you have added, select its check box in the lower list, and then click **Remove**.

e. Click **OK**.

- **ADA Code** (Services, RVU, and Patient Visits pages only) – Do one of the following:
  - If specific procedure codes are currently selected (a code and possibly a counter appear in the box), to include all procedure codes, click the **X**.



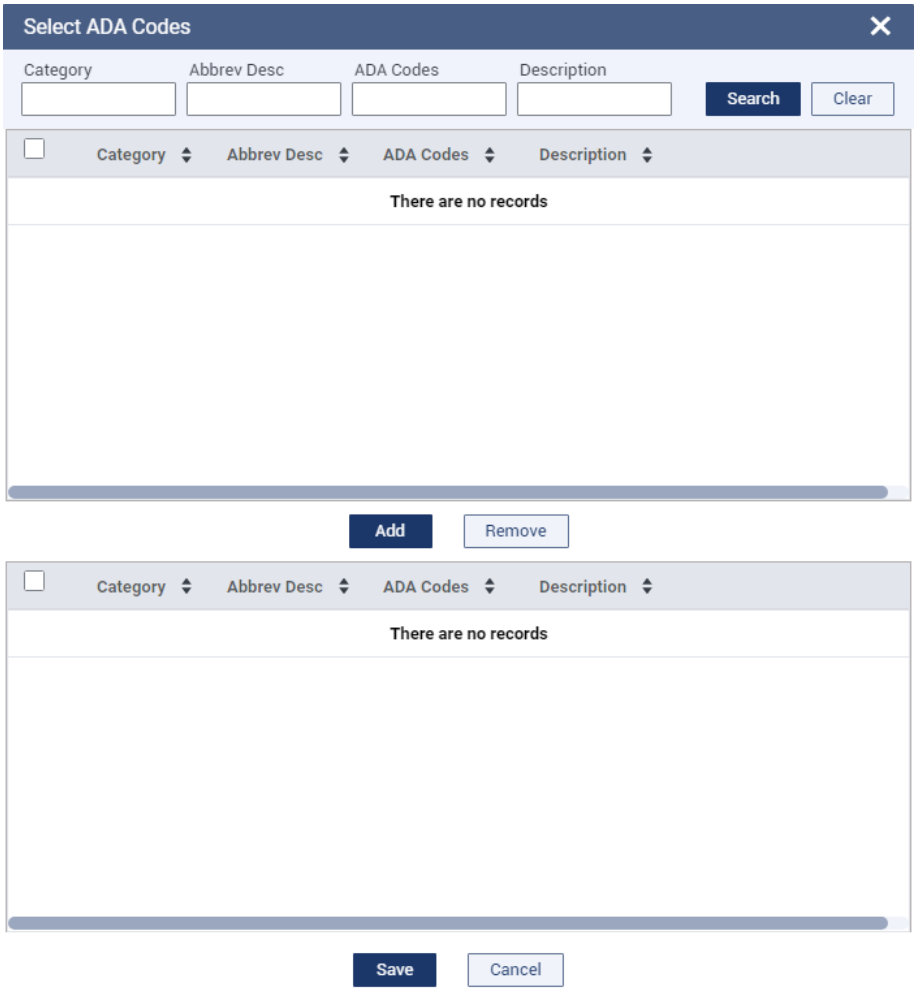
    The box then displays "All" to indicate that all procedure codes are included.
  - To quickly include or exclude procedure codes, expand the list, and then select or clear the check box of each procedure code to include or exclude.



    To specify which procedure codes to include, do the following:

    a. From the list, select **Select ADA Codes**.

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



b. To search for a procedure code, do one of the following:

- To get a list of all procedure codes, leave the **Category**, **Abbrev Desc**, **ADA Code**, and/or **Description** boxes empty.
- To search for specific procedure codes, enter the first character or more of a procedure code category, abbreviated description, code, and/or description in the **Category**, **Abbrev Desc**, **ADA Code**, and/or **Description** boxes.

c. Click **Search**.

All or the matching procedure codes appear in the upper list.

Note: To clear the search criteria so you can search again, click **Clear**.

d. In the upper list, select the check box of each procedure code to include, or select the check box at the top of the list to select all the check boxes.

e. Click **Add**.

Note: To remove a procedure code that you have added, select its check box in the lower list, and then click **Remove**.

f. Click **OK**.

- **List ADA Codes for Broken Appointments** (Patient Visits page only) – In the box, enter the codes (separated by semicolons) that you use to record broken appointments. By default, `D9986;D9987` is entered.

- **Include Broken Appt to Patient Visits** (Patient Visits page only) – Select or clear this check box:
  - With this check box selected, broken appointments are included in the calculations.
  - With this check box clear, broken appointments are not included in the calculations.
- **Include Patient Detail** (Services, RVU, and Patient Visits pages only) – Select or clear this check box:
  - With this check box selected, patient details (name, chart number) appear when you view the details for a summary tile.
  - With this check box clear, patient details do not appear when you view the details for a summary tiles.

Note: To reset all filters for the current page to the default values, click **Reset Filters**.

3. To save the current filter values for the next time you access the dashboard, click **Save As Default**.
4. Click **Apply Filters**.

Viewing Dynamic Reporting

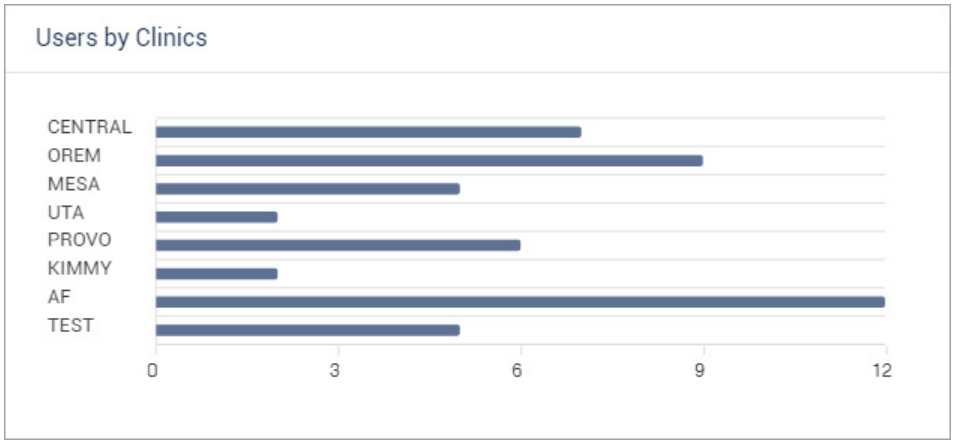
You can view the information on each page of the dashboard. Each time you open Dynamic Reporting, the first time that you view a page, you must click **Apply Filters** to load the information.

Resources

- **Total Users** – This totals strip displays the number of active primary and secondary providers and, if applicable, active staff members.

  Total Users **48**

  The *Number of Users* is the sum of the following:
  - The *Number of Primary Providers* is the number of active primary providers, of the specified providers in the specified clinics (in the Clinic Resource Setup), whose specialty is any of the specified primary specialties.
  - The *Number of Secondary Providers* is the number of active secondary providers, of the specified providers in the specified clinics (in the Clinic Resource Setup), whose specialty is any of the specified secondary specialties.
  - The *Number of Staff Members* (if applicable) is the number of active staff members in the specified clinics (in the Clinic Resource Setup).
- **Users by Clinics** – This summary tile displays the number of active users in each clinic.

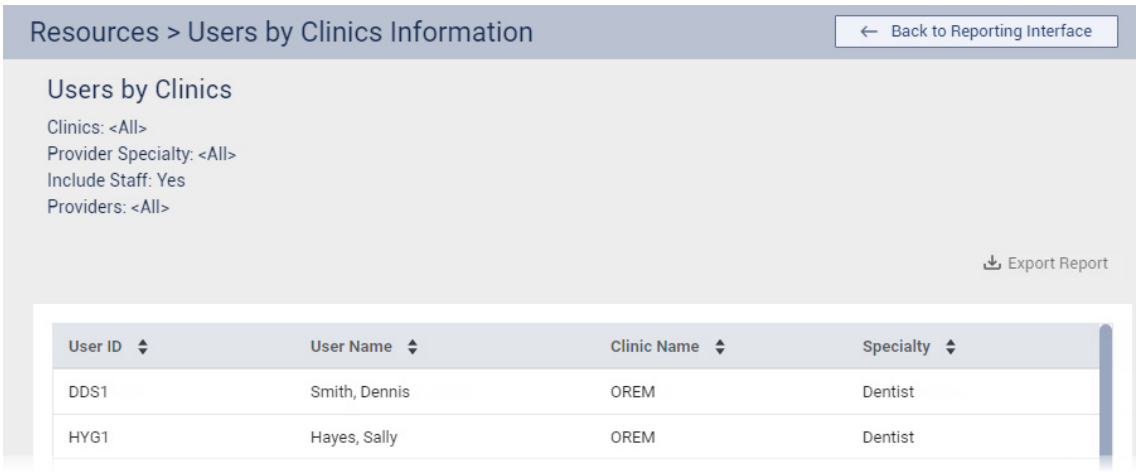


The *Number of Clinic Users* is the sum of the following for a clinic that is one of the specified clinics:

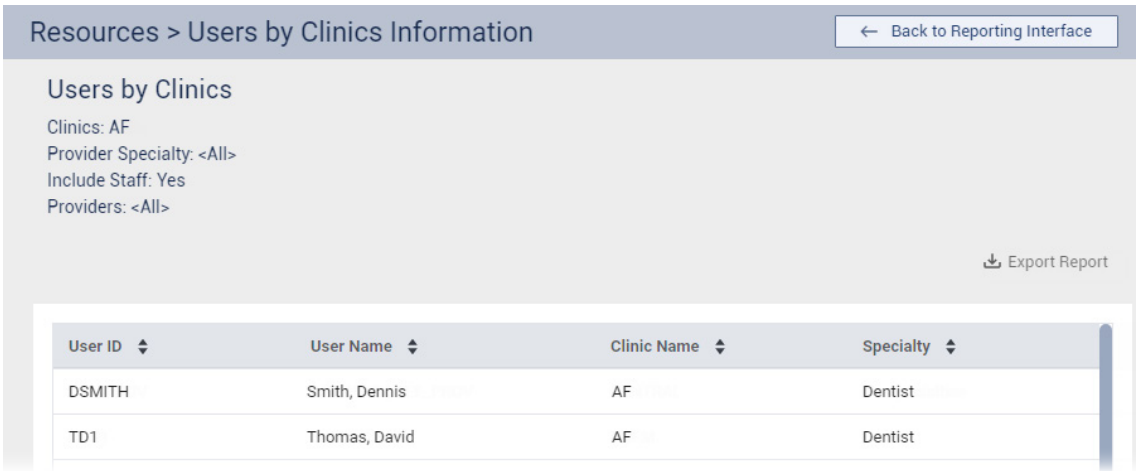
- The *Number of Primary Providers* is the number of active primary providers, of the specified providers in the clinic (in the Clinic Resource Setup), whose specialty is any of the specified primary specialties.
- The *Number of Secondary Providers* is the number of active secondary providers, of the specified providers in the clinic (in the Clinic Resource Setup), whose specialty is any of the specified secondary specialties.
- The *Number of Staff Members* (if applicable) is the number of active staff members in the clinic (in the Clinic Resource Setup).

Do any of the following:

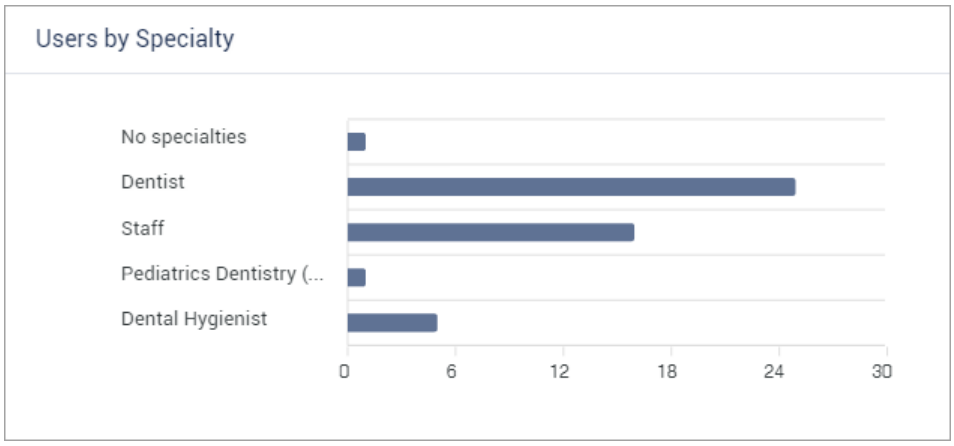
- Click the name of the summary tile to open the **Users by Clinics Information** page and view details of each user who is included in the calculation for the specified clinics. To return to the **Resources** page, click **Back to Reporting Interface**.



- Click a clinic on the summary tile to open the **Users by Clinics Information** page and view details of each user who is included in the calculation for that clinic. To return to the **Resources** page, click **Back to Reporting Interface**.



- **Users by Specialty** – This summary tile displays the number of active users for each specialty.

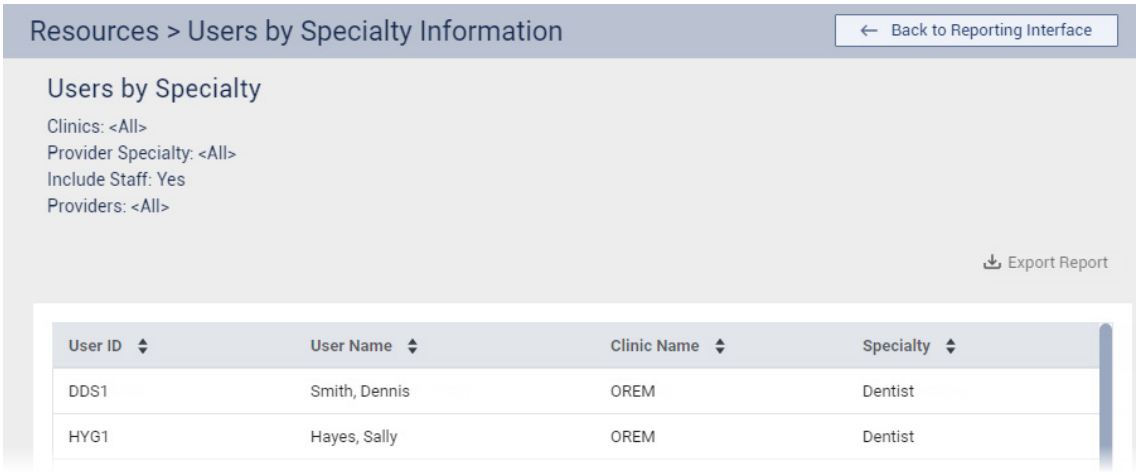


The *Number of Specialty Users* is the sum of the following for a specialty that is one of the specified specialties that are assigned to providers:

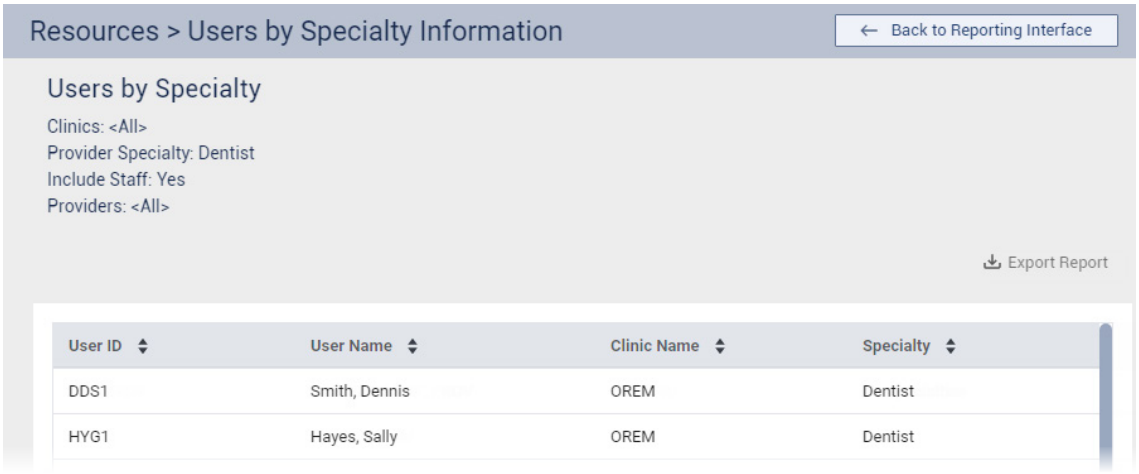
- The *Number of Primary Providers* is the number of active primary providers, of the specified providers in the specified clinics (in the Clinic Resource Setup) who is assigned the specialty.
- The *Number of Secondary Providers* is the number of active secondary providers, of the specified providers in the specified clinics (in the Clinic Resource Setup) who is assigned the specialty.

Do any of the following:

- Click the name of the summary tile to open the **Users by Specialty Information** page and view details of each user who is included in the calculation for the specified specialties. To return to the **Resources** page, click **Back to Reporting Interface**.



- Click a specialty on the summary tile to open the **Users by Specialty Information** page and view details of each user who is included in the calculation for that specialty. To return to the **Resources** page, click **Back to Reporting Interface**.



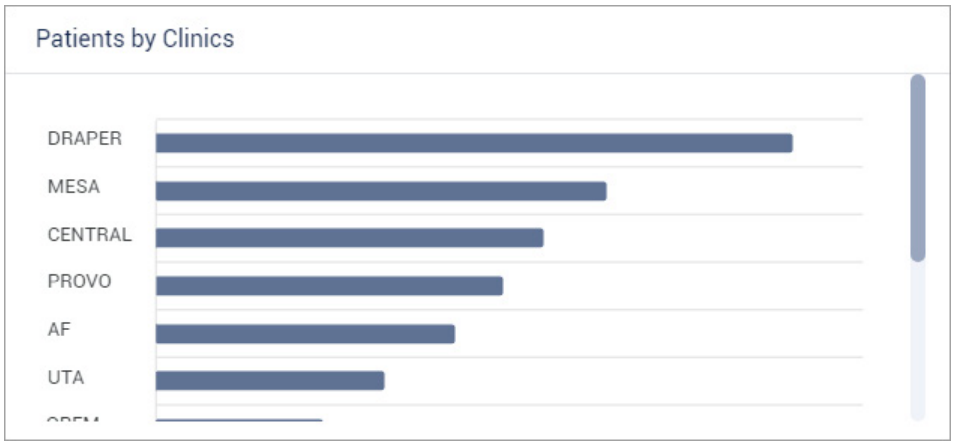
- **Total Patients** – This totals strip displays the number of patients.



The *Number of Patients* is the number of patients who meet the following criteria:

- The preferred clinic (in Family File) is any of the specified clinics.
- The status is any of the specified statuses.
- The preferred primary provider (**Prov1** in Family File), preferred secondary provider (**Prov2** in Family File), or initial provider (**Initial Provider** in Family File) is any of the specified providers whose specialty is any of the specified specialties.

- **Patients by Clinics** – This summary tile displays the number of patients in each clinic.

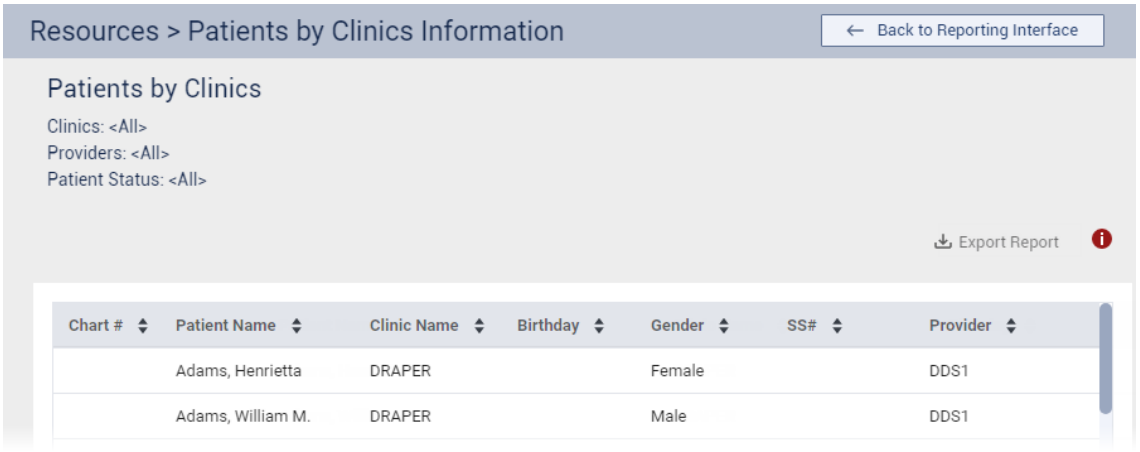


The *Number of Clinic Patients* is the number of patients who meet the following criteria for a clinic that is one of the specified clinics:

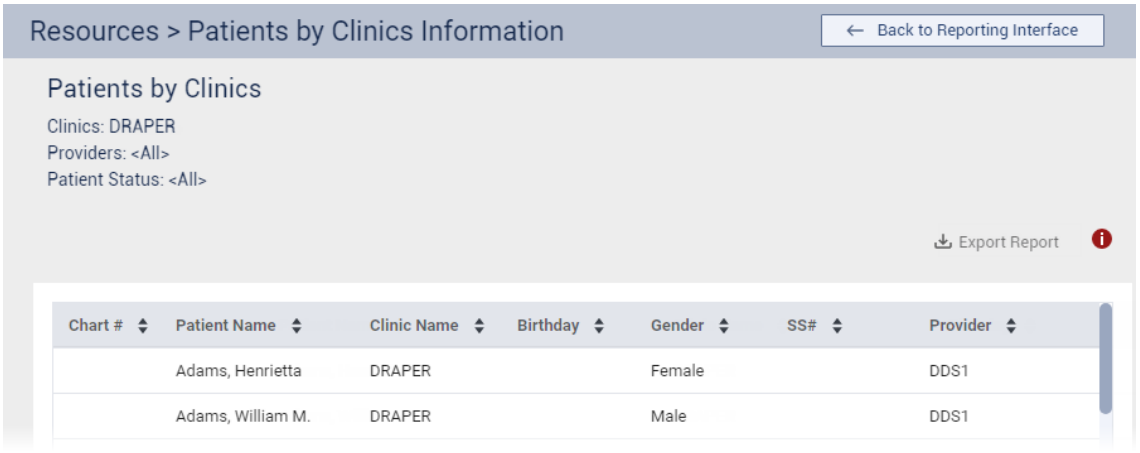
- The preferred clinic (in Family File) is that clinic.
- The status is any of the specified statuses.
- The preferred primary provider (**Prov1** in Family File), preferred secondary provider (**Prov2** in Family File), or initial provider (**Initial Provider** in Family File) is any of the specified providers whose specialty is any of the specified specialties.

Do any of the following:

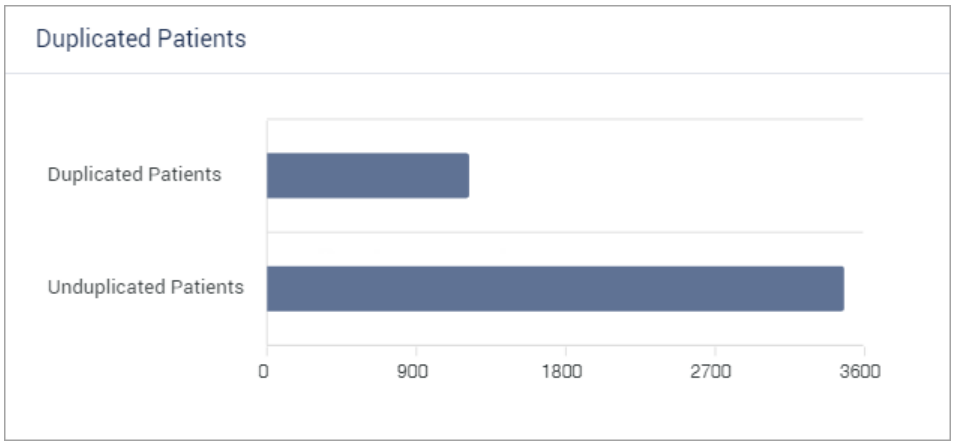
- Click the name of the summary tile to open the **Patients by Clinics Information** page and view details of each patient who is included in the calculation for the specified clinics. To return to the **Resources** page, click **Back to Reporting Interface**.



- Click a clinic on the summary tile to open the **Patients by Clinics Information** page and view details of each patient who is included in the calculation for that clinic. To return to the **Resources** page, click **Back to Reporting Interface**.



- **Duplicated Patients** – This summary tile displays the number of duplicate patients and the number of unique patients.



The *Number of Duplicate Patients* is the number of patients who meet the following criteria:

- Three or more of the following demographics are the same as another patient: first name, last name, Social Security Number, and birth date.
- The preferred clinic (in Family File) is any of the specified clinics.
- The status is any of the specified statuses.
- The preferred primary provider (**Prov1** in Family File), preferred secondary provider (**Prov2** in Family File), or initial provider (**Initial Provider** in Family File) is any of the specified providers whose specialty is any of the specified specialties.

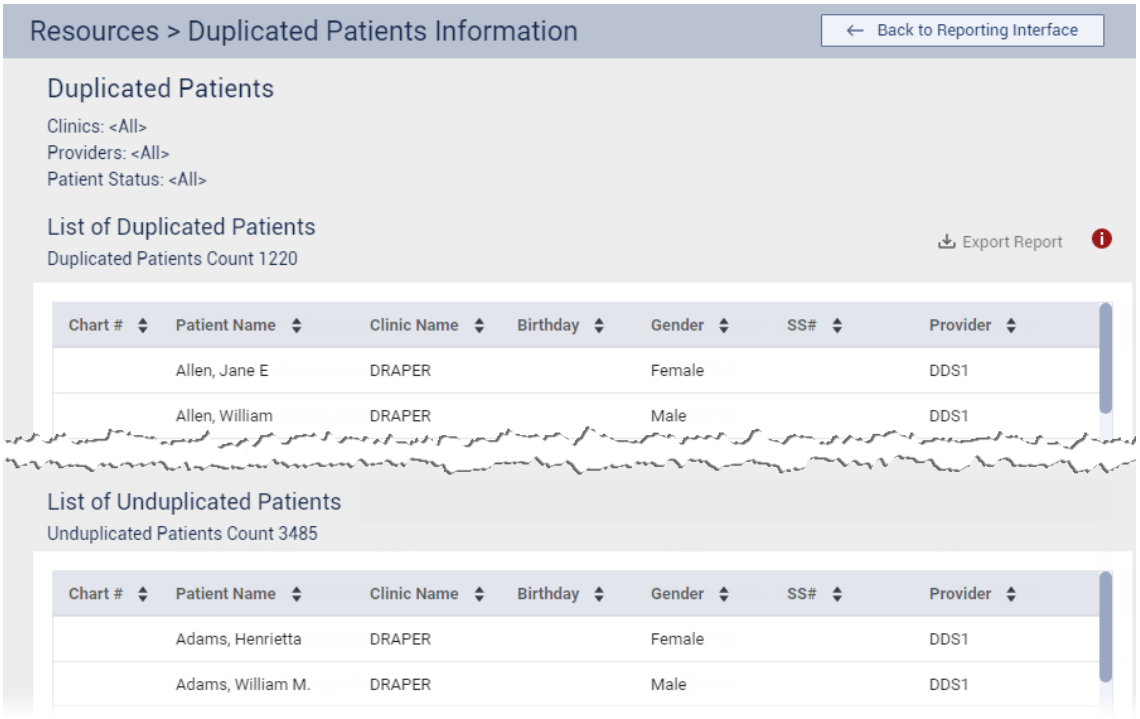
The *Number of Unique Patients* is the number of patients who meet the following criteria:

- Fewer than three of the following demographics are the same as another patient: first name, last name, Social Security Number, and birth date.
- The preferred clinic (in Family File) is any of the specified clinics.
- The status is any of the specified statuses.
- The preferred primary provider (**Prov1** in Family File), preferred secondary provider (**Prov2** in Family File), or initial provider (**Initial Provider** in Family File) is any of the specified providers whose specialty is any of the specified specialties.

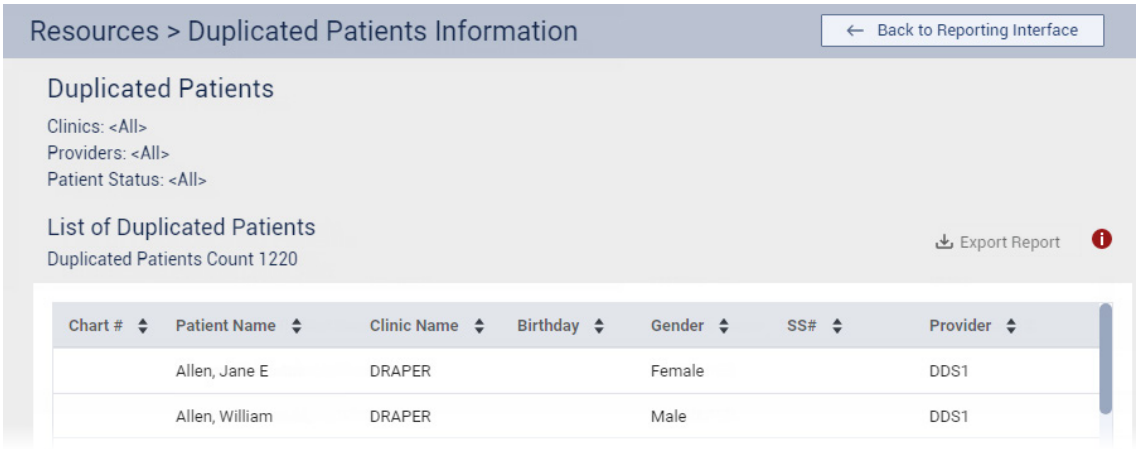
Note: A patient is included even if an inactive provider is assigned to the patient.

Do any of the following:

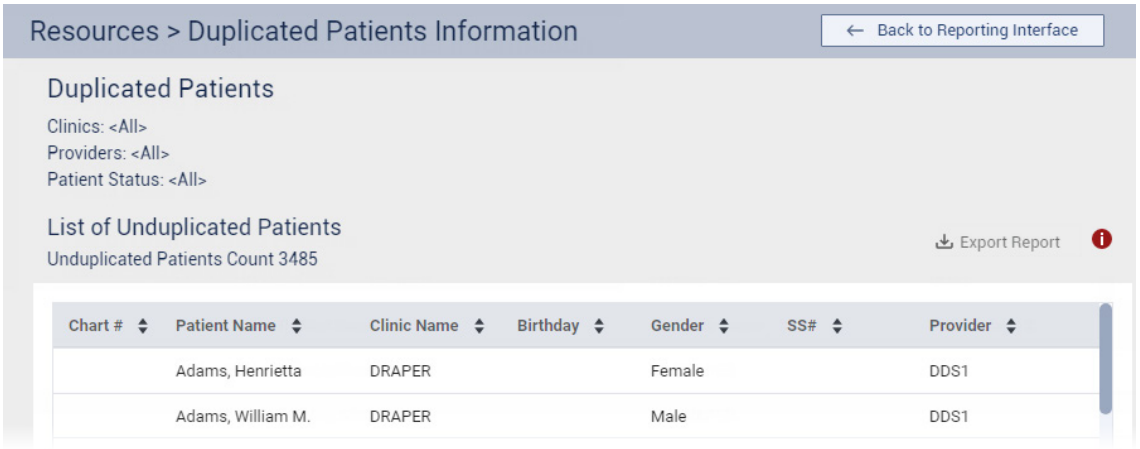
- Click the name of the summary tile to open the **Duplicated Patients Information** page and view details of each duplicate patient in the **List of Duplicated Patients** and of each unique patient in the **List of Unduplicated Patients**. To return to the **Resources** page, click **Back to Reporting Interface**.



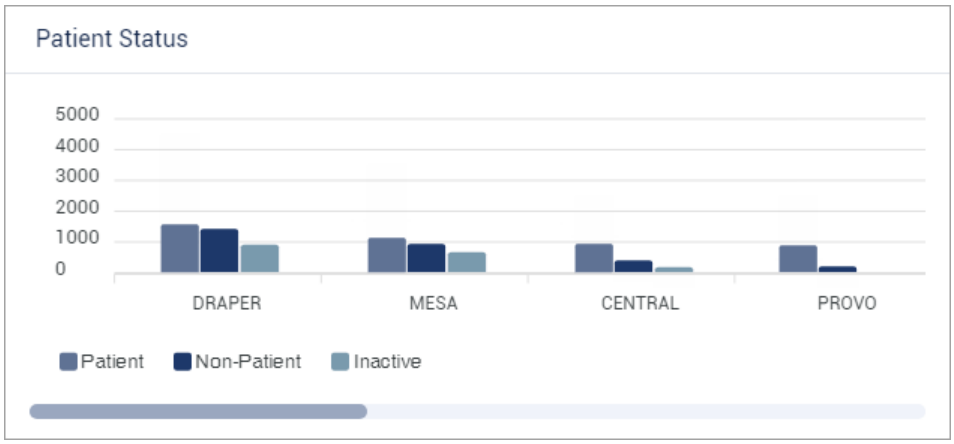
- Click **Duplicated Patients** on the summary tile to open the **Duplicated Patients Information** page and view details of each duplicate patient in the **List of Duplicated Patients**. To return to the **Resources** page, click **Back to Reporting Interface**.



- Click **Unduplicated Patients** on the summary tile to open the **Duplicated Patients Information** page and view details of each unique patient in the **List of Unduplicated Patients**. To return to the **Resources** page, click **Back to Reporting Interface**.



- **Patient Status** – This summary tile displays the number of patients with each status.



The *Number of Active Patients* is the number of patients who meet the following criteria:

- The status is Patient.
- The preferred clinic (in Family File) is any of the specified clinics.

- The preferred primary provider (**Prov1** in Family File), preferred secondary provider (**Prov2** in Family File), or initial provider (**Initial Provider** in Family File) is any of the specified providers whose specialty is any of the specified specialties.

The *Number of Non-patients* is the number of patients who meet the following criteria:

- The status is Non-patient.
- The preferred clinic (in Family File) is any of the specified clinics.
- The preferred primary provider (**Prov1** in Family File), preferred secondary provider (**Prov2** in Family File), or initial provider (**Initial Provider** in Family File) is any of the specified providers whose specialty is any of the specified specialties.

The *Number of Inactive Patients* is the number of patients who meet the following criteria:

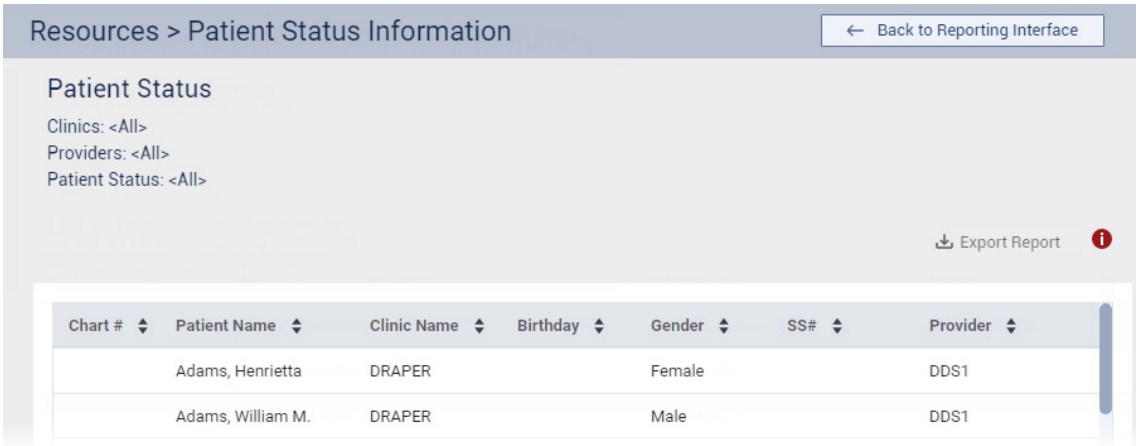
- The status is Inactive.
- The preferred clinic (in Family File) is any of the specified clinics.
- The preferred primary provider (**Prov1** in Family File), preferred secondary provider (**Prov2** in Family File), or initial provider (**Initial Provider** in Family File) is any of the specified providers whose specialty is any of the specified specialties.

The *Number of Archived Patients* is the number of patients who meet the following criteria:

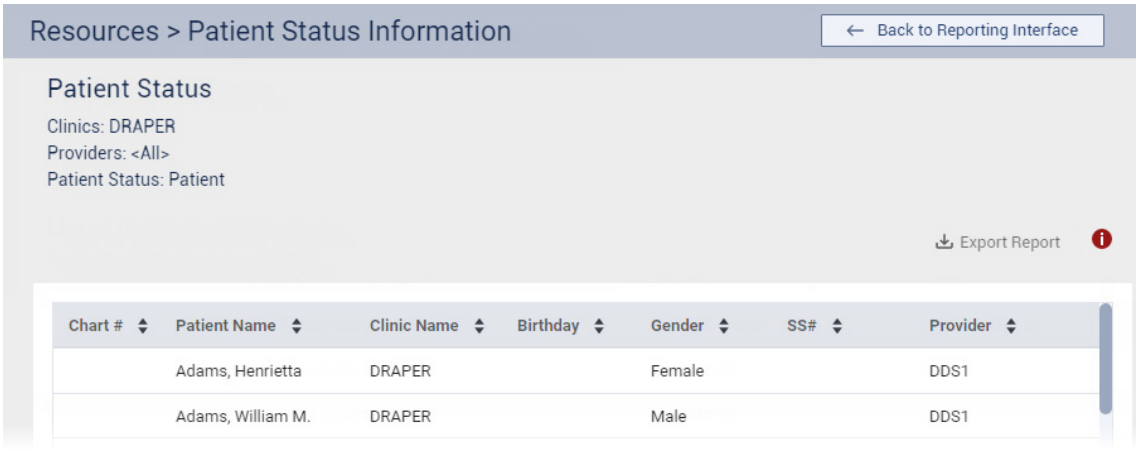
- The status is Archived.
- The preferred clinic (in Family File) is any of the specified clinics.
- The preferred primary provider (**Prov1** in Family File), preferred secondary provider (**Prov2** in Family File), or initial provider (**Initial Provider** in Family File) is any of the specified providers whose specialty is any of the specified specialties.

Do any of the following:

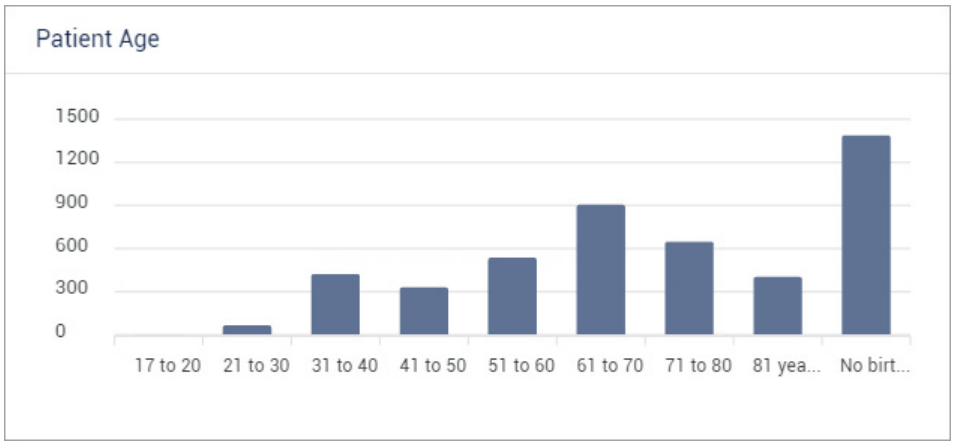
- Click the name of the summary tile to open the **Patient Status Information** page and view details of each patient who is included in the calculation for the specified statuses. To return to the **Resources** page, click **Back to Reporting Interface**.



- Click a status for a clinic on the summary tile to open the **Patient Status Information** page and view details of each patient in that clinic who is included in the calculation for that status. To return to the **Resources** page, click **Back to Reporting Interface**.



- **Patient Age** – This summary tile displays the number of patients in various age ranges.

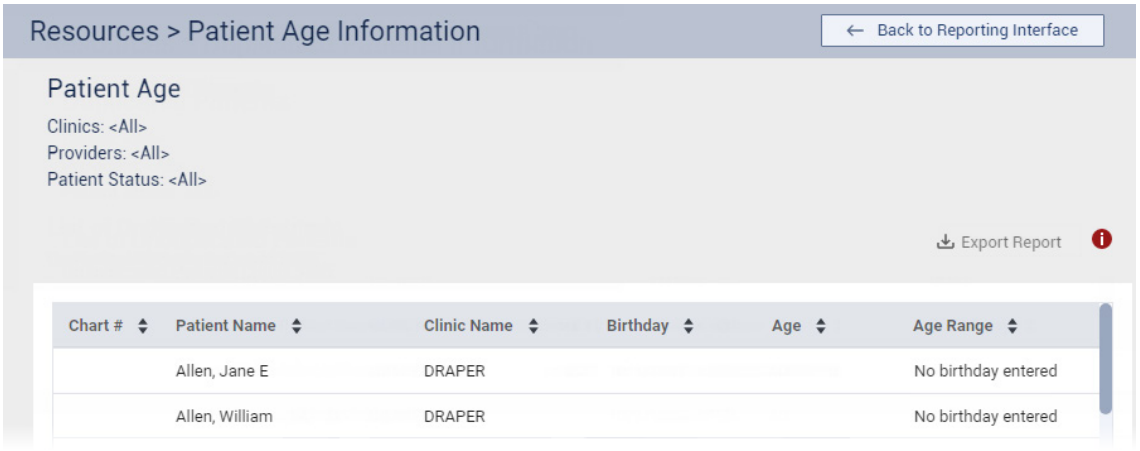


The *Number of Aged Patients* is the number of patients who meet the following criteria:

- The age is within a certain range.
- The preferred clinic (in Family File) is any of the specified clinics.
- The status is any of the specified statuses.
- The preferred primary provider (**Prov1** in Family File), preferred secondary provider (**Prov2** in Family File), or initial provider (**Initial Provider** in Family File) is any of the specified providers whose specialty is any of the specified specialties.

Do any of the following:

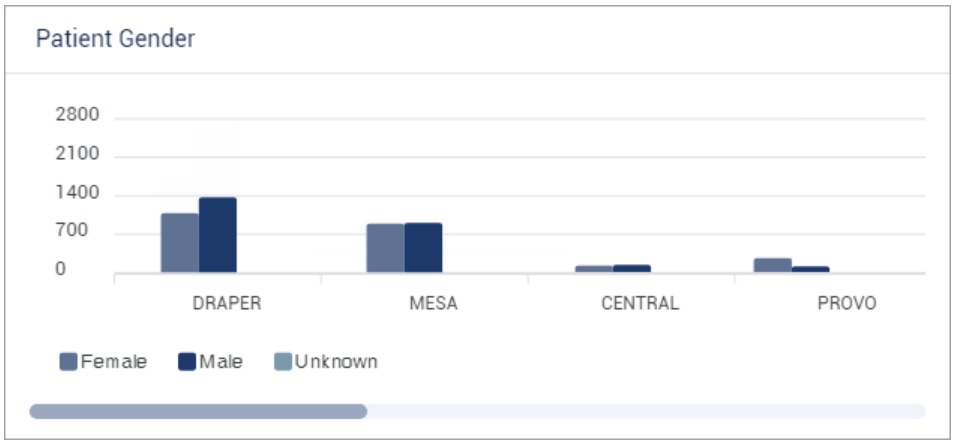
- Click the name of the summary tile to open the **Patient Age Information** page and view details of each patient who is included in the calculation for the age ranges. To return to the **Resources** page, click **Back to Reporting Interface**.



- Click an age range on the summary tile to open the **Patient Age Information** page and view details of each patient who is included in the calculation for that age range. To return to the **Resources** page, click **Back to Reporting Interface**.



- **Patient Gender** – This summary tile displays the number of patients of each gender.



The *Number of Male Patients* is the number of patients who meet the following criteria:

- The gender (**Sex** in Family File) is Male.
- The preferred clinic (in Family File) is any of the specified clinics.

- The preferred primary provider (**Prov1** in Family File), preferred secondary provider (**Prov2** in Family File), or initial provider (**Initial Provider** in Family File) is any of the specified providers whose specialty is any of the specified specialties.

The *Number of Female Patients* is the number of patients who meet the following criteria:

- The gender (**Sex** in Family File) is Female.
- The preferred clinic (in Family File) is any of the specified clinics.
- The preferred primary provider (**Prov1** in Family File), preferred secondary provider (**Prov2** in Family File), or initial provider (**Initial Provider** in Family File) is any of the specified providers whose specialty is any of the specified specialties.

The *Number of Other Patients* is the number of patients who meet the following criteria:

- The gender (**Sex** in Family File) is Other.
- The preferred clinic (in Family File) is any of the specified clinics.
- The preferred primary provider (**Prov1** in Family File), preferred secondary provider (**Prov2** in Family File), or initial provider (**Initial Provider** in Family File) is any of the specified providers whose specialty is any of the specified specialties.

The *Number of Unknown Patients* is the number of patients who meet the following criteria:

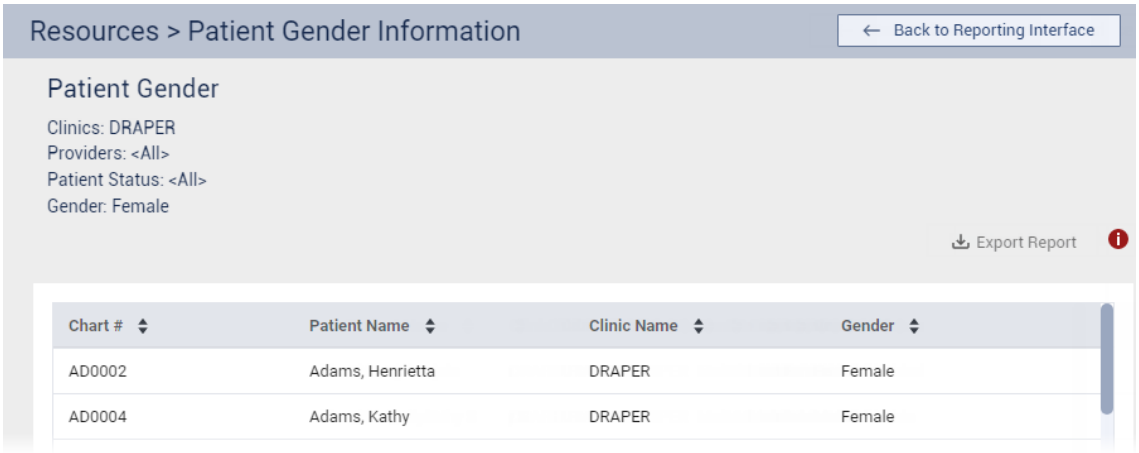
- The gender (**Sex** in Family File) is Unknown.
- The preferred clinic (in Family File) is any of the specified clinics.
- The preferred primary provider (**Prov1** in Family File), preferred secondary provider (**Prov2** in Family File), or initial provider (**Initial Provider** in Family File) is any of the specified providers whose specialty is any of the specified specialties.

Do any of the following:

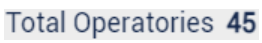
- Click the name of the summary tile to open the **Patient Gender Information** page and view details of each patient who is included in the calculation for the specified genders. To return to the **Resources** page, click **Back to Reporting Interface**.



- Click a gender for a clinic on the summary tile to open the **Patient Gender Information** page and view details of each patient in that clinic who is included in the calculation for that gender. To return to the **Resources** page, click **Back to Reporting Interface**.

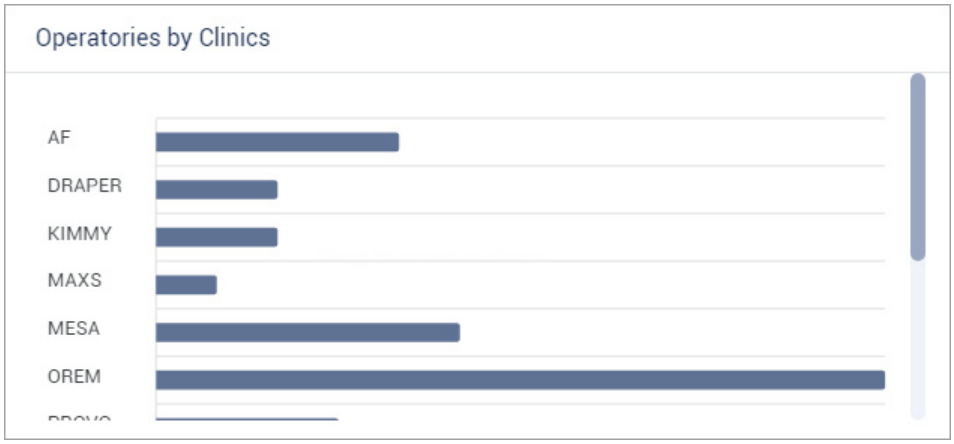


- **Total Operatories** – This totals strip displays the number of operatories.



The *Number of Operatories* is the number of operatories in the specified clinics (in the Clinic Resource Setup).

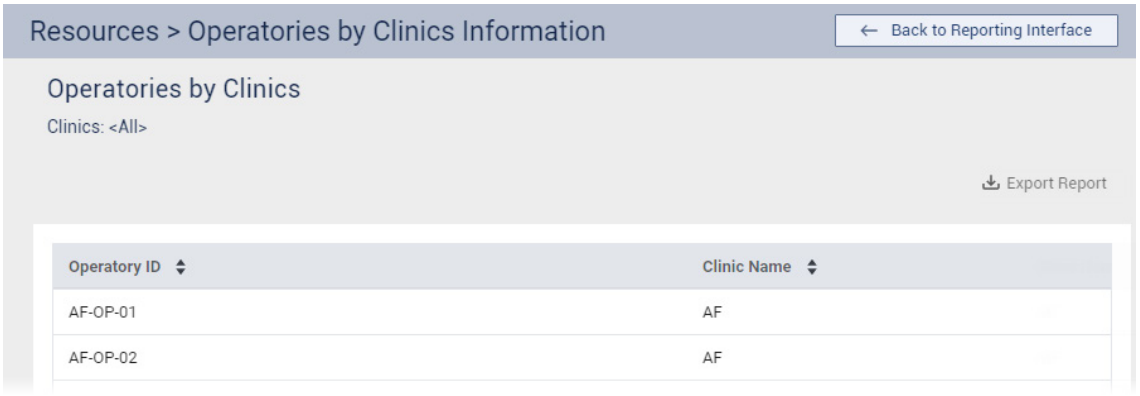
- **Operatories by Clinics** – This summary tile displays the number of operatories in each clinic.



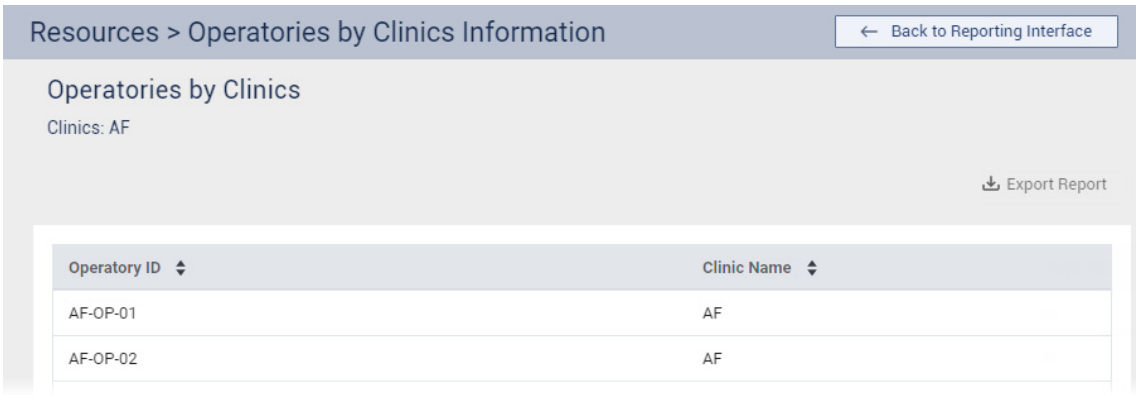
The *Number of Clinic Operatories* is the number of operatories in a clinic that is one of the specified clinics.

Do any of the following:

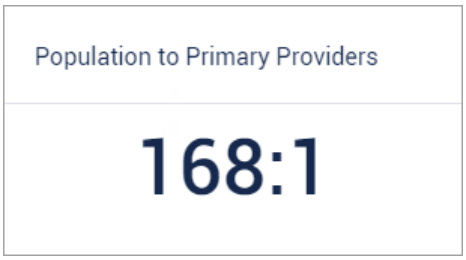
- Click the name of the summary tile to open the **Operatories by Clinics Information** page and view details of each operatory that is included in the calculation for the specified clinics. To return to the **Resources** page, click **Back to Reporting Interface**.



- Click a clinic on the summary tile to open the **Operatories by Clinics Information** page and view details of each operatory that is included in the calculation for that clinic. To return to the **Resources** page, click **Back to Reporting Interface**.

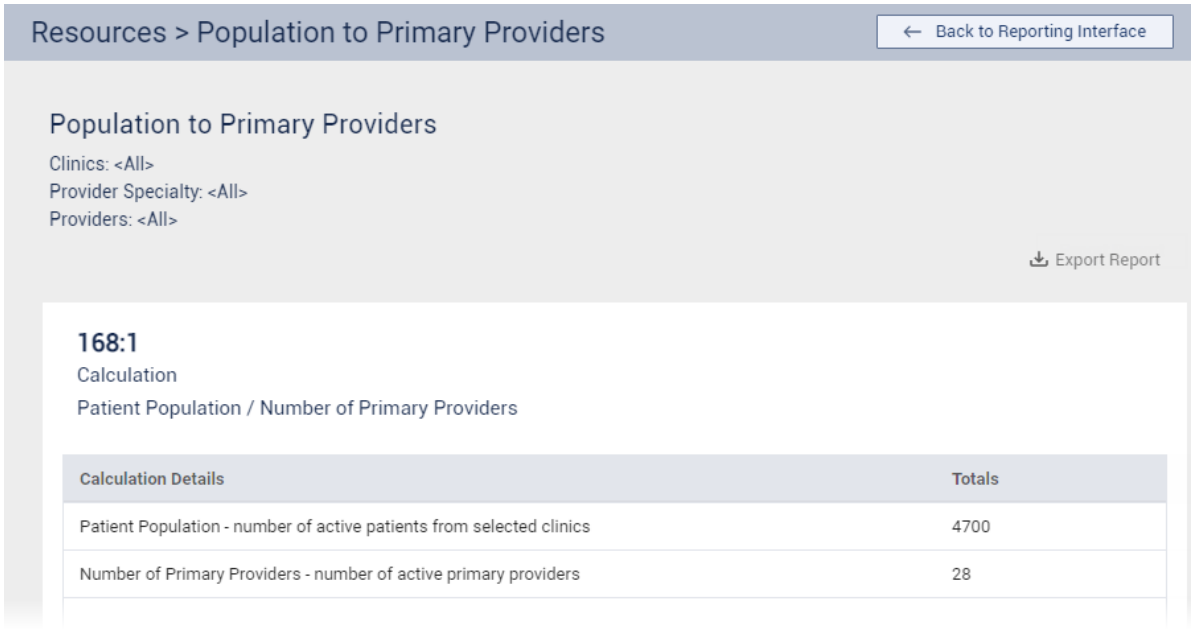


- **Population to Primary Providers** – This ratio tile displays the ratio of patients to primary providers.



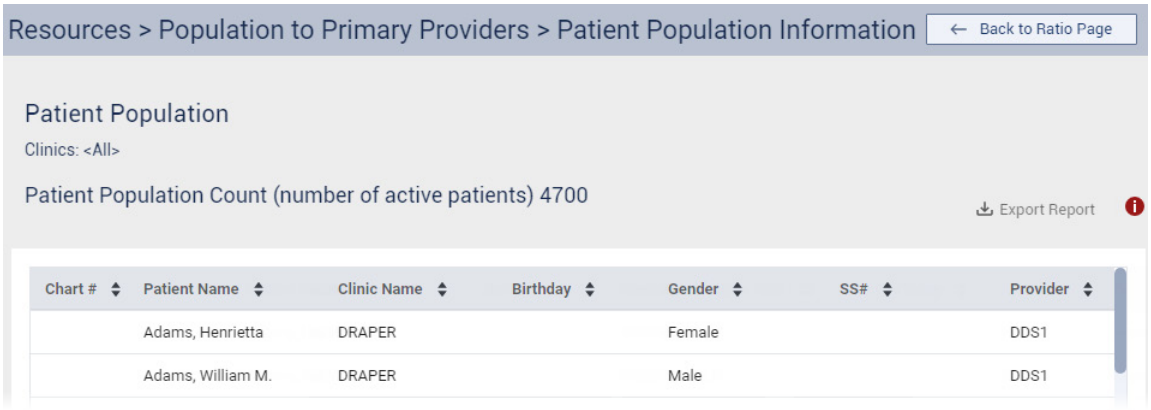
  - The *Number of Patients* is the number of active patients whose preferred clinic (in Family File) is any of the specified clinics.
  - The *Number of Primary Providers* is the number of active primary providers, of the specified providers in the specified clinics (in the Clinic Resource Setup), whose specialty is any of the specified primary specialties.
  - The first value for the ratio is the *Number of Patients* divided by the *Number of Primary Providers*. The second value of the ratio is always 1.

Click the name of the ratio tile to open the **Population to Primary Providers** page and view totals for the **Patient Population** and **Number of Primary Providers**.

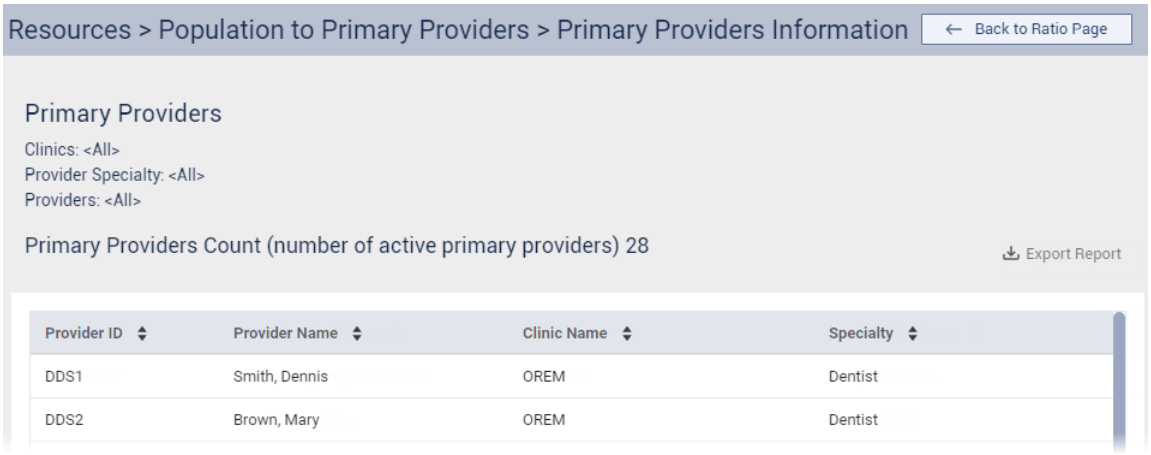


On the **Population to Primary Providers** page, do any of the following:

- To open the **Patient Population Information** page and view details of each patient who is included in the calculation, click **Patient Population** in the **Calculation Details** list. To return to the **Population to Primary Providers** page, click **Back to Ratio Page**.

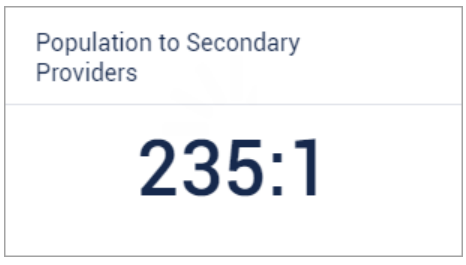


- To open the **Primary Providers Information** page and view details of each provider who is included in the calculation, click **Number of Primary Providers** in the **Calculation Details** list. To return to the **Population to Primary Providers** page, click **Back to Ratio Page**.



- To return to the **Resources** page, click **Back to Reporting Interface**.

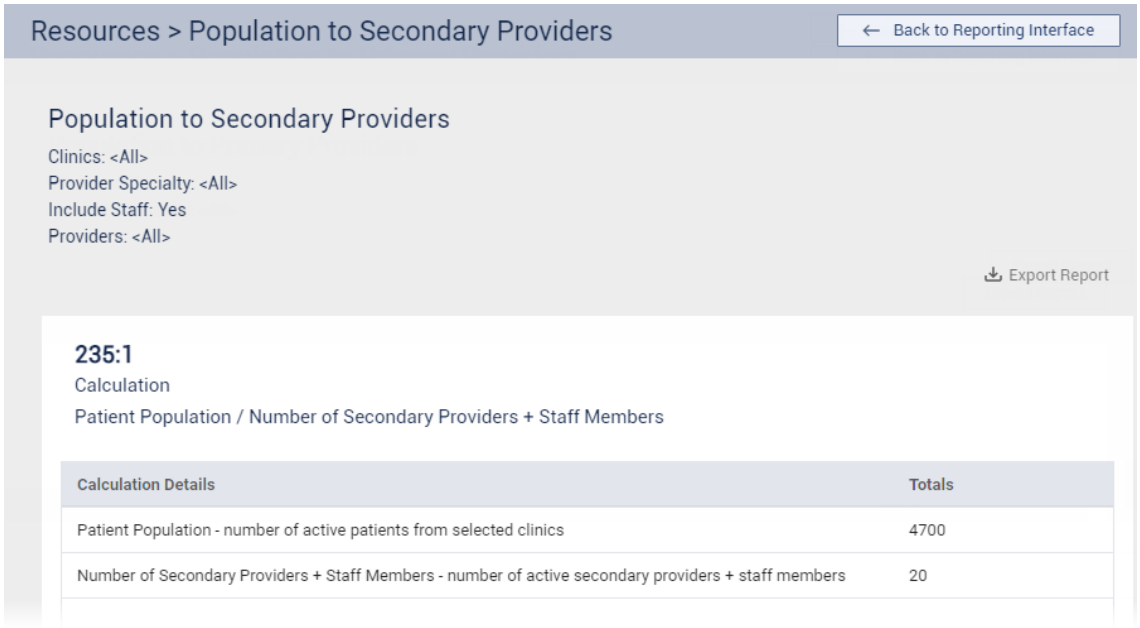
- **Population to Secondary Providers** – This ratio tile displays the ratio of patients to secondary providers and, if applicable, staff members.



- The *Number of Patients* is the number of active patients whose preferred clinic (in Family File) is any of the specified clinics.
- The *Number of Secondary Providers* is the number of active secondary providers, of the specified providers in the specified clinics (in the Clinic Resource Setup), whose specialty is any of the specified secondary specialties. And if applicable, the count includes the number of active staff members in the specified clinics (in the Clinic Resource Setup).

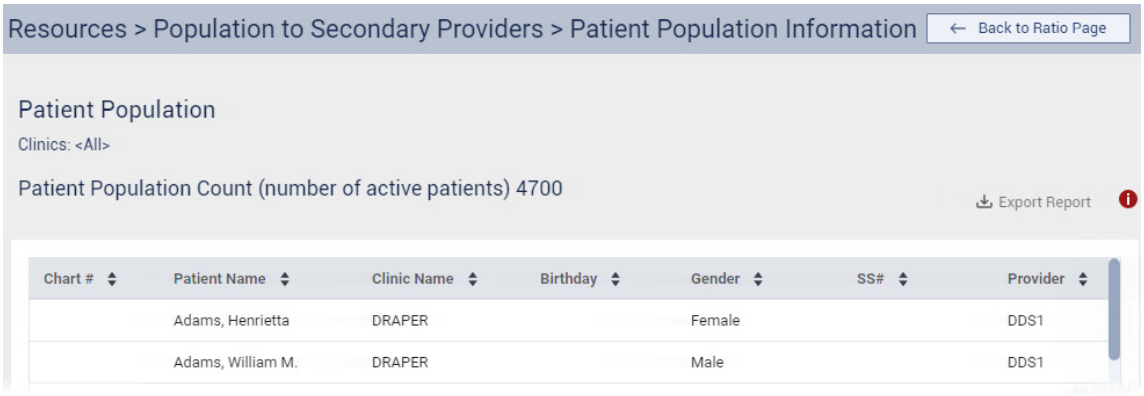
- The first value for the ratio is the *Number of Patients* divided by the *Number of Secondary Providers*. The second value of the ratio is always 1.

Click the name of the ratio tile to open the **Population to Secondary Providers** page and view totals for the **Patient Population** and **Number of Secondary Providers + Staff Members**.

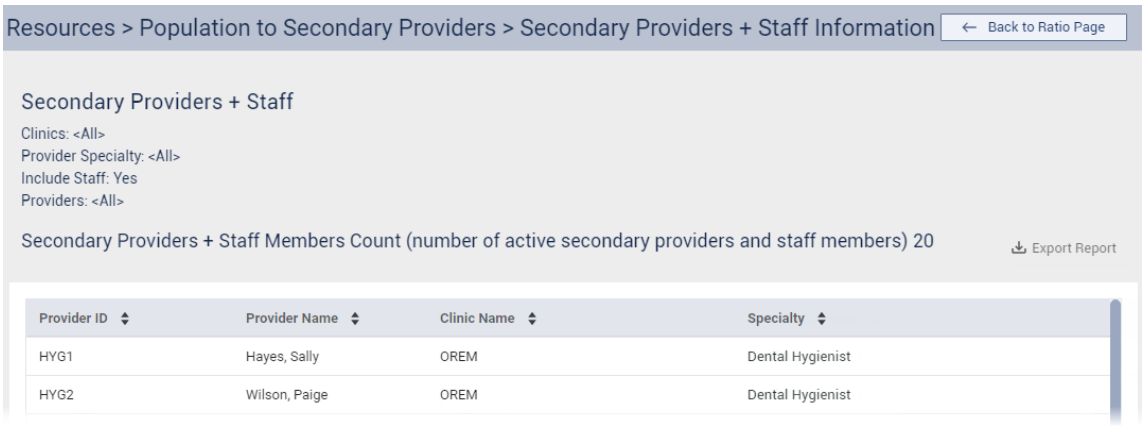


On the **Population to Secondary Providers** page, do any of the following:

- To open the **Patient Population Information** page and view details of each patient who is included in the calculation, click **Patient Population** in the **Calculation Details** list. To return to the **Population to Secondary Providers** page, click **Back to Ratio Page**.



- To open the **Secondary Providers + Staff Members Population Information** page and view details of each provider and staff member (if applicable) who is included in the calculation, click **Number of Secondary Providers + Staff Members** in the **Calculation Details** list. To return to the **Population to Secondary Providers** page, click **Back to Ratio Page**.



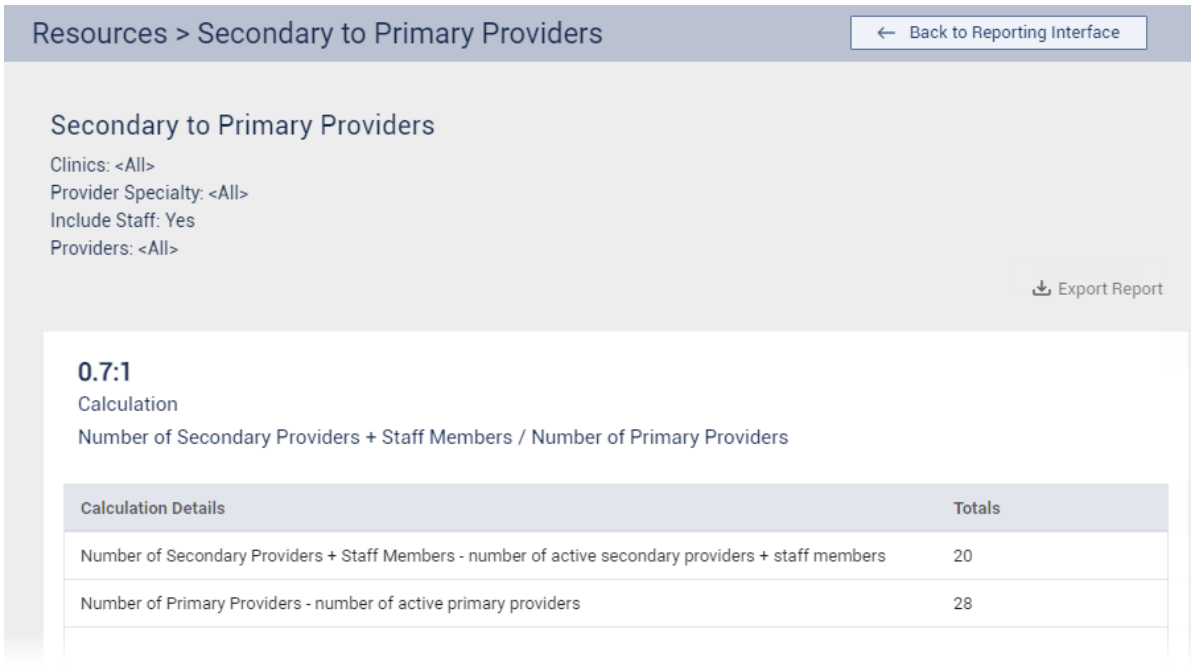
- To return to the **Resources** page, click **Back to Reporting Interface**.

- **Secondary to Primary Providers** – This ratio tile displays the ratio of secondary providers and, if applicable, staff members to the number of primary providers.



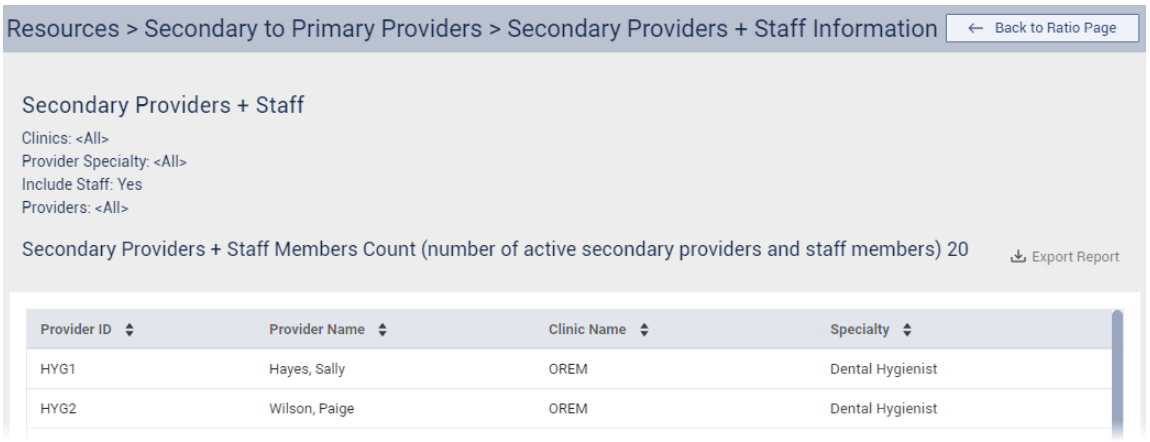
  - The *Number of Secondary Providers* is the number of active secondary providers, of the specified providers in the specified clinics (in the Clinic Resource Setup), whose specialty is any of the specified secondary specialties. And if applicable, the count includes the number of active staff members in the specified clinics (in the Clinic Resource Setup).
  - The *Number of Primary Providers* is the number of active primary providers, of the specified providers in the specified clinics (in the Clinic Resource Setup), whose specialty is any of the specified primary specialties.
  - The first value for the ratio is the *Number of Secondary Providers* divided by the *Number of Primary Providers*. The second value of the ratio is always 1.

Click the name of the ratio tile to open the **Secondary to Primary Providers** page and view totals for the **Number of Secondary Providers + Staff Members** and **Number of Primary Providers**.

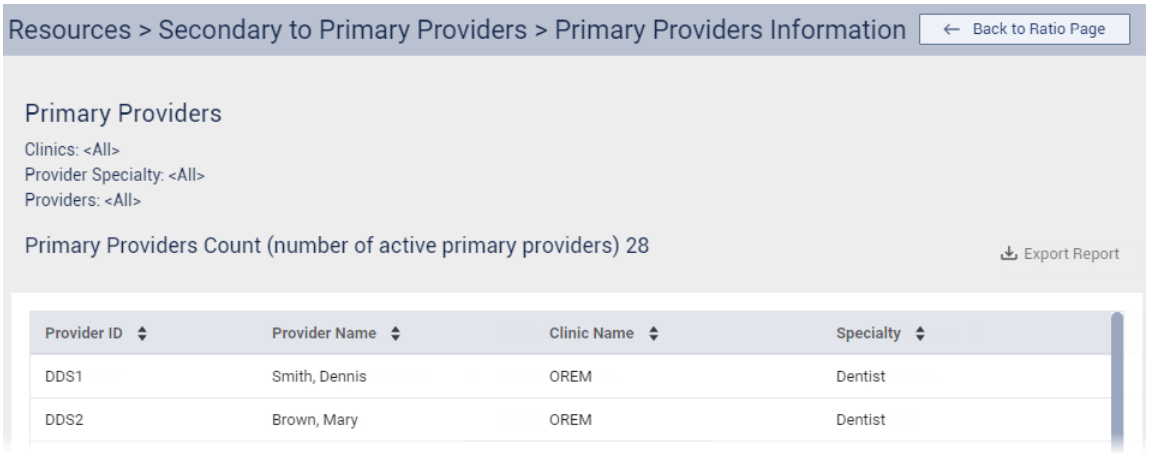


On the **Secondary to Primary Providers** page, do any of the following:

- To open the **Secondary Providers + Staff Member Information** page and view details of each secondary provider and staff member (if applicable) who is included in the calculation, click **Number of Secondary Providers + Staff Members** in the **Calculation Details** list. To return to the **Secondary to Primary Providers** page, click **Back to Ratio Page**.



- To open the **Primary Providers Information** page and view details of each primary provider who is included in the calculation, click **Number of Primary Providers** in the **Calculation Details** list. To return to the **Secondary to Primary Providers** page, click **Back to Ratio Page**.



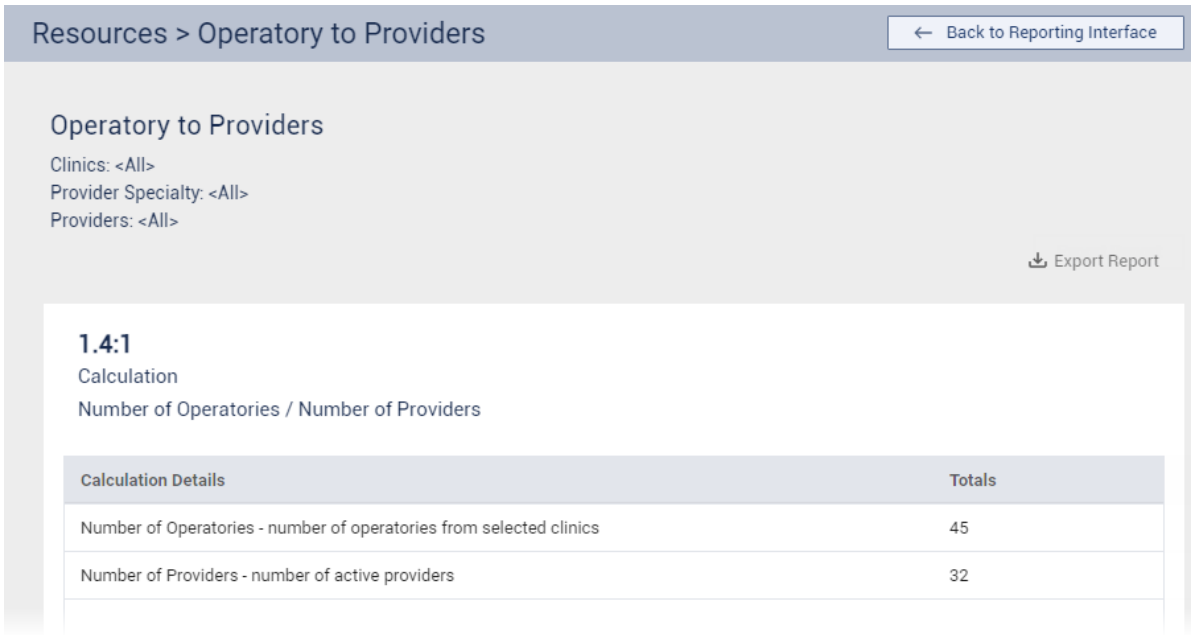
- To return to the **Resources** page, click **Back to Reporting Interface**.

- **Operatory to Providers** – This ratio tile displays the ratio of operatories to providers.



  - The *Number of Operatories* is the number of operatories in the specified clinics (in the Clinic Resource Setup).
  - The *Number of Primary Providers* is the number of active primary providers, of the specified providers in the specified clinics (in the Clinic Resource Setup), whose specialty is any of the specified primary specialties.
  - The first value for the ratio is the *Number of Operatories* divided by the *Number of Primary Providers*. The second value of the ratio is always 1.

Click the name of the ratio tile to open the **Operatory to Providers** page and view totals for the **Number of Operatories** and **Number of Providers**.



On the **Operatory to Providers** page, do any of the following:

- To open the **Operatories Information** page and view details of each operatory that is included in the calculation, click **Number of Operatories** in the **Calculation Details** list. To return to the **Operatory to Providers** page, click **Back to Ratio Page**.



- To open the **Providers Information** page and view details of each provider who is included in the calculation, click **Number of Primary Providers** in the **Calculation Details** list. To return to the **Operatory to Providers** page, click **Back to Ratio Page**.



- To return to the **Resources** page, click **Back to Reporting Interface**.

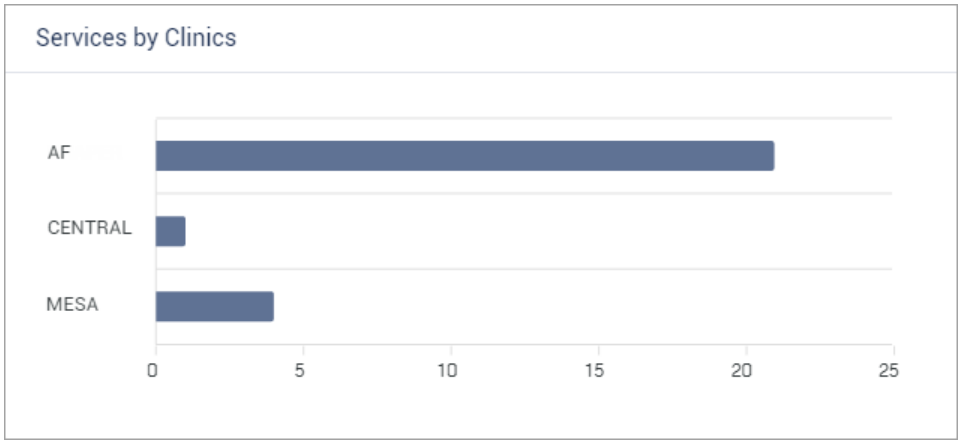
Services

- **Total Services** – This totals strip displays the production amount from completed procedures.

  The *Production Amount* is the sum of the charges for each completed procedure that meets the following criteria:

  - The procedure code is any of the specified codes.
  - The procedure code's category is any of the specified categories.
  - The date is within the specified time period.
  - The clinic is any of the specified clinics.
  - The provider is any of the specified providers whose specialty is any of the specified specialties.
  - The billing type of the associated patient is any of the specified billing types.
- **Services by Clinics** – This summary tile displays the production amount from completed procedures in each clinic.



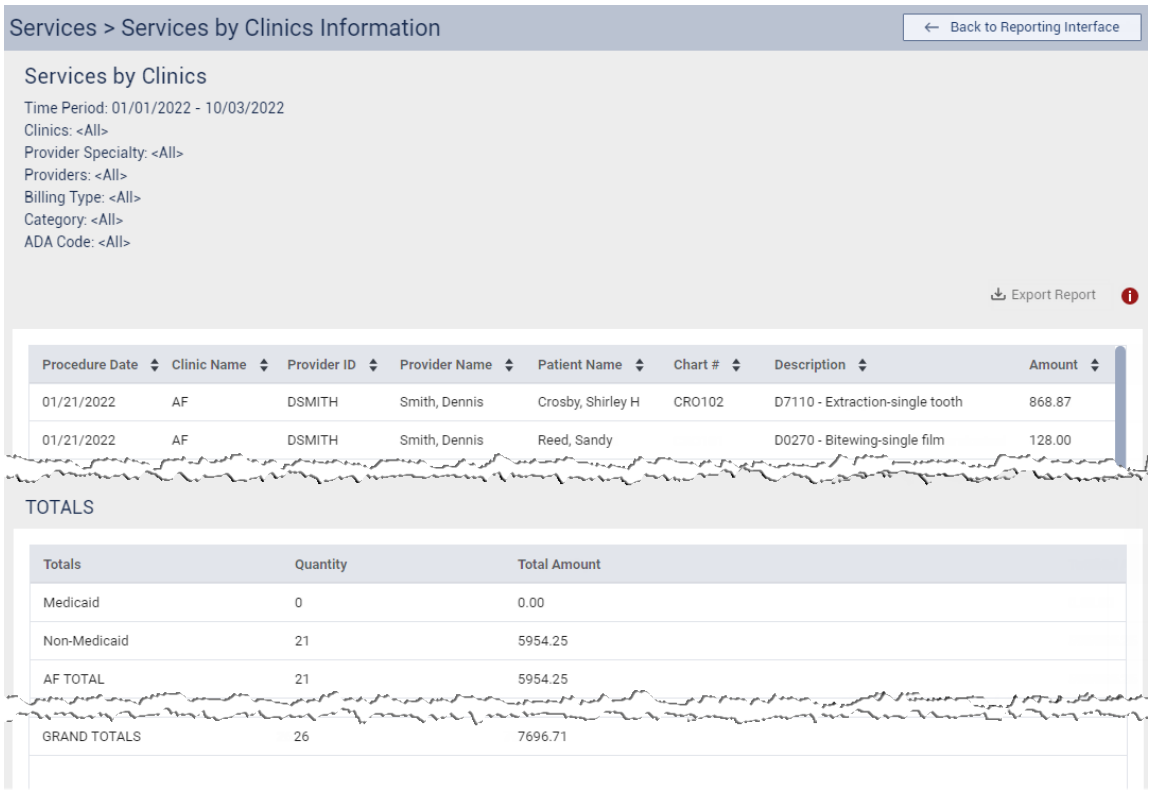
The *Clinic Production Amount* is the sum of the charges for each completed procedure in a clinic that is one of the specified clinics. A completed procedure must also meet the following criteria:

- The procedure code is any of the specified codes.
- The procedure code's category is any of the specified categories.
- The date is within the specified time period.
- The provider is an active provider and is any of the specified providers whose specialty is any of the specified specialties.
- The billing type of the associated patient is any of the specified billing types.

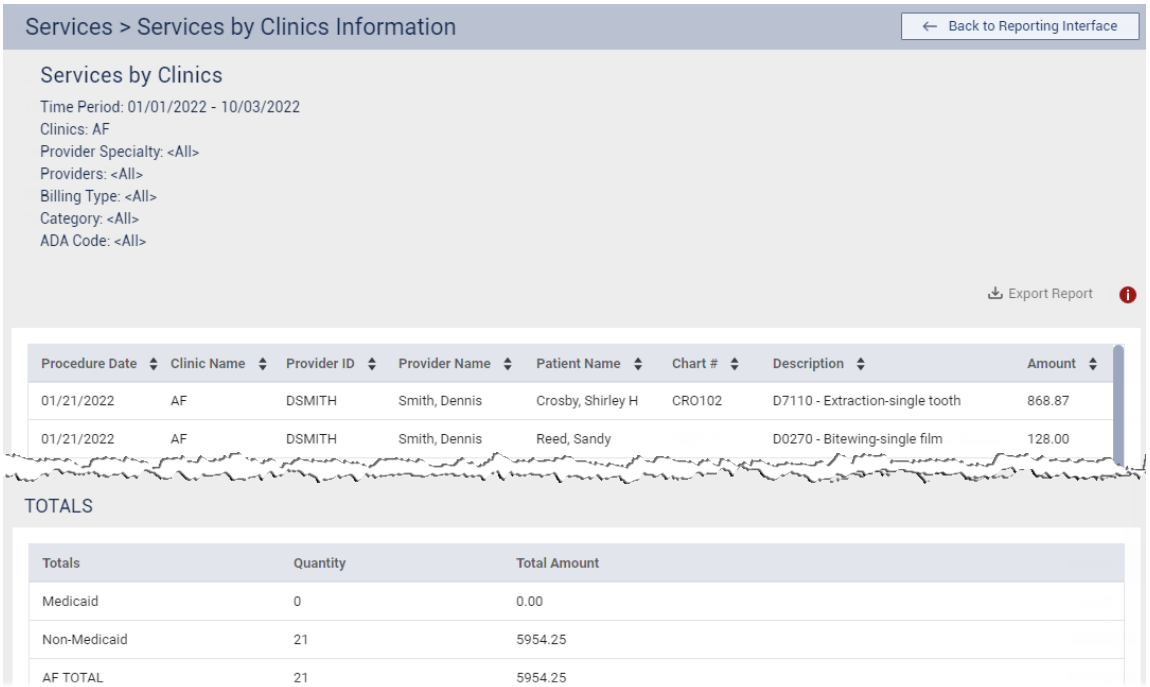
Note: Compare to the Production Summary Report.

Do any of the following:

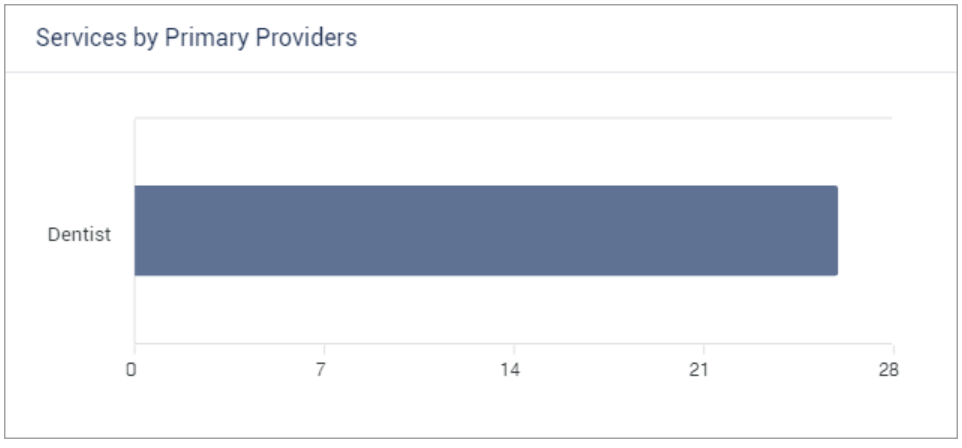
- Click the name of the summary tile to open the **Services by Clinics Information** page and view details of each procedure that is included in the calculation for the specified clinics. The **Services by Clinics Information** page also displays production totals for procedures for Medicaid and non-Medicaid patients and a combined total for each clinic. To return to the **Resources** page, click **Back to Reporting Interface**.



- Click a clinic on the summary tile to open the **Services by Clinics Information** page and view details of each procedure that is included in the calculation for that clinic. The **Services by Clinics Information** page also displays production totals for procedures for Medicaid and non-Medicaid patients and a combined total for the clinic. To return to the **Resources** page, click **Back to Reporting Interface**.



- **Services by Primary Providers** – This summary tile displays the production amount from completed procedures for each primary provider.



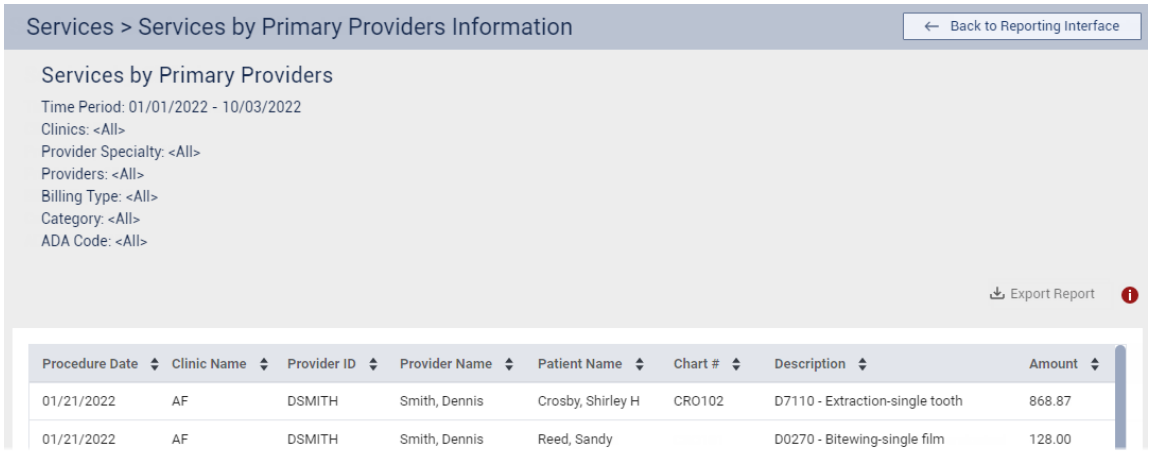
The *Primary Provider Production Amount* is the sum of the charges for each completed procedure that is associated with an active primary provider who is one of the specified providers. A completed procedure must also meet the following criteria:

- The procedure code is any of the specified codes.
- The procedure code's category is any of the specified categories.
- The date is within the specified time period.
- The billing type of the associated patient is any of the specified billing types.

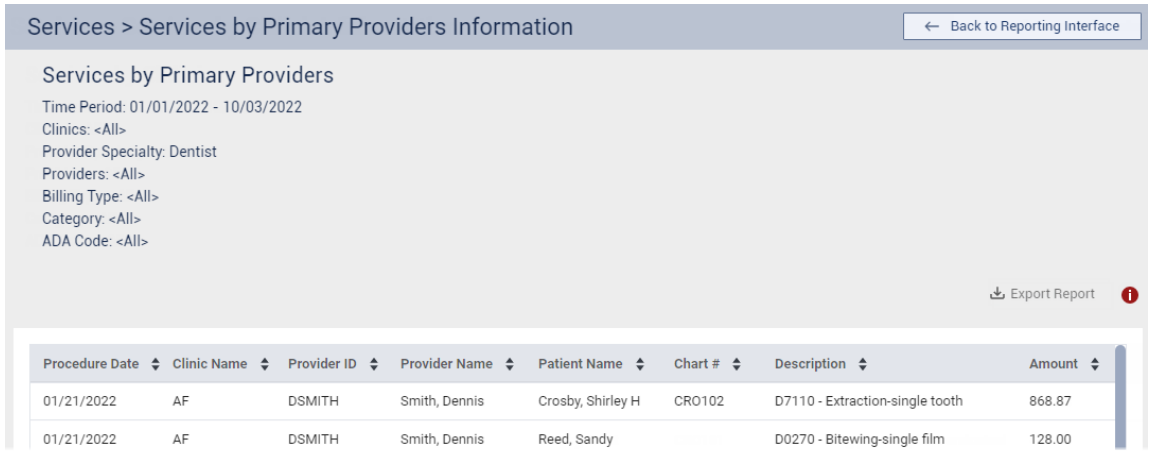
- The clinic is any of the specified clinics.
- The provider's specialty is any of the specified primary specialties.

Do any of the following:

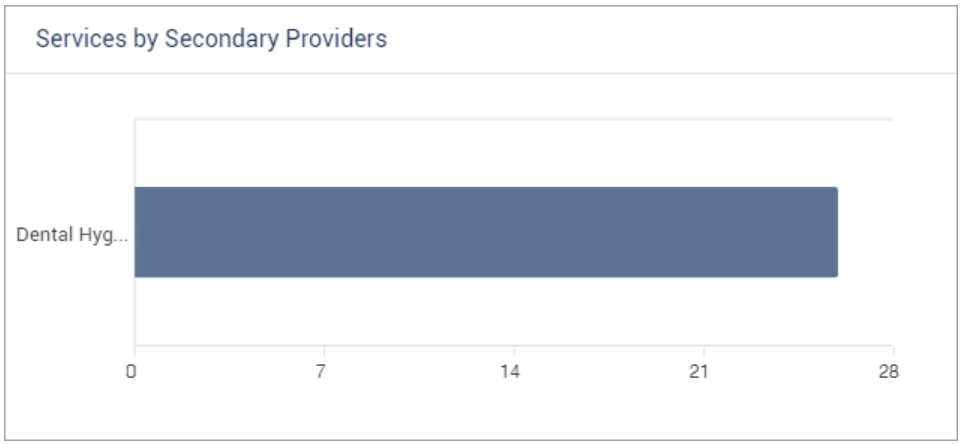
- Click the name of the summary tile to open the **Services by Primary Providers Information** page and view details of each procedure that is included in the calculation for the specified providers with the specified primary specialties. To return to the **Resources** page, click **Back to Reporting Interface**.



- Click a specialty on the summary tile to open the **Services by Primary Providers Information** page and view details of each procedure that is included in the calculation for the specified providers with that primary specialty. To return to the **Resources** page, click **Back to Reporting Interface**.



- **Services by Secondary Providers** – This summary tile displays the production amount from completed procedures for each secondary provider.

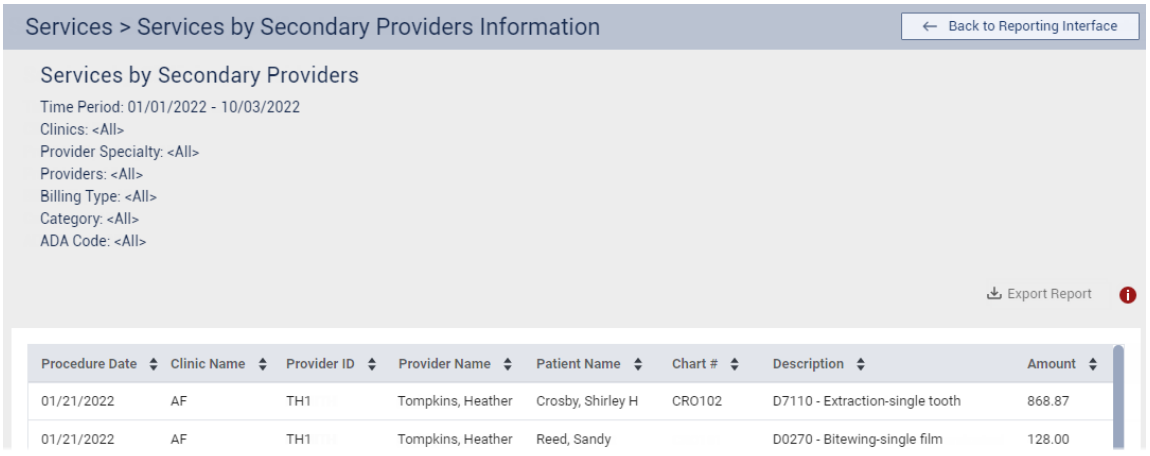


The *Secondary Provider Production Amount* is the sum of the charges for each completed procedure that is associated with an active secondary provider who is one of the specified providers. A completed procedure must also meet the following criteria:

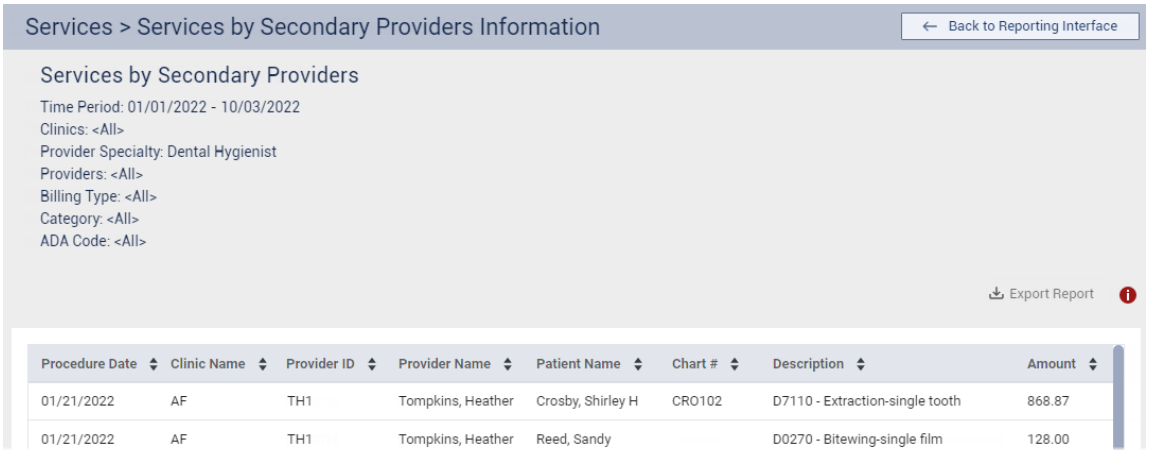
- The procedure code is any of the specified codes.
- The procedure code's category is any of the specified categories.
- The date is within the specified time period.
- The billing type of the associated patient is any of the specified billing types.
- The clinic is any of the specified clinics.
- The provider's specialty is any of the specified secondary specialties.

Do any of the following:

- Click the name of the summary tile to open the **Services by Secondary Providers Information** page and view details of each procedure that is included in the calculation for the specified providers with the specified secondary specialties. To return to the **Resources** page, click **Back to Reporting Interface**.



- Click a specialty on the summary tile to open the **Services by Secondary Providers Information** page and view details of each procedure that is included in the calculation for the specified providers with that secondary specialty. To return to the **Resources** page, click **Back to Reporting Interface**.



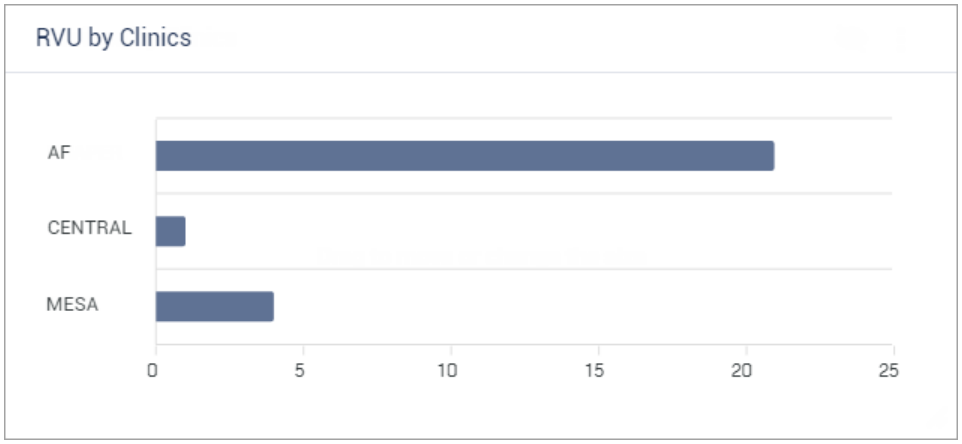
RVU

- **Total RVU** – This totals strip displays the relative value units (RVU) for completed procedures.

  The *Completed RVU* is the sum of the RVU for each completed procedure that meets the following criteria:

  - The procedure code is any of the specified codes.
  - The procedure code's category is any of the specified categories.
  - The date is within the specified time period.
  - The clinic is any of the specified clinics.
  - The provider is any of the specified providers whose specialty is any of the specified specialties.
  - The billing type of the associated patient is any of the specified billing types.
- **RVU by Clinics** – This summary tile displays the RVU for completed procedures in each clinic.



The *Clinic Completed RVU* is the sum of the RVU for each completed procedure in a clinic that is one of the specified clinics. A completed procedure must also meet the following criteria:

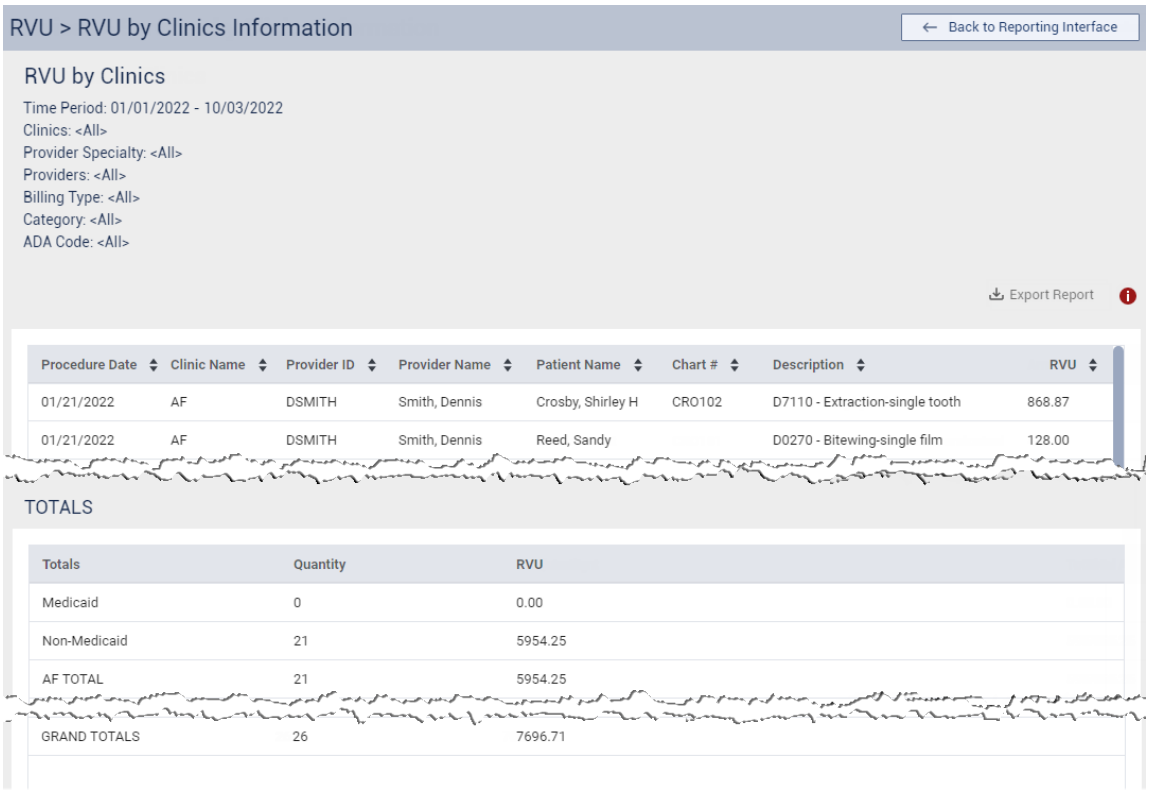
- The procedure code is any of the specified codes.
- The procedure code's category is any of the specified categories.

- The date is within the specified time period.
- The provider is any of the specified providers whose specialty is any of the specified specialties.
- The billing type of the associated patient is any of the specified billing types.

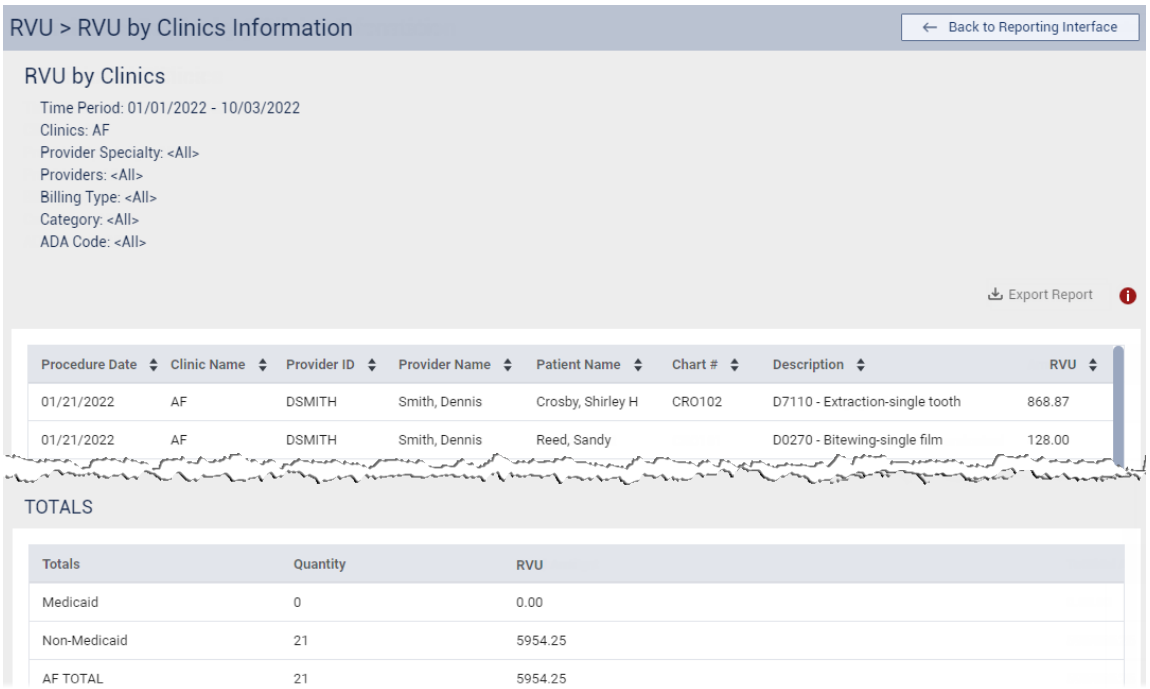
Note: Compare to the RVU day sheet.

Do any of the following:

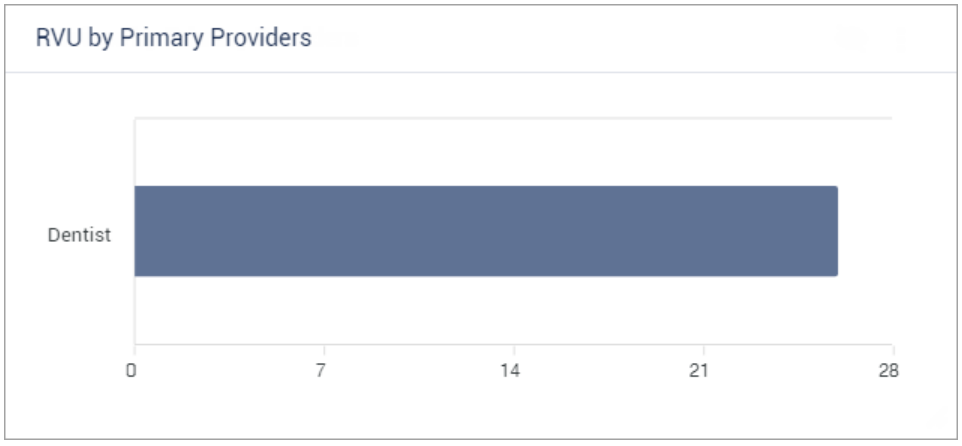
- Click the name of the summary tile to open the **RVU by Clinics Information** page and view details of each procedure that is included in the calculation for the specified clinics. The **RVU by Clinics Information** page also displays the total RVU for each clinic. To return to the **Resources** page, click **Back to Reporting Interface**.



- Click a clinic on the summary tile to open the **RVU by Clinics Information** page and view details of each procedure that is included in the calculation for that clinic. The **RVU by Clinics Information** page also displays the total RVU for the clinic. To return to the **Resources** page, click **Back to Reporting Interface**.



- **RVU by Primary Providers** – This summary tile displays the RVU from completed procedures for each primary provider.



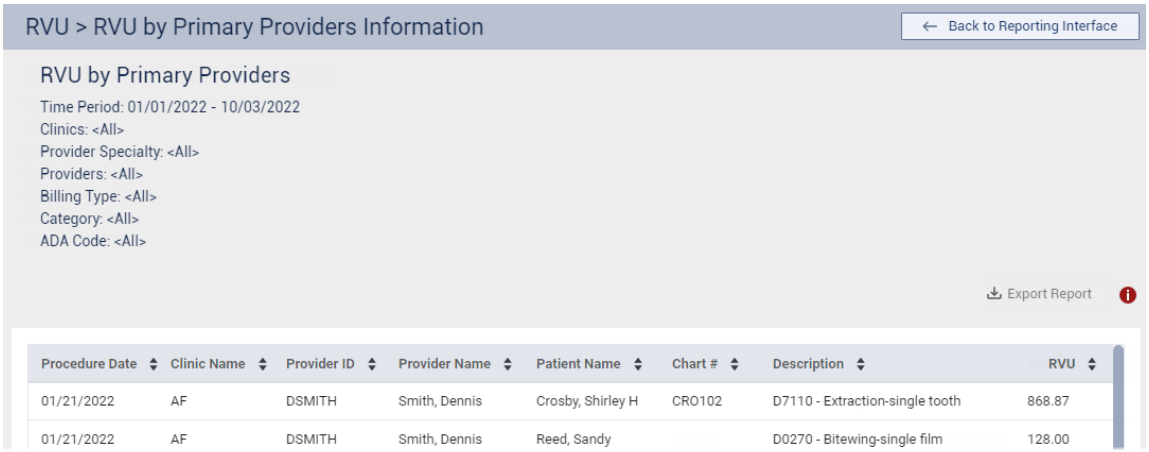
The *Primary Provider Completed RVU* is the sum of the charges for each completed procedure that is associated with an active primary provider who is one of the specified providers. A completed procedure must also meet the following criteria:

- The procedure code is any of the specified codes.
- The procedure code's category is any of the specified categories.
- The date is within the specified time period.
- The clinic is any of the specified clinics.
- The billing type of the associated patient is any of the specified billing types.
- The provider's specialty is any of the specified primary specialties.

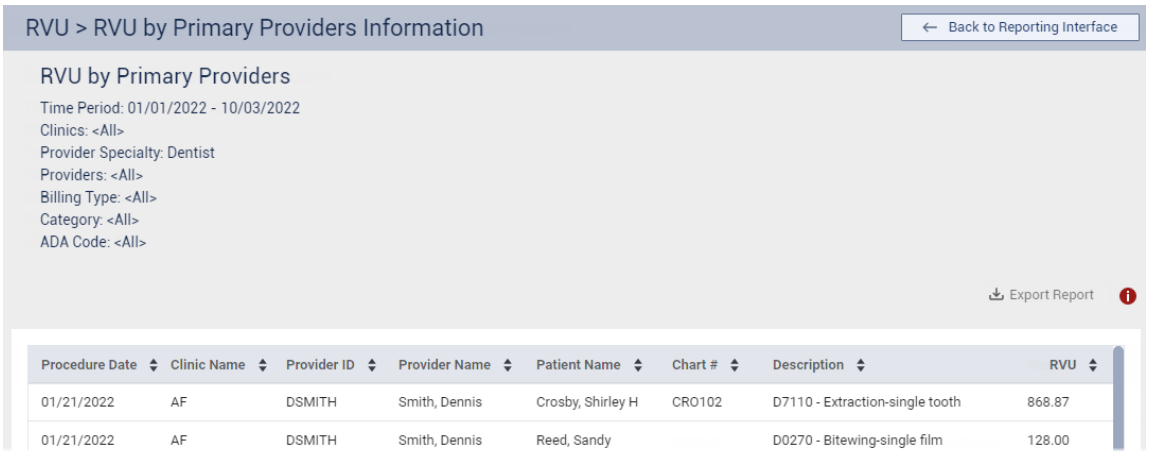
Note: Compare to the RVU day sheet.

Do any of the following:

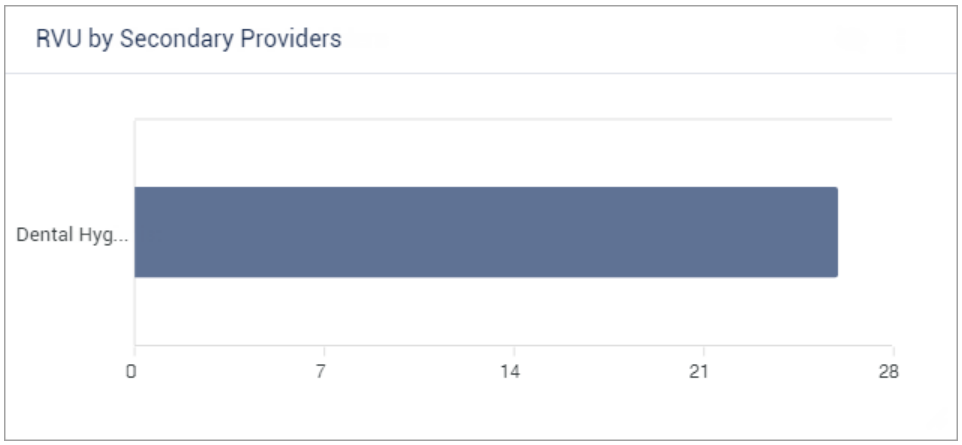
- Click the name of the summary tile to open the **RVU by Primary Providers Information** page and view details of each procedure that is included in the calculation for the specified providers with the specified primary specialties. To return to the **Resources** page, click **Back to Reporting Interface**.



- Click a specialty on the summary tile to open the **RVU by Primary Providers Information** page and view details of each procedure that is included in the calculation for the specified providers with that primary specialty. To return to the **Resources** page, click **Back to Reporting Interface**.



- **RVU by Secondary Providers** – This summary tile displays the RVU from completed procedures for each secondary provider.



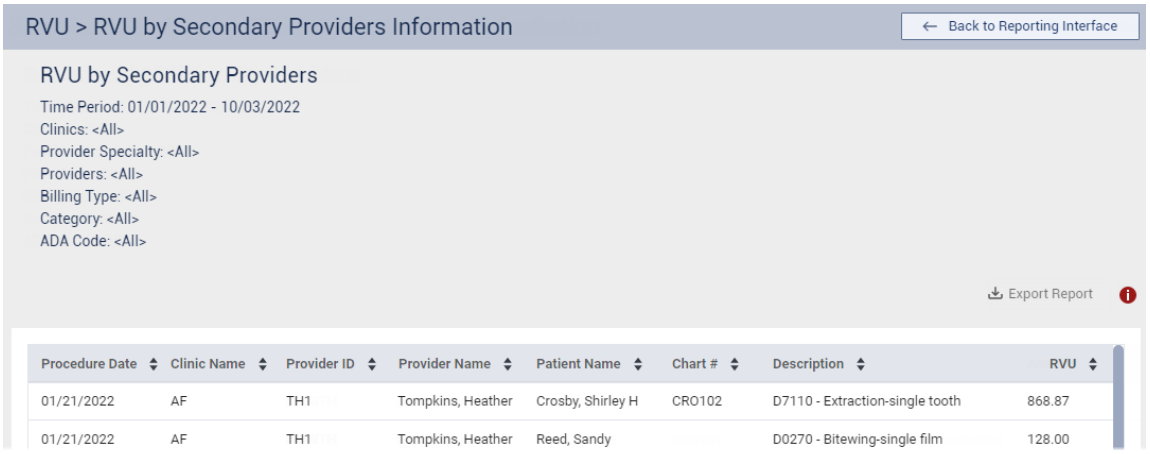
The *Secondary Provider Completed RVU* is the sum of the RVU for each completed procedure that meets the following criteria:

- The procedure code is any of the specified codes.
- The procedure code's category is any of the specified categories.
- The date is within the specified time period.
- The clinic is any of the specified clinics.
- The billing type of the associated patient is any of the specified billing types.
- The provider's specialty is any of the specified secondary specialties.

Note: Compare to the RVU day sheet.

Do any of the following:

- Click the name of the summary tile to open the **RVU by Secondary Providers Information** page and view details of each procedure that is included in the calculation for the specified providers with the specified secondary specialties. To return to the **Resources** page, click **Back to Reporting Interface**.



- Click a specialty on the summary tile to open the **RVU by Secondary Providers Information** page and view details of each procedure that is included in the calculation for the specified providers with that secondary specialty. To return to the **Resources** page, click **Back to Reporting Interface**.



Patient Visits

- **Total Patient Visits** – This totals strip displays the number of visits.
  - The count includes broken appointments if the **Include Broken Appt to Patient Visits** check box is selected under **Filters**.

    Total Patient Visits (including broken appointments) **15**

  - The count does not include broken appointment if the **Include Broken Appt to Patient Visits** check box is clear under **Filters**.

    Total Patient Visits (not including broken appointments) **15**

  A *Visit* occurs when one or more of the specified completed procedures are posted for a patient on a given day.

  The *Number of Visits* is the number of *Visits* that meet the following criteria:

  - The procedure code is for any of the specified codes or any of the specified broken appointment codes.
  - The procedure code category is any of the specified categories.
  - The date is within the specified time period.
  - The clinic is any of the specified clinics.
  - The provider is an active provider who is any of the specified providers whose specialty is any of the specified specialties.
  - The billing type of the associated patient is any of the specified billing types.
- **Total Broken and Missed Appointments** – This totals strip displays the number of broken and missed appointments.

  Total Broken and Missed Appointments **0**

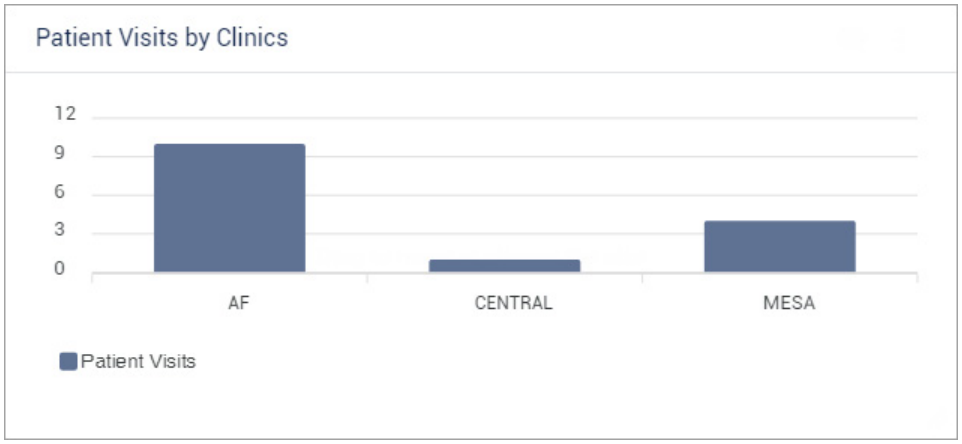
  A *Missed Visit* occurs when one of the specified broken appointment codes is posted for a patient on a given day.

  The *Number of Missed Visits* is the number of *Missed Visits* that also meet the following criteria:

  - The procedure code category is any of the specified categories.
  - The date is within the specified time period.

- The clinic is any of the specified clinics.
- The provider is an active provider who is any of the specified providers whose specialty is any of the specified specialties.
- The billing type of the associated patient is any of the specified billing types.

- **Patient Visits by Clinics** – This summary tile displays the number of visits and of broken/missed appointments in each clinic.



A *Visit* occurs when one or more of the specified completed procedures are posted for a patient on a given day.

The *Number of Clinic Visits* is the number of *Visits* in a clinic that is one of the specified clinics.

A *Missed Visit* occurs when one of the specified broken appointment codes is posted for a patient on a given day.

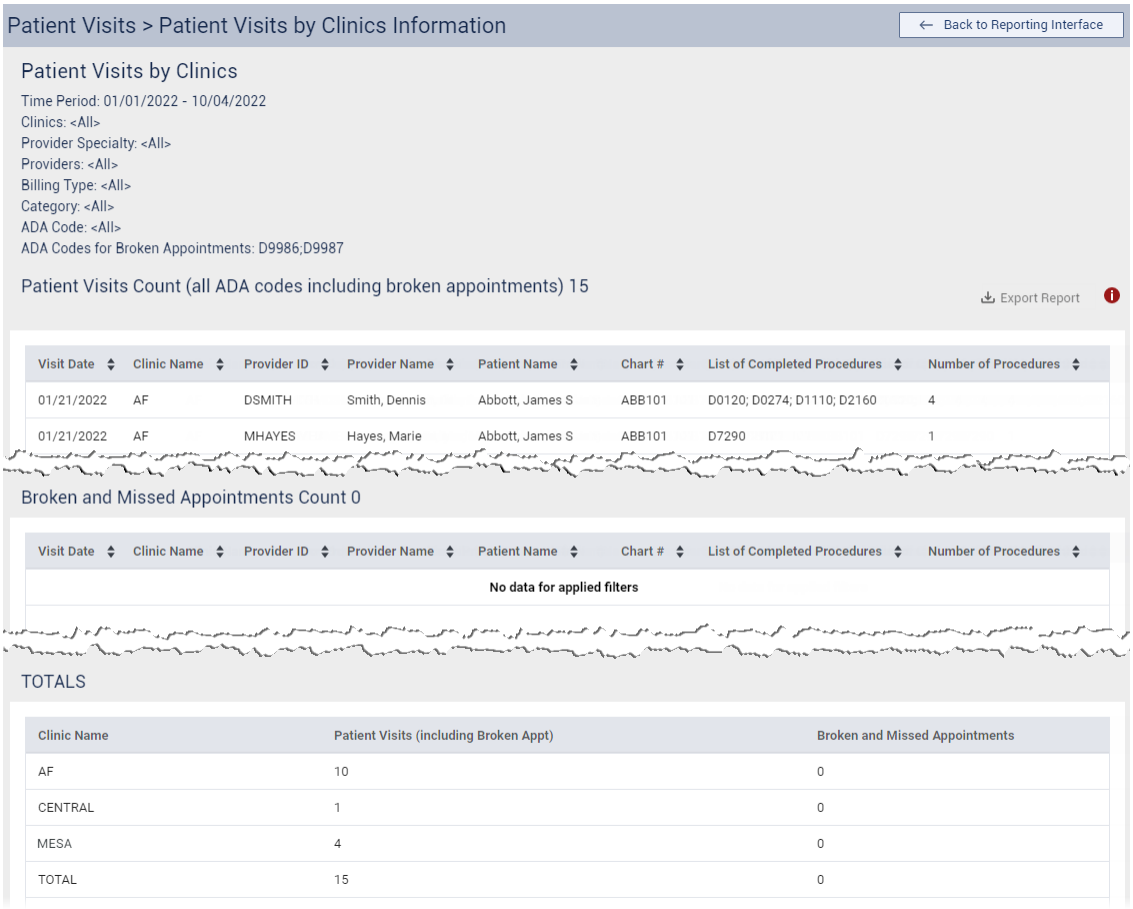
The *Number of Clinic Missed Visits* is the number of *Missed Visits* in a clinic that is one of the specified clinics.

A *Visit* or *Missed Visit* must also meet the following criteria:

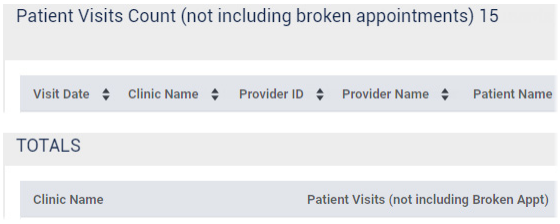
- The procedure code category is any of the specified categories.
- The date is within the specified time period.
- The provider is an active provider who is any of the specified providers whose specialty is any of the specified specialties.
- The billing type of the associated patient is any of the specified billing types.

Do any of the following:

- Click the name of the summary tile to open the **Patient Visits by Clinics Information** page and view details of each visit that is included in the calculation for the specified clinics. The **Patient Visits by Clinics Information** page also displays the visit and broken/missed appointment totals for each clinic. To return to the **Resources** page, click **Back to Reporting Interface**.



Note: The visit counts do not include broken appointments if the **Include Broken Appt to Patient Visits** check box is clear under **Filters**.



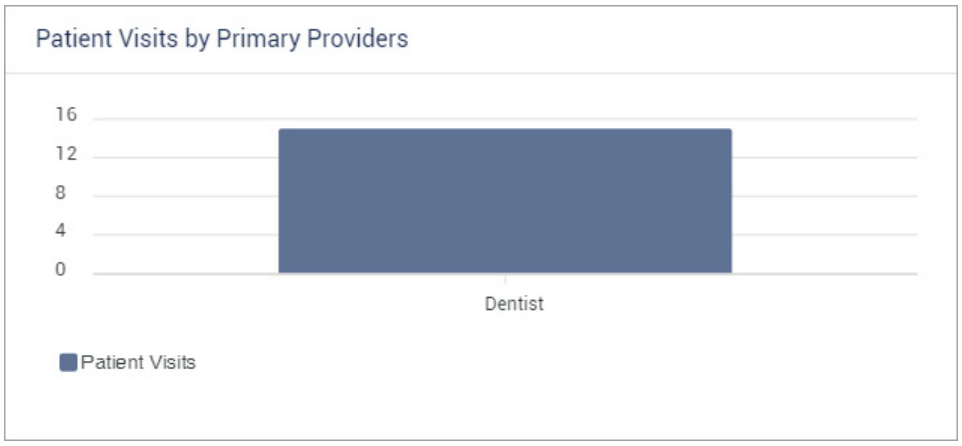
- Click a visit or broken appointment on the summary tile to open the **Patient Visits by Clinics Information** page and view details of each visit that is included in the calculation for that clinic. The **Patient Visits by Clinics Information** page also displays the total number of visits for the clinic. To return to the **Resources** page, click **Back to Reporting Interface**.



Note: The visit counts do not include broken appointments if the **Include Broken Appt to Patient Visits** check box is clear under **Filters**.



- **Patient Visits by Primary Providers** – This summary tile displays the number of visits and of broken/missed appointments for each primary provider.



A *Visit* occurs when one or more of the specified completed procedures are posted for a patient on a given day.

The *Number of Primary Provider Visits* is the number of *Visits* with an active primary provider who is one of the specified providers whose specialty is any of the specified primary specialties.

A *Missed Visit* occurs when one of the specified broken appointment codes is posted for a patient on a given day.

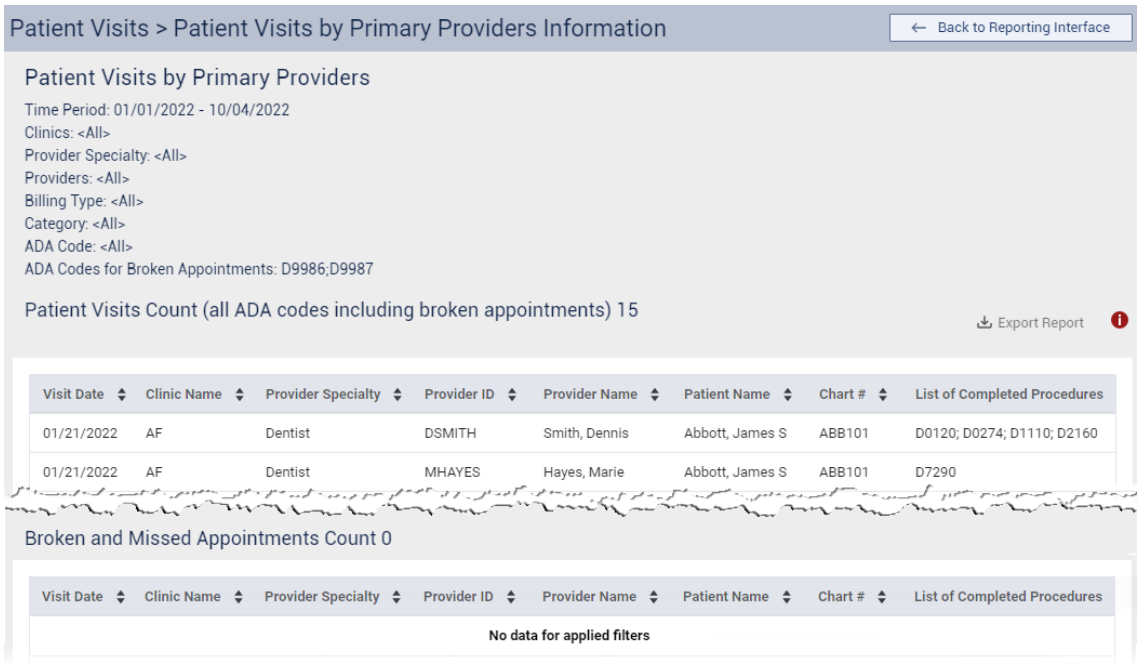
The *Number of Primary Provider Missed Visits* is the number of *Missed Visits* with an active primary provider who is one of the specified providers whose specialty is any of the specified primary specialties.

A *Visit* or *Missed Visit* must also meet the following criteria:

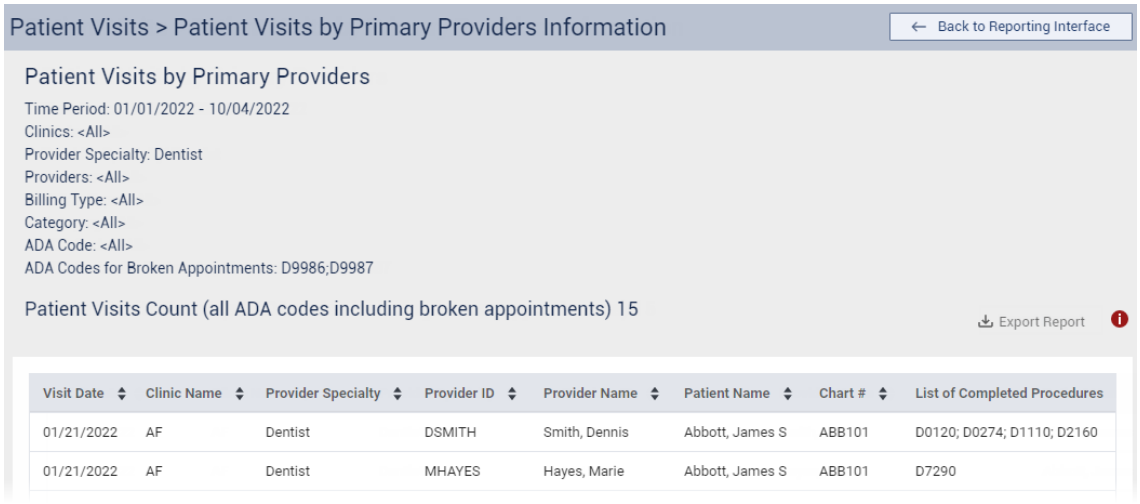
- The procedure code category is any of the specified categories.
- The date is within the specified time period.
- The clinic is any of the specified clinics.
- The billing type of the associated patient is any of the specified billing types.

Do any of the following:

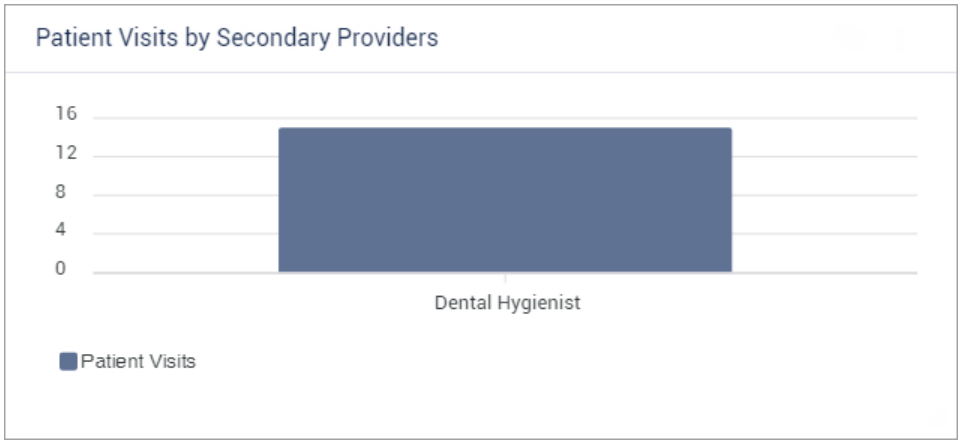
- Click the name of the summary tile to open the **Patient Visits by Primary Providers Information** page and view details of each visit that is included in the calculation for the specified providers with the specified primary specialties. The **Patient Visits by Primary Providers Information** page also displays a count of broken/missed appointments and details of each broken/missed appointment. To return to the **Resources** page, click **Back to Reporting Interface**.



- Click a specialty on the summary tile to open the **Patient Visits by Primary Providers Information** page and view details of each visit that is included in the calculation for the specified providers with that primary specialty. To return to the **Resources** page, click **Back to Reporting Interface**.



- **Patient Visits by Secondary Providers** – This summary tile displays the number of visits and the number of broken/missed appointments for each secondary provider.



A *Visit* occurs when one or more of the specified completed procedures are posted for a patient on a given day.

The *Number of Secondary Provider Visits* is the number of *Visits* with an active secondary provider who is one of the specified providers whose specialty is any of the specified secondary specialties.

A *Missed Visit* occurs when one of the specified broken appointment codes is posted for a patient on a given day.

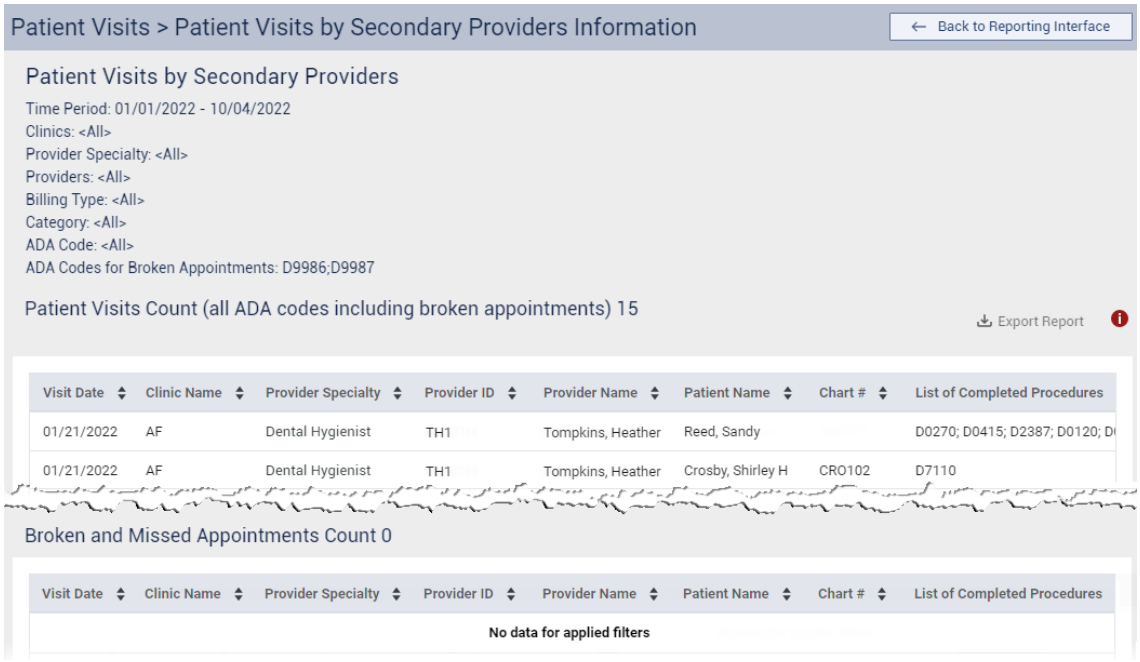
The *Number of Secondary Provider Missed Visits* is the number of *Missed Visits* with an active secondary provider who is one of the specified providers whose specialty is any of the specified secondary specialties.

A *Visit* or *Missed Visit* must also meet the following criteria:

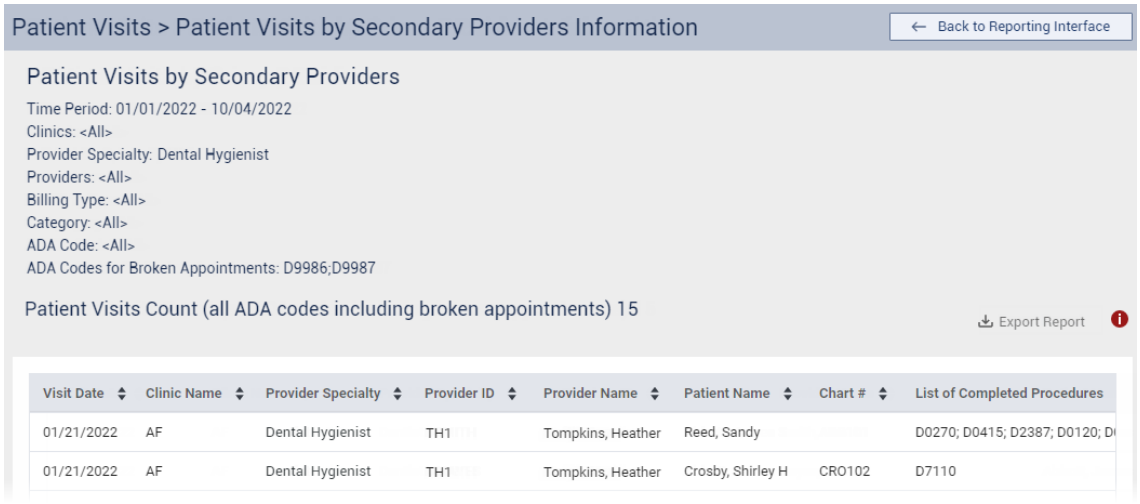
- The procedure code category is any of the specified categories.
- The date is within the specified time period.
- The clinic is any of the specified clinics.
- The billing type of the associated patient is any of the specified billing types.

Do any of the following:

- Click the name of the summary tile to open the **Patient Visits by Secondary Providers Information** page and view details of each visit that is included in the calculation for the specified providers with the specified secondary specialties. The **Patient Visits by Secondary Providers Information** page displays a count of broken/missed appointments and details of each broken/missed appointment. To return to the **Resources** page, click **Back to Reporting Interface**.

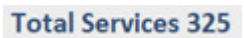


- Click a specialty on the summary tile to open the **Patient Visits by Secondary Providers Information** page and view details of each visit that is included in the calculation for the specified providers with that secondary specialty. To return to the **Resources** page, click **Back to Reporting Interface**.



Level of Care

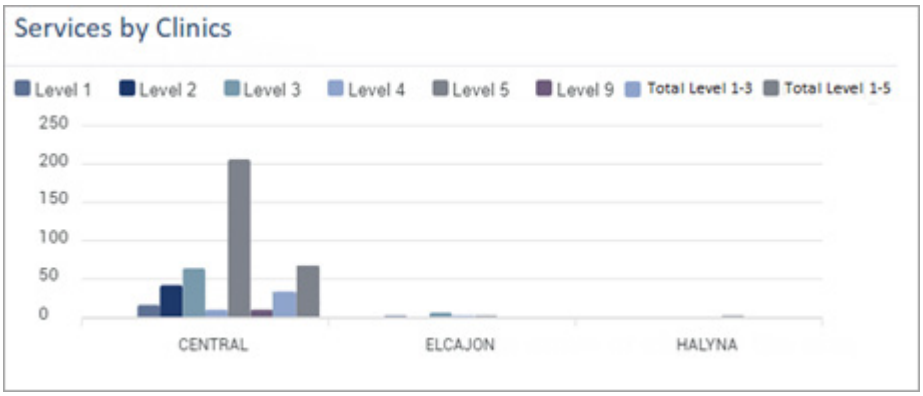
- **Total Services** – This totals strip displays the production amount from completed procedures at all levels of care.



The *LOC Production Amount* is the sum of the charges for each completed procedure, at all levels of care, that meets the following criteria:

- The date is within the specified time period.
- The clinic is any of the specified clinics.
- The provider is any of the specified providers whose specialty is any of the specified specialties.

- **Services by Clinics** – This summary tile displays the production amount from completed procedures, at each level of care, in each clinic.

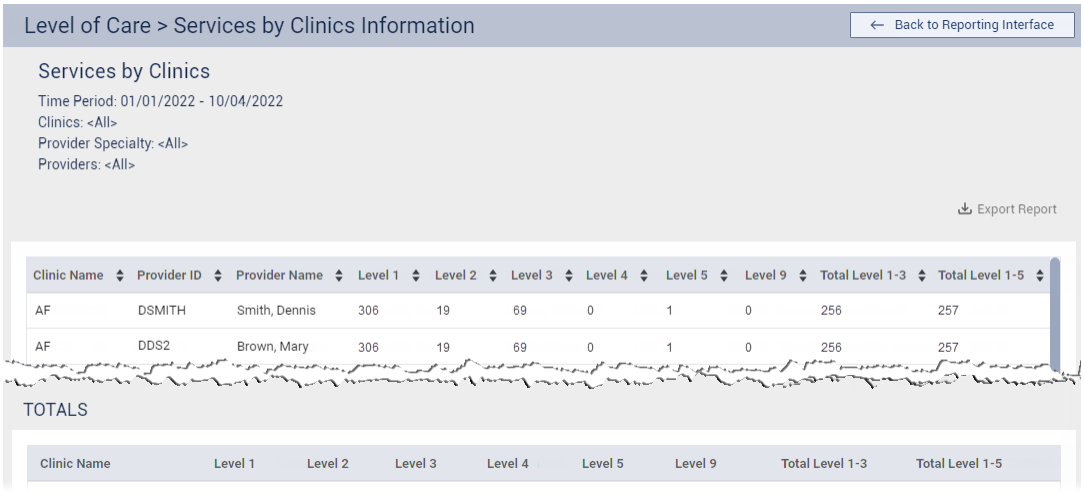


The *LOC Clinic Production Amount* is the sum of the charges for each completed procedure, at a given level of care, in a clinic that is one of the specified clinics. A completed procedure must also meet the following criteria:

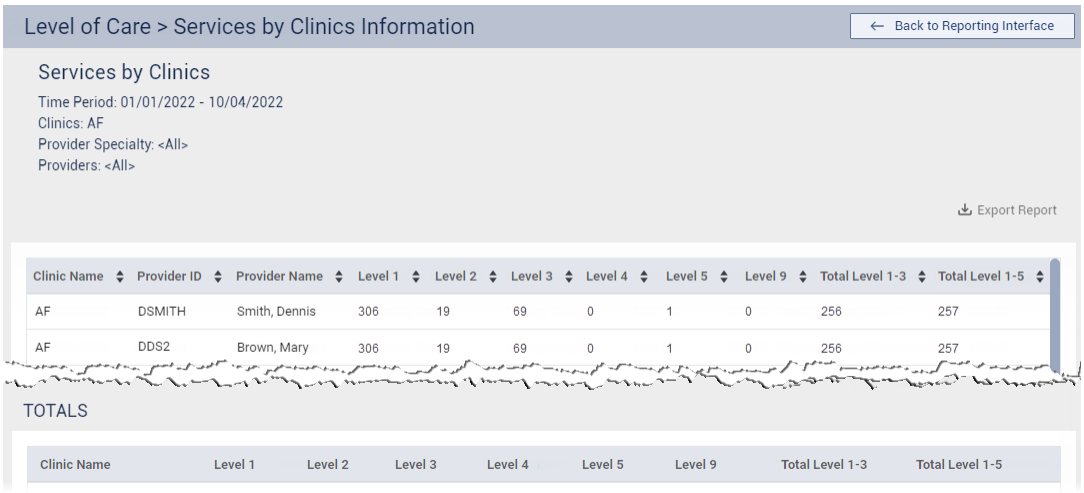
- The date is within the specified time period.
- The provider is an active provider and is any of the specified providers whose specialty is any of the specified specialties.

Do any of the following:

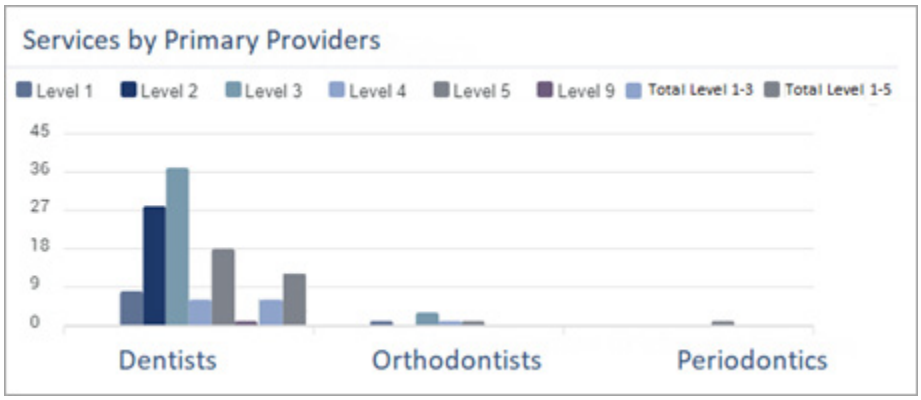
- Click the name of the summary tile to open the **Services by Clinics Information** page and view a breakdown of the levels of care for procedures that are included in the calculation for the specified clinics. The **Services by Clinics Information** page also displays the level-of-care totals for each clinic and combined totals for all clinics. To return to the **Resources** page, click **Back to Reporting Interface**.



- Click a clinic on the summary tile to open the **Services by Clinics Information** page and view a breakdown of the levels of care for procedures that are included in the calculation for that clinic. The **Services by Clinics Information** page also displays the level-of-care totals for the clinic. To return to the **Resources** page, click **Back to Reporting Interface**.



- **Services by Primary Providers** – This summary tile displays the production amount from completed procedures, at each level of care, for each primary provider.

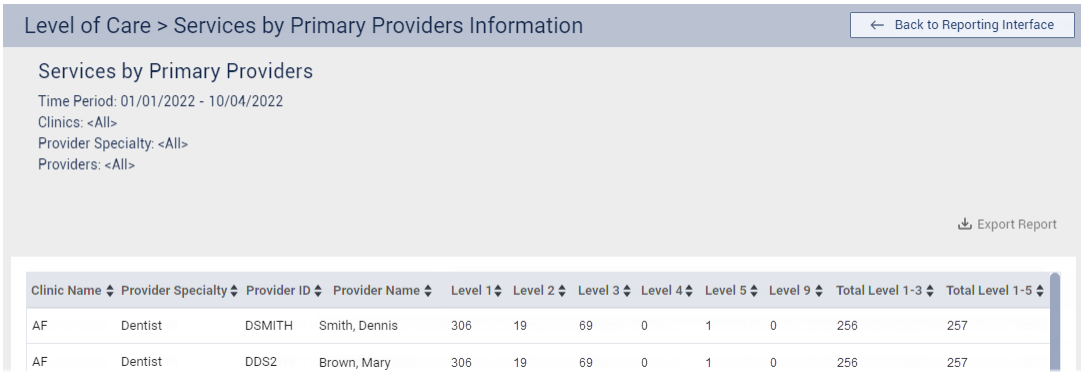


The *LOC Primary Provider Production Amount* is the sum of the charges for each completed procedure, at a given level of care, that is associated with an active primary provider who is one of the specified providers. A completed procedure must also meet the following criteria:

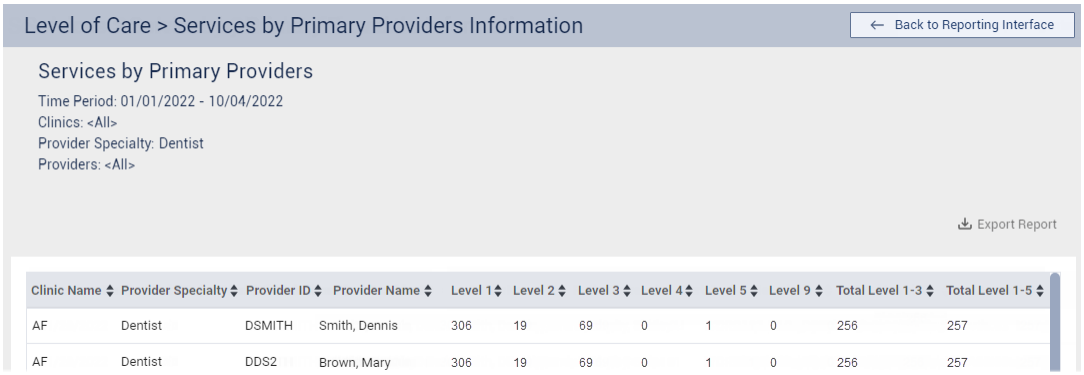
- The date is within the specified time period.
- The clinic is any of the specified clinics.
- The provider's specialty is any of the specified primary specialties.

Do any of the following:

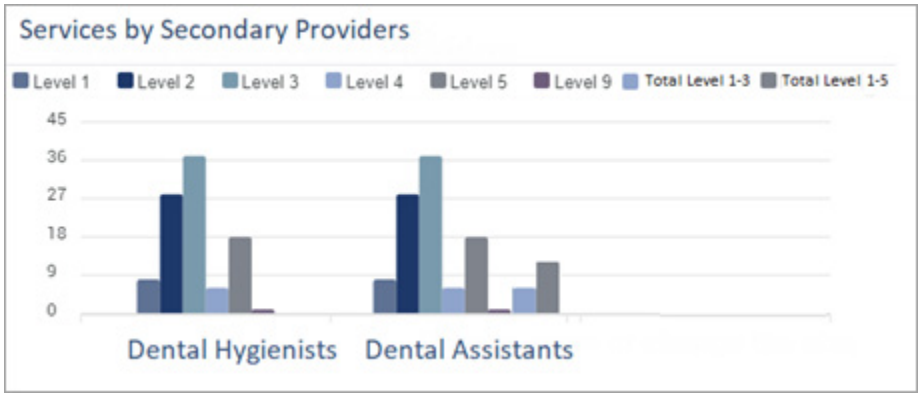
- Click the name of the summary tile to open the **Services by Primary Providers Information** page and view a breakdown of the levels of care for procedures that are included in the calculation for the specified providers with the specified primary specialties. To return to the **Resources** page, click **Back to Reporting Interface**.



- Click a specialty on the summary tile to open the **Services by Primary Providers Information** page and view a breakdown of the levels of care for procedures that are included in the calculation for the specified providers with that primary specialty. To return to the **Resources** page, click **Back to Reporting Interface**.



- **Services by Secondary Providers** – This summary tile displays the production amount from completed procedures, at each level of care, for each secondary provider.

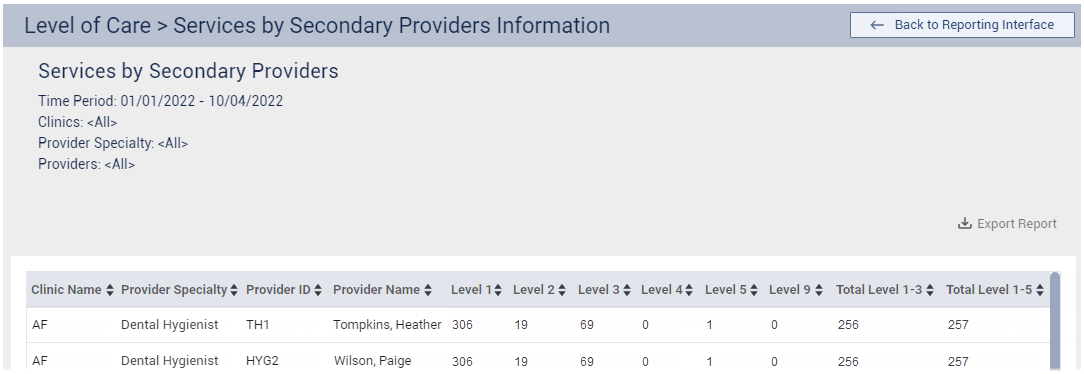


The *LOC Secondary Provider Production Amount* is the sum of the charges for each completed procedure, at a given level of care, that is associated with an active secondary provider who is one of the specified providers. A completed procedure must also meet the following criteria:

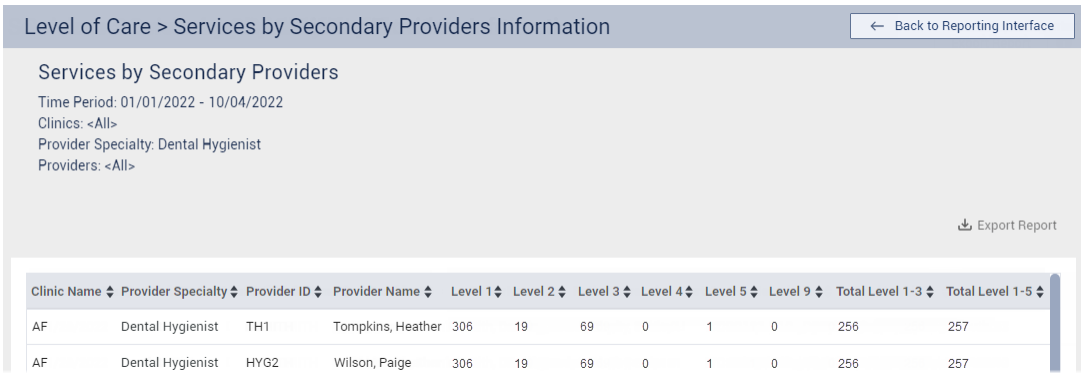
- The date is within the specified time period.
- The clinic is any of the specified clinics.
- The provider's specialty is any of the specified secondary specialties.

Do any of the following:

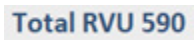
- Click the name of the summary tile to open the **Services by Secondary Providers Information** page and view a breakdown of the levels of care for procedures that are included in the calculation for the specified providers with the specified secondary specialties. To return to the **Resources** page, click **Back to Reporting Interface**.



- Click a specialty on the summary tile to open the **Services by Secondary Providers Information** page and view a breakdown of the levels of care for procedures that are included in the calculation for the specified providers with that secondary specialty. To return to the **Resources** page, click **Back to Reporting Interface**.



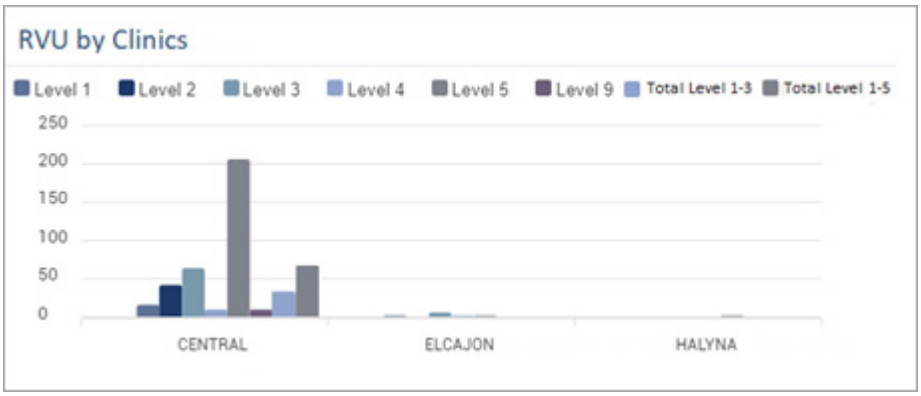
- **Total RVU** – This totals strip displays the relative value units (RVU) for completed procedures at all levels of care.



The *LOC Completed RVU* is the sum of the RVU for each completed procedure, at all levels of care, that meets the following criteria:

- The date is within the specified time period.
- The clinic is any of the specified clinics.
- The provider is any of the specified providers whose specialty is any of the specified specialties.

- **RVU by Clinics** – This summary tile displays the RVU for completed procedures, at each level of care, in each clinic.



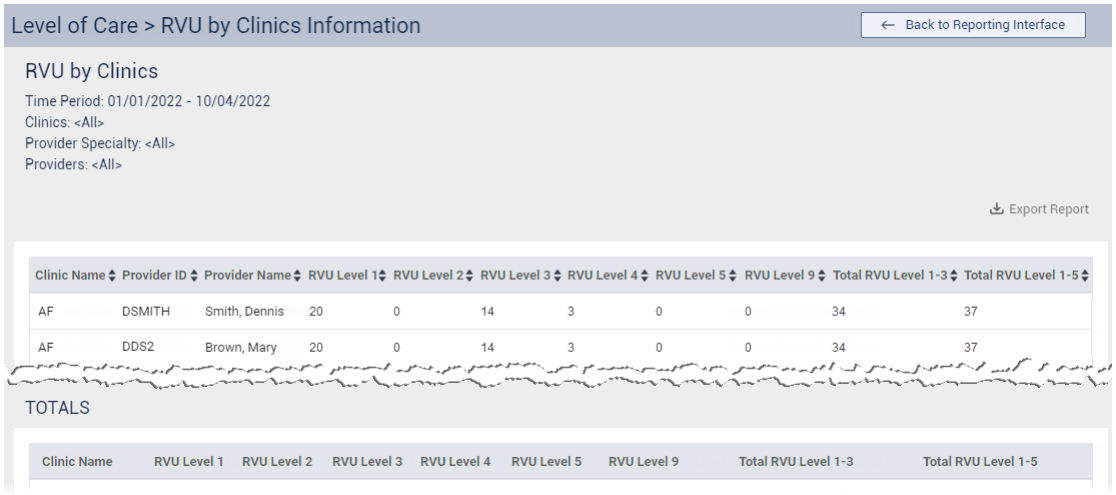
The *LOC Clinic Completed RVU* is the sum of the RVU for each completed procedure, at a given level of care, in a clinic that is one of the specified clinics. A completed procedure must also meet the following criteria:

- The date is within the specified time period.
- The provider is any of the specified providers whose specialty is any of the specified specialties.

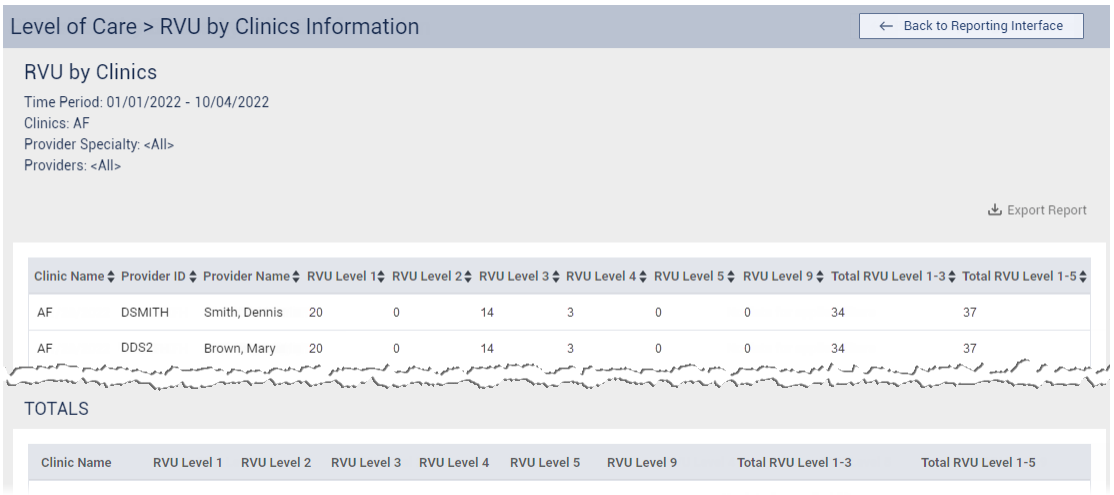
Note: Compare to the RVU day sheet.

Do any of the following:

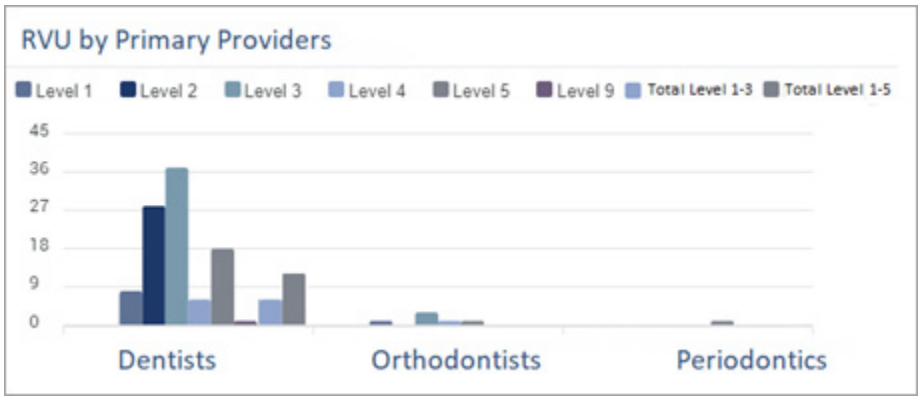
- Click the name of the summary tile to open the **RVU by Clinics Information** page and view a breakdown of the levels of care for procedures that are included in the calculation for the specified clinics. The **RVU by Clinics Information** page also displays the level-of-care totals for each clinic and combined totals for all clinics. To return to the **Resources** page, click **Back to Reporting Interface**.



- Click a clinic on the summary tile to open the **RVU by Clinics Information** page and view a breakdown of the levels of care for procedures that are included in the calculation for that clinic. The **RVU by Clinics Information** page also displays the level-of-care totals for the clinic. To return to the **Resources** page, click **Back to Reporting Interface**.



- **RVU by Primary Providers** – This summary tile displays the RVU from completed procedures, at each level of care, for each primary provider.



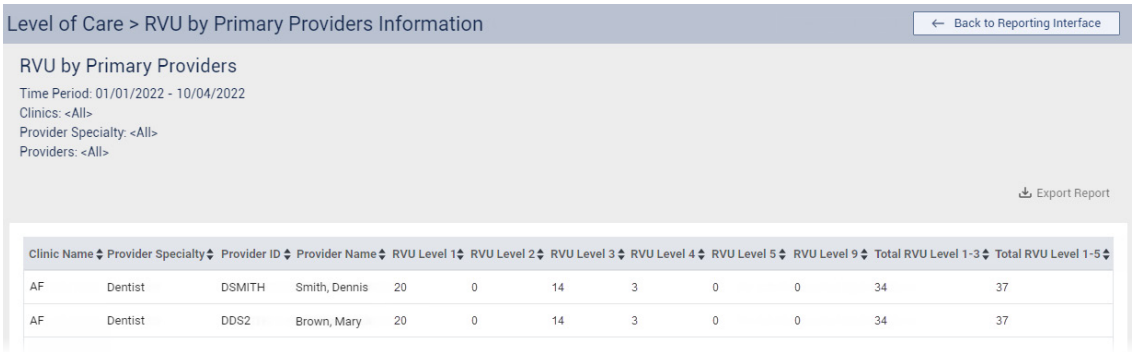
The *LOC Primary Provider Completed RVU* is the sum of the charges for each completed procedure, at a given level of care, that is associated with an active primary provider who is one of the specified providers. A completed procedure must also meet the following criteria:

- The date is within the specified time period.
- The clinic is any of the specified clinics.
- The provider's specialty is any of the specified primary specialties.

Note: Compare to the RVU day sheet.

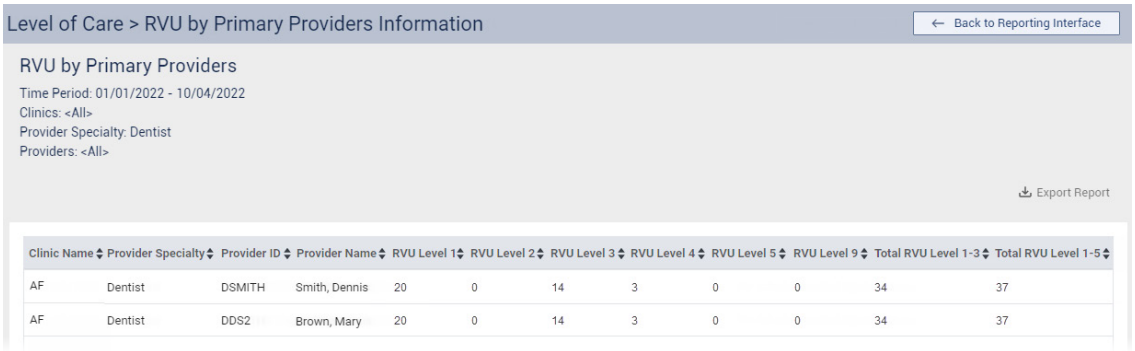
Do any of the following:

- Click the name of the summary tile to open the **RVU by Primary Providers Information** page and view a breakdown of the levels of care for procedures that are included in the calculation for the specified providers with the specified primary specialties. To return to the **Resources** page, click **Back to Reporting Interface**.



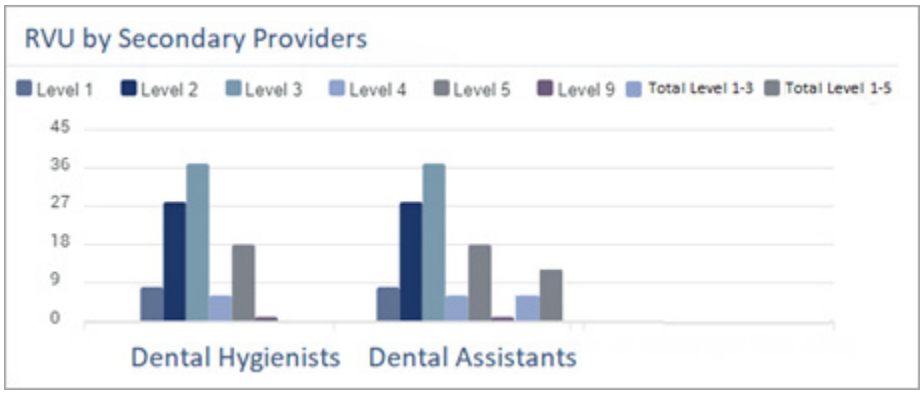
Clinic Name	Provider Specialty	Provider ID	Provider Name	RVU Level 1	RVU Level 2	RVU Level 3	RVU Level 4	RVU Level 5	RVU Level 9	Total RVU Level 1-3	Total RVU Level 1-5
AF	Dentist	DSMITH	Smith, Dennis	20	0	14	3	0	0	34	37
AF	Dentist	DDS2	Brown, Mary	20	0	14	3	0	0	34	37

- Click a specialty on the summary tile to open the **RVU by Primary Providers Information** page and view a breakdown of the levels of care for procedures that are included in the calculation for the specified providers with that primary specialty. To return to the **Resources** page, click **Back to Reporting Interface**.



Clinic Name	Provider Specialty	Provider ID	Provider Name	RVU Level 1	RVU Level 2	RVU Level 3	RVU Level 4	RVU Level 5	RVU Level 9	Total RVU Level 1-3	Total RVU Level 1-5
AF	Dentist	DSMITH	Smith, Dennis	20	0	14	3	0	0	34	37
AF	Dentist	DDS2	Brown, Mary	20	0	14	3	0	0	34	37

- **RVU by Secondary Providers** – This summary tile displays the RVU from completed procedures, at each level of care, for each secondary provider.



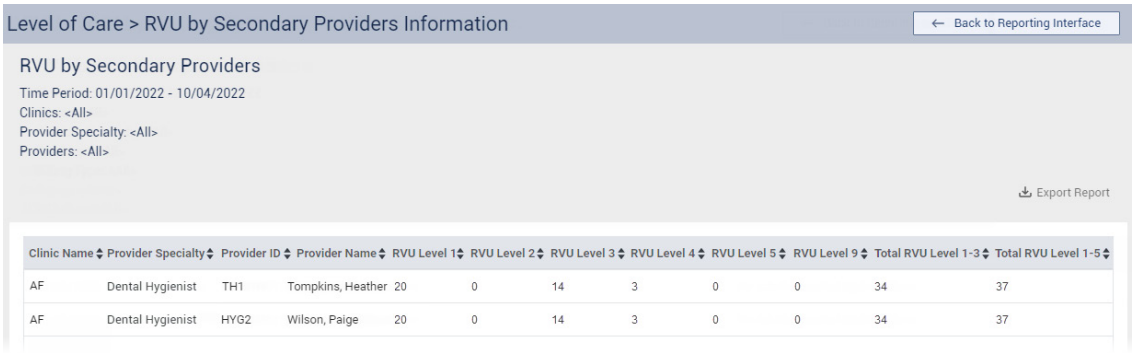
The *Secondary Provider Completed RVU* is the sum of the RVU for each completed procedure, at a given level of care, that meets the following criteria:

- The date is within the specified time period.
- The clinic is any of the specified clinics.
- The provider's specialty is any of the specified secondary specialties.

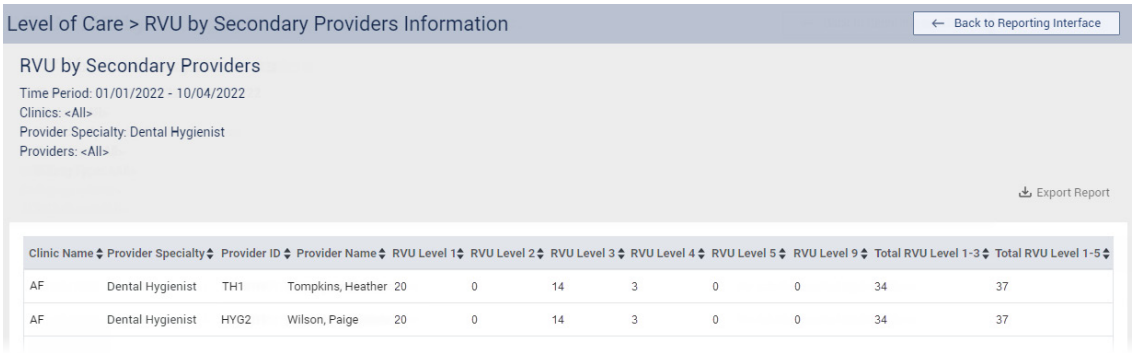
Note: Compare to the RVU day sheet.

Do any of the following:

- Click the name of the summary tile to open the **RVU by Secondary Providers Information** page and view a breakdown of the levels of care for procedures that are included in the calculation for the specified providers with the specified secondary specialties. To return to the **Resources** page, click **Back to Reporting Interface**.



- Click a specialty on the summary tile to open the **RVU by Secondary Providers Information** page and view a breakdown of the levels of care for procedures that are included in the calculation for the specified providers with that secondary specialty. To return to the **Resources** page, click **Back to Reporting Interface**.

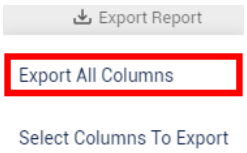


Exporting Dynamic Reporting Information

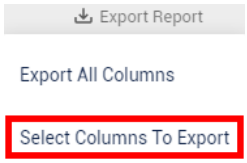
In Dynamic Reporting, while viewing totals and details for a Dynamic Reporting metric, you can export the information as needed.

To export report information

1. While viewing an information page, do one of the following:
   - To export details in all columns, on the **Export Report** menu, click **Export All Columns**.



   - To export details in specific columns only, do the following:
     a. On the **Export Report** menu, click **Select Columns To Export**.

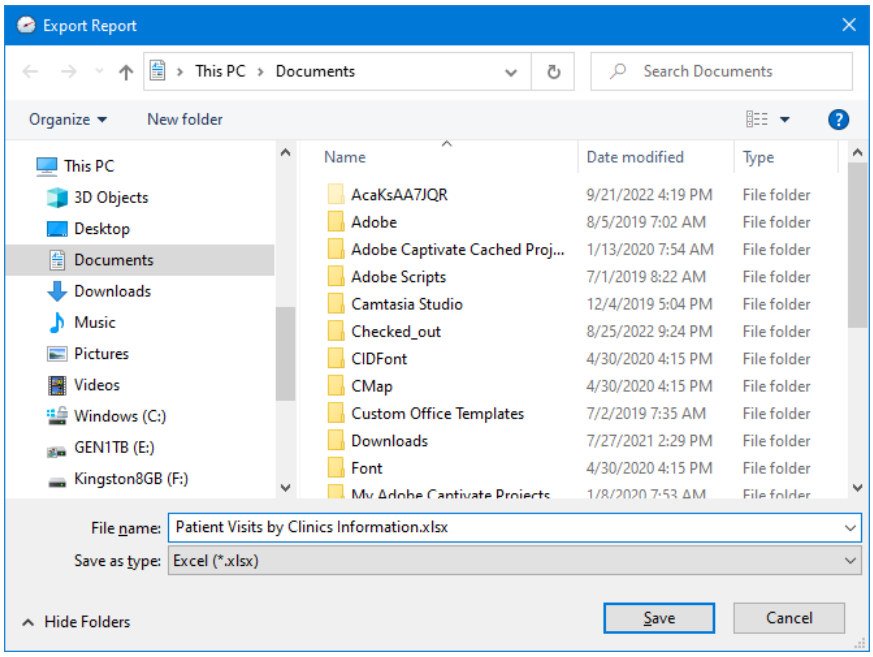


     The **Select Columns To Report** dialog box appears.



     b. Clear the check boxes of the details to exclude from the report.
     c. Click **Export Report**.

The **Export Report** dialog box appears.



2. Navigate to where you want to save the file.
3. In the **File name** box, enter a name for the file.
4. From the **Save as type** list, select whether you want to save the file as a .xlsx or .pdf file.
5. Click **Save**.

Chapter 9: DXOne Reporting

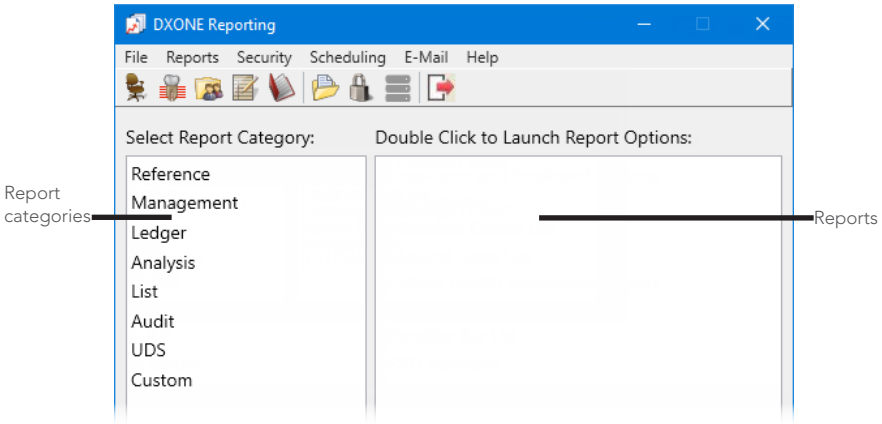
The DXOne Reporting module provides you with reports that will assist you in analyzing your practice. You can schedule these reports to be generated automatically on a daily, weekly, monthly, or one-time basis. Additionally, you can send reports generated in DXOne Reporting as an email attachment to the Central clinic, a consultant, or an accountant.

This chapter covers the following topics:

- The DXOne Reporting Window
- Setting Up Report Security
- Generating DXOne Reporting Reports
- Working with Previewed Reports
- Using Report Templates

The DXOne Reporting Window

The **DXOne Reporting** window consists of the menu bar, toolbar, report category list, and report list.



This section covers the following topics to help you understand how to use the **DXOne Reporting** window:

- The DXOne Reporting Toolbar
- Selecting a Report

The DXOne Reporting Toolbar

The toolbar contains several buttons that you can click to access certain areas of Dentrix Enterprise and DXOne Reporting.



The function of the buttons specific to DXOne Reporting are explained in the following table.

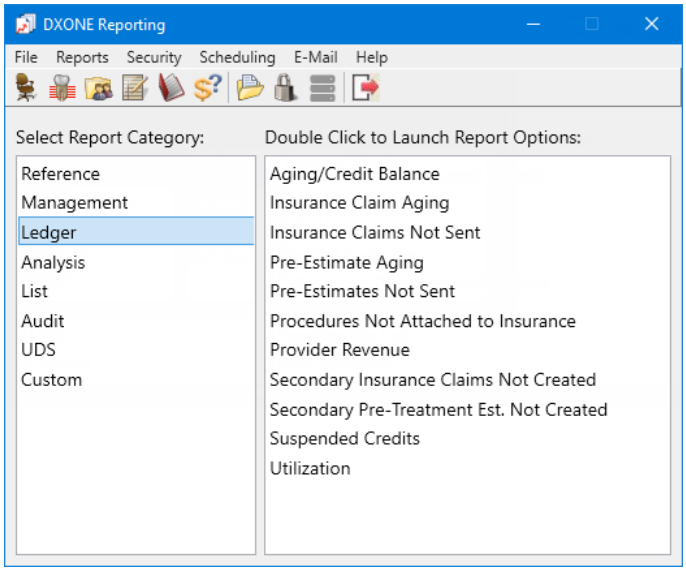
	Click the **Open Report** button to view a saved report.
	Click the **Security** button to assign rights to allow only certain users to access specific reports.
	Click the **Report Server** button to assign services for running report jobs.

Selecting a Report

Reports are organized by category to help you find a report easily.

To select a report

1. From the **Select Report Category** list box, select a report category.



2. A list of available reports for the selected category appears in the **Double Click to Launch Report Options** list box. To set up the filters for generating a report, double-click that report.

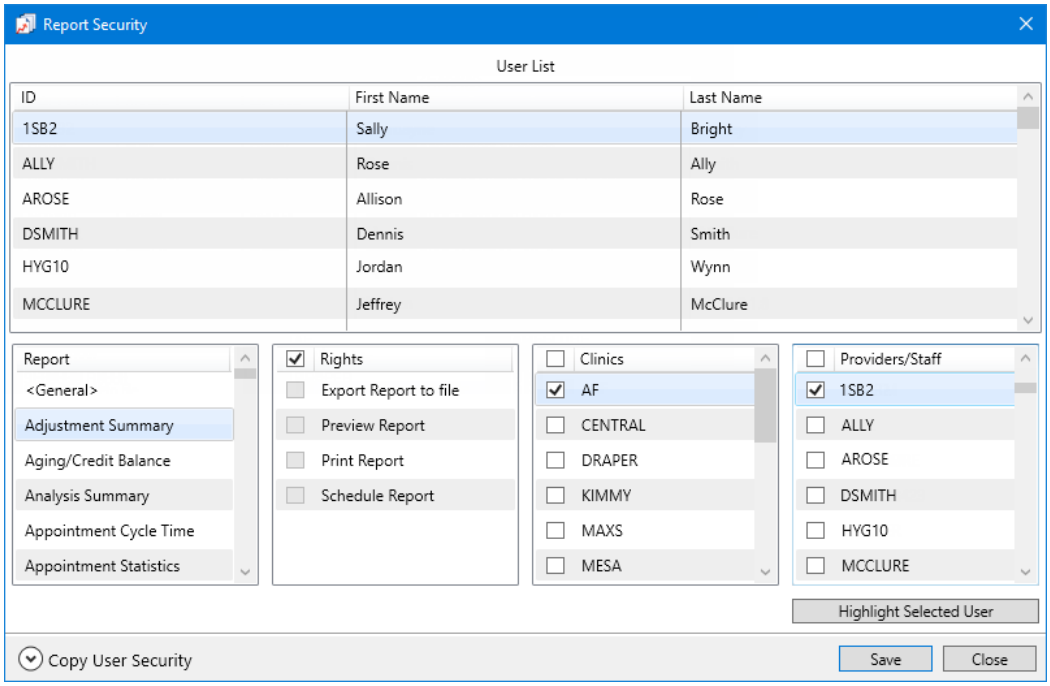
Setting Up Report Security

In DXOne Reporting, you can control which reports can be generated by which users.

To set up user rights and security for DXOne Reporting

1. In DXOne Reporting, from the menu bar, click the **Security** button .

   The **Report Security** dialog box appears.



2. Under **User List**, select a user.
3. Select the report for which you want to **Set Security**, or leave **<General>** selected to assign general rights (such as managing scheduled jobs and selecting clinics) for the selected user.
4. Set up the following options:
   - **Rights** – Select the rights that correspond to the tasks that the user can do, or select the check box at the top of the list to select all the rights.

     Tip: If you have multiple employees with the same level of security, click **Copy User Security** to select the user from which you want to copy settings.

   - **Clinics** – Select the clinics for which the user can generate reports, or select the check box at the top of the list to select all clinics.
   - **Provider/Staff** – Select the providers and staff members for whom the user can generate reports, or select the check box at the top of the list to select all providers/staff members

     Tip: To select the user selected under **User List,** click **Highlight Selected User**.

5. Click **Save**.

   If necessary, repeat steps 3–5 for each report the selected user will have access to. Then, repeat steps 2–5 for each user.

6. Click **Close**.

Generating DXOne Reporting Reports

The reports in the DXOne Reporting window are grouped into the following categories:

- Reference Reports
- Management Reports
- Ledger Reports
- Analysis Reports
- List Reports
- Audit Reports
- UDS Reports
- Custom Reports

The sections that follow provide a description of each available report. For a comprehensive explanation of all the options for running these reports see the "Generating DXOne Reporting reports" topic and its subtopics in the Dentrix Enterprise Help. Also, to see samples of and read an explanation of what appears on each report, refer to the *Dentrix Enterprise Reports Reference*.

Reference Reports

In DXOne Reporting, select **Reference**, and then double-click a reference report:

- **Employers and Employed Patients Report** – The Employers and Employed Patients Report is a list of all employers, including name, address, and phone number. You may also select to include employed patients with each employer.
- **Fee Schedule Report** – The Fee Schedule Report is a list of procedure codes and the associated fees. Lab and material expenses associated with each procedure are also included.
- **Insurance Carrier List** – The Insurance Carrier List is a list of carrier names, addresses, phone numbers, contact names, and all related insurance information. You can also include the insured subscribers for each insurance plan.
- **Patient Health Assessment Report** – The Patient Health Assessment Report displays health information entered for a range of patients in specified clinics. The blood pressure, pulse rate, age, height, weight, and body mass index (BMI) of each patient appears on the report.
- **Practice Organization List** – The Practice Organization List is a list of the primary and secondary providers and staff members that have been set up for your practice. The report includes the corresponding provider or staff information.
- **Provider IDs List** – The Provider IDs List is a report of providers and relevant information.
- **RVU Schedule Report** – The RVU Schedule is a list of the procedure codes and the associated RVU fees. Lab and material expenses associated with each procedure are also included.

Management Reports

In DXOne Reporting, select **Management**, and then double-click a management report:

- **Analysis Summary Report** – The Analysis Summary Report displays the transaction totals that are normally shown at the bottom of a day sheet, by provider, or by date, for a specific provider and date range.
- **Appointment Cycle Time Report** – The Appointment Cycle Time Report helps you analyze changes in appointments' statuses. The report provides statistics regarding how long patients wait to be treated and how long they spend in treatment.
- **Appointment Statistics Report** – The Appointment Statistics Report provides an overview of the productivity and efficiency of your practice regarding patient visits. This report displays statistics for late appointments, on-time appointments, wait/will call appointments, broken appointments, appointments that remained in specified statuses for a specified length of time, and appointment durations based on specified statuses.
- **Assigned Rights Report** – The Assigned Rights Report lists the current security rights assigned to each selected user and clinic.
- **Daily Summary Report** – The Daily Summary Report displays statistics for new guarantors, new patients, patients seen, appointments made, production, collections, and adjustments.
- **Day sheet** – The day sheet lists all transactions for the day (alphabetically or chronologically), according to the providers and billing types selected.
- **Day sheet - adjustments** – The day sheet - adjustments lists all adjustment transactions for the day.
- **Day sheet - deposit slip** – The day sheet - deposit slip lists all payment transactions for the day in a format suitable for a bank deposit slip.
- **Day sheet - receipts** – The day sheet - receipts report lists all payment transactions for the day.
- **Day sheet by operator** – The operator day sheet lists financial transactions (charges, payments, and adjustments) that have been posted and displays some patient and practice statistics.
- **Dental Encounters Report** – The Dental Encounters Report lists procedures posted during a specified date range (each procedure must be attached to a claim to appear on the report), along with the amount that is expected to be paid by insurance. For each procedure, the date of service, name of the patient who received treatment, the subscriber ID (Beneficiary ID) of the subscriber of the patient's insurance plan, and the appropriate NPI numbers are shown.
- **Finance / Late Charge Report** – The Finance / Late Charge Report lists accounts that received finance or late charges, according to the parameters set. The report lists the date of the charge, guarantor's name, amount of the charge, billing type, and guarantor's primary provider. A total of finance and late charges are calculated and listed at the bottom of the report.
- **Insurance Carrier Production Report** – The Insurance Carrier Production Report lists insurance plans' production amounts, payments, and adjustments. The report can also include details about each procedure and insurance plan totals. The summary report and the full report will give you grand totals.
- **Practice Statistics Report** – The Practice Statistics Report provides a detailed cross-section of the practice's patient base, including demographic, age, and continuing care information.
- **Provider Accounts Receivable Totals Report** – The Provider A/R Totals Report lists each provider's accounts receivables totals for a date range or lists a daily total for each day in the range. Suspended credits are not included on this report except when **Initial Provider** is selected under **Group By**; in which case, the full credit is always shown.

- **Referred By Doctor/Other Report** – The Referred By Doctor/Other Report lists each referring doctor or non-person referral source (for example, an advertisement) that has referred a patient to your practice within a specified date range. For each referring doctor/other listed, a list of referred patients is included with patient information and details regarding production generated by the referral. You can also print mailing labels for each referral source.
- **Referred By Patient Report** – The Referred By Patient Report lists each patient who has referred another patient to your practice within a specified date range. For each referring patient listed, there is a list of patients that have been referred, including production details resulting from that referral. You can also print mailing labels for each referral source.
- **Referred To Doctor Report** – The Referred To Doctor Report lists the number of patients who have been referred to another practice during a specified time period. Depending on report settings, this report also lists the name and referral date of each referred patient. The statistics and patients on the report are grouped by referral. You can also create mailing labels for those doctors to whom your patients have been referred.
- **RVU day sheet** – The RVU day sheet is a list of RVU production items. The report also displays the total RVU and net RVU.
- **RVU Production Summary Report** – The RVU Production Summary Report is a summary of RVU production. The report also displays the Quantity, Total, Average, Percent, and Net RVU.
- **RVU Utilization Report** – The RVU Utilization Report lists insurance carriers and, for each carrier, the relevant RVU production items along with details about the procedure.

Ledger Reports

In DXOne Reporting, select **Ledger**, and then double-click a ledger:

- **Aging / Credit Balance Report** – The Aging/Credit Balance Report displays the guarantor's name, phone number, billing type, last payment amount, last statement date, agreed payment amount and balances per aging period, insurance estimates, guarantor portion, and total account balance or credit. The report also provides totals and payments for each amount.
- **Insurance Claim Aging Report** – The Insurance Claim Aging Report displays each insurance carrier with outstanding claims, including the insurance plan name, group plan name, insurance phone number, and group number, and each outstanding insurance claim.

  The insurance claim information will include a notation of primary or secondary, the date the claim was sent, the date a tracer was sent, the date the claim was placed on hold, the date the claim was re-sent, the patient name, patient birthday, the subscriber name, subscriber ID number, the estimated insurance payment, and the amount billed to insurance. The amount billed to insurance will be placed in the current, 31 – 60, 61 – 90, or > 180 column, based on how long ago the claim was sent and whether the **Age Insurance Estimate instead of Total Billed figure** check box is selected. The primary and secondary claim amounts will each be totaled and printed, and a combined total will appear at the bottom of the report.
- **Insurance Claims Not Sent Report** – The Insurance Claims Not Sent Report shows all insurance claims that have been created in the Ledger but not sent to the Batch Processor, printed, or sent electronically. This report includes the range of patients, providers, and carriers to be included. The report includes the claim date, type of claim (primary or secondary) patient name, insurance company name, claim amount and expiration date. A total of the amounts for primary claims and secondary claims and a combined total prints at the end of the report.
- **Pre-Estimate Aging Report** – The Pre-Estimate Aging Report shows when pre-treatment estimates were sent to insurance carriers. You can specify the range of patients, providers, and carriers to be included.

- **Pre-Estimates Not Sent Report** – The Pre-Estimates Not Sent Report lists pre-estimates that have been created in the Ledger but not sent to the Batch Processor, printed, or sent electronically. This report includes the range of patients, providers, and carriers you specify. The report includes the claim date, type (primary/secondary), patient name, insurance company name, amount, and expiration date. A total amounts for primary and secondary claims and a combined total appear at the end of the report.
- **Procedures Not Attached To Insurance Report** – The Procedures Not Attached To Insurance Report shows insured patients with completed procedures that have not had an insurance claim created from the Ledger. This report includes the range of patients and providers you specify. The report includes the patient name, each procedure with the date of the procedure, tooth number, procedure code and description, amount, and claim expiration date. The total amount of unattached procedures is calculated for each patient. A grand total is provided, as well.
- **Provider Revenue Report** – The Provider Revenue Report lists credits allocated to charges that have been posted to each provider.
- **Secondary Insurance Claims Not Created Report** – The Secondary Insurance Claims Not Created Report creates a list of primary insurance claims for patients with secondary insurance claims that have not yet been created. The report includes the primary claim date, patient name, secondary insurance company, claim account, and date the primary claim expires. The report is sorted by the expiration date and indicates the total of the claims accounts.

  When primary insurance claims are evaluated for this report, they are only included if the patient had secondary insurance in the Family File at the time the primary insurance claim was created, and no secondary insurance claim was created.
- **Secondary Pre-Treatment Estimates Not Created Report** – The Secondary Pre-Treatment Estimates Not Created Report is a list of primary pre-treatment estimates for patients with secondary pre-treatment estimates that have not yet been created. The report includes the primary pre-estimate date, patient name, secondary insurance company, claim account, and date the primary pre-treatment expires. The report is sorted by the expiration date and indicates the total of the claims accounts.
- **Suspended Credits Report** – The Suspended Credits Report lists any payments or credits that have been suspended including the guarantor of the account, date and description of the credit, amount of credit and the amount suspended, the balance on the ledger, and the collecting clinic.
- **Utilization Report** – The Utilization Report is designed for use with managed care insurance plans. The report lists all procedures that have been completed under selected insurance plans for selected date ranges. In addition, you can monitor co-payments versus the practice's regular fees.

Analysis Reports

In DXOne Reporting, select **Analysis**, and then double-click an analysis report:

- **Adjustment Summary Report** – With the Adjustment Summary Report, you can review the account adjustments applied during a date range in both a numeric and graphic format.
- **Insurance Transaction Analysis Report** – The Insurance Transaction Analysis Report displays charges (claims) and payments posted for a selected date range. Charges and payments are grouped by insurance carrier. The report can be run for dental or medical insurance and includes an itemization of claims sent within the specified range, as well as total insured charges, payments, and adjustments made for each carrier.
- **Payment Summary Report** – With the Payment Summary Report, you can review the guarantor and insurance payments applied during a date range in both a numeric and graphic format.
- **Practice Analysis Report** – The Practice Analysis Report details production and receivable information as well as financial agreements and an activity analysis of the patients in your practice.

- **Production Summary Report** – With the Production Summary Report, you can review production by procedure code categories for a date range.
- **Referral Analysis Report** – The Referral Analysis Report shows the production, number of patients, and percentage of totals associated with a particular referral and includes a breakdown by clinic. Use this report to analyze the effectiveness of your advertising dollars by running a single report.
- **Transaction Summary Report** – The Transaction Summary Report lists financial transactions (charges, payments, credit adjustments, charge adjustments, finance charges, and late charges) that have been posted to Ledger.

List Reports

In DXOne Reporting, select **Lists**, and then double-click a list report:

- **As Soon As Possible (ASAP) List** – The ASAP List shows patients that have requested an appointment as soon as possible. Select the providers and appointment date to be covered. This is useful for helping to keep the appointment list full in case of cancellations. The list includes patient's name appointment dates, time and status, provider, appointment reason, duration of appointment, and the patient's phone number.
- **Birthday List** – A Birthday List for a selected period can be printed with this report. You can select the range of patients and providers to be included and choose to print mailing labels.
- **Caries Prevalence and Periodontal Index Report** – The Caries Prevalence and Periodontal Index Report indicates, for various age ranges, how many patients have caries and how many do not, the number of patients with certain conditions, and patients' perio measurements (for example, pocket depths and loss of attachment).
- **Clinical Notes Report** – The Clinical Notes Report lists clinical notes for patients. You can also print clinical notes from the Clinical Notes window.
- **Daily Appointment List** – The Daily Appointment List displays all appointments for a selected range of dates. The report displays the following information for each appointment: date, time, status, patient's name, provider and operatory, appointment reason, and appointment length, and patient's phone number.
- **Daily Appointment List - route slip** – The route slip provides up-to-date, comprehensive information for a patient with a scheduled appointment. You can use the route slip to reference important information for a patient's visit: medical alerts, patient notes, collection information, and so on. You can generate individual route slips for each patient with an appointment within a specified date range.
- **Document Center - Documents List Report** – The Document Center - Documents List Report displays the list of documents that were acquired within a specified date range and their corresponding details. You can filter the list of documents to include documents that are associated with patients, providers/staff, referrals (inbound and outbound), insurance plans (dental and medical), and employers.
- **Initial Health History Report** – The Initial Health History Report displays the percentage of new oral health patients who have a **First Visit Date** in the Family File that is within a specified time frame and who had an initial health history entered into their electronic records during the same time frame. The Numerator and Denominator on the report are determined by the ADA and/or condition codes you specify.

  For example, you may want to track new patients who received a comprehensive oral exam (ADA code D0150)—the denominator code—and who have a history of smoking or tobacco use (a condition code; for example, 15995)—the numerator code.

- **Oral Health Education Report** – The Oral Health Education Report displays the percentage of oral health patients who received oral health education at least once during a specified time frame. The Numerator and Denominator on the report are determined by the ADA and/or condition codes you specify.

  For example, you may want to track patients who received a comprehensive oral exam (ADA code D0150) or a periodic recall oral evaluation (ADA code D0120)—the denominator codes—and then received oral hygiene instructions (ADA code D1330) or tobacco counseling (ADA code D1320)—the numerator codes.
- **Patient and Inactive Patient List** – The Patient/Inactive Patient List displays patients that have been entered into Dentrix Enterprise and information about each patient. You can filter the report to include patients with no continuing care date and no future appointments, a last visit before a specified date, and a specified status.
- **Patient Revenue List by Payer Report** – The Patient Revenue List by Payer Report displays the total amount of charges, payments, and adjustments that have been posted to a given patient's record, on a given service date or entry date, and for a given payer.
- **Periodontal Exam Report** – The Periodontal Exam Report displays the percentage of oral health patients who received a periodontal exam at least once during a specified time frame. The Numerator and Denominator on the report are determined by the ADA and/or condition codes you specify.

  For example, you may want to track patients who received a comprehensive oral exam (ADA code D0150) or a periodic recall oral evaluation (ADA code D0120)—the denominator codes—and then received a periodontal exam (ADA code D0180)—the numerator code.
- **Procedures by Contracted Amount Report** – The Procedures by Contracted Amount Report displays completed procedures (and other charges) and the payments and adjustments that are associated with those procedures (or charges). For each completed procedure, the contracted rate with the patient's insurance carrier (payer) also appears.
- **Unscheduled Appointment List** – The Unscheduled Appointment List displays appointments that have been broken or marked as wait/will call.

Audit Reports

In DXOne Reporting, select **Audit**, and then double-click an audit report:

- **Audit - Appointments Report** – The Audit - Appointments Report details changes made to appointments.
- **Audit - Audit Log Status Report** – The Audit - Audit Log Status Report lists the changes to the "patient access logging" and "patient print logging" settings during the specified date range.
- **Audit - Clinics Report** – The Audit - Clinics Report lists clinic information that has been inserted, modified, and/or deleted.
- **Audit - Combined Report** – The Audit - Combined Report lists patient information that was created, altered, deleted, viewed, printed, and exported during the specified date range.
- **Audit - Patients Report** – The Audit - Patients Report lists patient and medical consultation information that has been inserted, modified, and/or deleted.
- **Audit - Providers and Staff Report** – The Audit - Providers/Staff Report lists provider and staff information that has been inserted, modified, and/or deleted.
- **Audit - Transactions Report** – The Audit - Transaction Report lists all transaction entries that have been changed, deleted, or inserted. Appointment changes and limited patient changes are also included.

- **Audit Rights - Assigned Individually Report** – The Audit Rights - Assigned Individually Report lists any changes made to a user's assigned password rights as well as the user who made the changes.
- **Audit Rights - Assigned to Grouips** – The Audit Rights - Assigned to Groups Report lists any changes made to a user group's assigned password rights as well as the user who made the changes.
- **Audit Rights - Group Names Report** – The Audit Rights - Group Names Report lists user groups that were added, removed, and renamed as well as the user who made each change.
- **Audit Rights Users to Groups** – The Audit Rights - Users to Groups Report lists users who were added to and removed from user groups as well as the user who made each change.
- **Patient Information Accessed Report** – The Patient Information Accessed Report helps you track when any patient's record has been viewed. A patient record is considered to have been viewed in the following situations:
  - When you select a patient in the **Select Patient** dialog box and then click **OK**.
  - When you select a patient in the **Select Patient** dialog box and then click **More Patient Information**.
  - When you double-click a patient's appointment and then click **Patient Info**.
  - When you switch from one module to another (patient-specific modules only) with a patient selected. For example, if you open a patient's Patient Chart and then switch to that patient's Family File record, Dentrix Enterprise logs two entries for the report.
  - When accessing the same patient record later in the day (in the same module, at the same clinic, on the same date, and by the same user after a specified number of minutes has elapsed since the last time that patient's record was accessed).

  Each entry on the report provides the date and time when the patient information was accessed, the module from which it was accessed, the clinic from which it was accessed, the user who accessed it, and the name and chart number of the patient whose record it was.

UDS Reports

In DXOne Reporting, select **Audit**, and then double-click a UDS (Uniform Data System) report:

- **UDS – Age / Gender Report** – The UDS - Age/Gender Report lists the total of each gender for each age group.
- **UDS – Encounter and User Statistics Report** – The UDS - Encounter/User Statistics Report lists the number of encounters by provider and procedure code.
- **UDS – Insurance Financial Class Report (2012 and Prior)** – The UDS - Insurance Financial Class Report lists the total number of users per financial class type or self-pay (no insurance).
- **UDS – Insurance Financial Class Report (2013)** – The UDS - Insurance Financial Class Report (2013) lists the total number of patients who have completed procedures in their records within a specified date range.
- **UDS – Medicaid/Medicare Report** – The UDS - Medicaid/Medicare Report is a new report that displays a count of patients with Medicaid and/or Medicare and who have had a visit within the reporting period. Patients are counted on the report if they have had claims created during the reporting period for any insurance plans that have the specified financial classes attached.
- **UDS - Patient Related Revenue Report** – The UDS - Patient Related Revenue Report displays revenue totals for patients with procedures that were completed within a specified date range and for which claims have been created.

- **UDS – Patient Status Report** – The UDS - Patient Status Report displays the total the number of patients who have completed procedures within a specified date range and who have specified statuses (race, language, poverty level, worker status, homeless status, sexual orientation, homeless status, veteran status, ethnicity, religion, user-defined, housing status, and/or gender identity) attached to their Family File records. The report can also list patients on the report by ZIP Code and display patient information for the patients on the report.
- **UDS – Sealant Statistics Report** – The UDS - Sealant Statistics Report displays the percentage of children, ages 6 through 9, who are at a moderate to high risk for caries and who received a sealant on a permanent first molar during the reporting period.
- **UDS – Tobacco Use and Intervention Report** – The UDS - Tobacco Use and Intervention Report displays the percentage of patients, ages 18 and older, who received screenings and interventions for cessation of tobacco use during the reporting period.

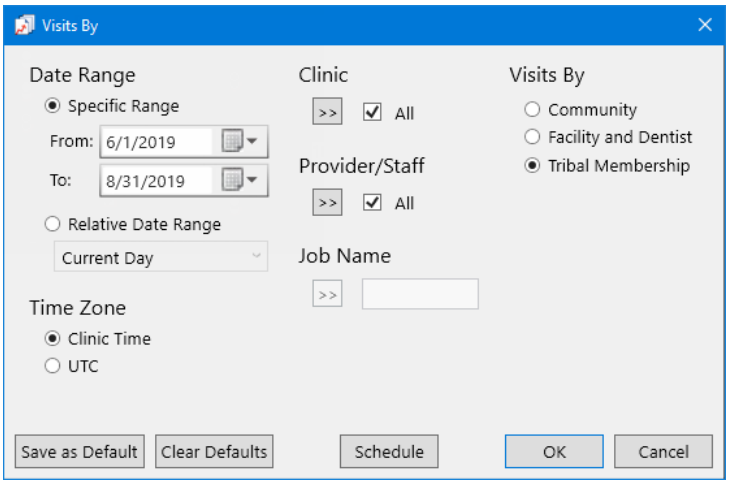
Custom Reports

In DXOne Reporting, select **Custom**, and then double-click a custom report:

- **Visits By reports** – The Visits By reports display the number of visits to an office or clinic by community, dentist and facility, and tribal membership. All the procedure(s) for a given patient on a given day in the Ledger are counted as one visit. On the report, the first visit, revisit, broken appointment, and PTC (planned treatment completed) values are calculated from the IHS condition codes and sometimes the ADA codes set up from the Office Manager.
- **RVU by Provider Report** – The RVU by Provider Report indicates, for each provider, the number of services and RVUs (Relative Value Units) at each given level. A total of all providers is also shown at the bottom of the report.
- **OHSS Report** – The OHSS Report indicates, for various age ranges, how many patients have caries and how many do not, the number of patients with certain conditions, and patients' perio measurements (for example, pocket depths and loss of attachment).
- **Dentist Activity reports** – The Dentist Activity reports display the number of patients seen by each provider and the types of treatment given. Also, the report displays the RVUs (relative value units) and RVU percentages for the treatment provided. The values on the report are calculated using the IHS custom codes and ADA codes set up from the Office Manager.
- **Dental Hygienists Activity reports** – The Dental Hygienists Activity reports display the number of patients seen by each secondary provider and the types of treatment given. Also, the report displays the RVUs (relative value units) and RVU percentages for the treatment provided. The values on the report are calculated using the IHS custom codes and ADA codes set up from the Office Manager.
- **Endodontic Tooth Access Report** – The Endodontic Tooth Access Report displays, for each provider, the number of teeth accessed, accessed and completed, accessed and extracted, accessed and restored, and accessed and crowned in a specified date range.
- **Oral Health Status Report** – The Oral Health Status (OHS) Report displays OHS survey data within a specified date range and can include patient details.
- **OHS Outcome after Appointment Report** – The OHS Outcome after Appointment Report measures changes in oral health after appointments, which may indicate the benefit or effectiveness of treatment performed. This report should be used at the Service Unit level only.
- **Oral Health Literacy Report** – The Oral Health Literacy Report displays occurrences of educational materials being provided to patients in conjuction with their appointments and a count of how many patients were involved in those occurrences. Use this report to track information regarding oral health that was provided to patients by providers at the clinical level. This report is aggregated at the service level only and will be used by Administrators or the Health Promotion Disease Prevention (HPDP) specialist at the service unit level.
- **Dental Procedure & Finance Report** – The Dental Procedure & Finance Report displays the details of transactions within a specified date range. The details of the transactions on the report appear in a format that you can easily export to a spreadsheet program.
- **Medicaid Cost Report** – The Medicaid Cost Report displays cost information (charges, adjustments, and net insurance payments) regarding procedures billed to insurance carriers that you may be able to submit to Medicaid. The report displays procedures that are associated only with dental claims.

The sections that follow explain in more detail how to run some of these custom reports.

Visits By reports



1. Click the **Job Name** search button >> if you want to select a job name from a list of available jobs and templates to apply the corresponding settings. You can leave the settings that are applied or change any of them as needed.
2. Set up the following options:
   - **Date Range** – Select **Specific Range**, and then enter a date range in the **From** and **To** fields; or select **Relative Date Range**, and then select a date range. The report uses the procedure date of Ledger transactions.

     Note: Using a relative date range is ideal when saving your report settings as default. Then, you don't have to manually enter a date range each time you run the report.

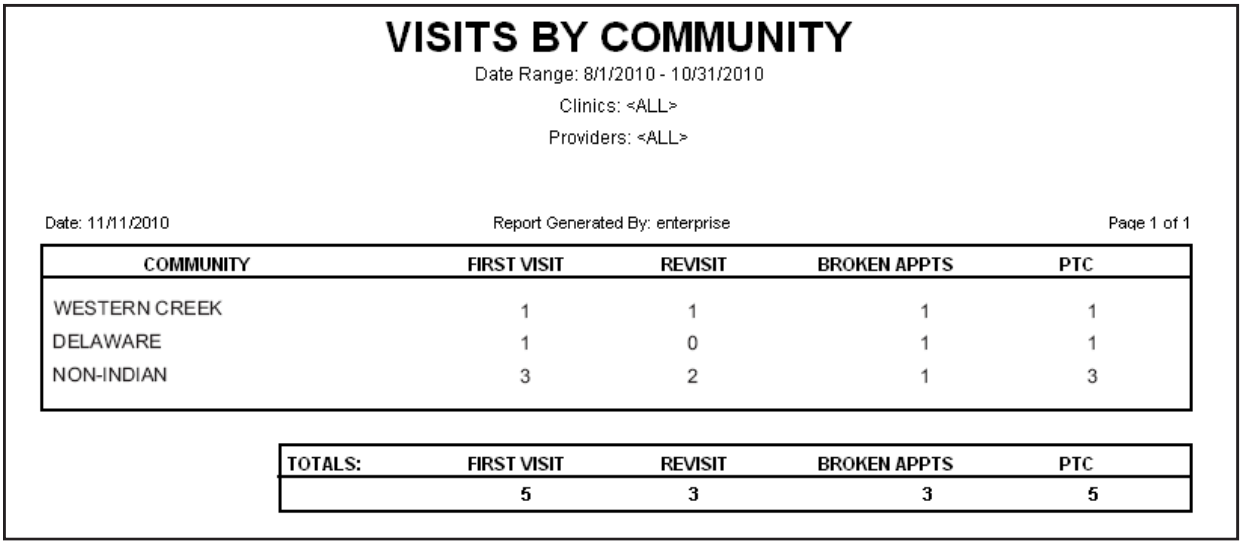
   - **Time Zone** – Select either **Clinic Time** to use the clinic time zone or **UTC** to use Coordinated Universal Time.
   - **Clinic** – Click the search button >> to select the clinics you want to include on the report, or select **All** to include all clinics.
   - **Provider/Staff** – Click the search >> button to select the providers and staff you want to include on the report, or select **All** to include all providers and staff.
3. Select how you want to run the report:
   - **Community** – The report will include visits by patients according to the community entered in the **Current Community** field of the **Addtional Info** dialog box, which can be opened by clicking the **Additional Info** button in the Family File.

     The communities will be listed on the report alphabetically; visits for patients without a community entered in the Family File will be given as well.
   - **Facility and Dentist** – The report will include visits by patients according to the provider and clinic assigned to a procedure in the Ledger.

     The dentists and clinics will be listed on the report alphabetically.
   - **Tribal Mambership** – The report will include visits by patients according to the tribe entered in the **Tribe of Membership** field of the **Addtional Info** dialog box, which can be opened by clicking the **Additional Info** button in the Family File.

     The tribes will be listed on the report alphabetically; visits for patients without a tribe entered in the Family File will be given as well.

4. Do any of the following:
   - To save these settings for future uses of this report, click **Save as Default**.
   - To schedule the report to run at a later time or on a recurring basis, click **Schedule**.
   - To clear any changes you have made to the settings and start over, click **Clear Defaults**.
5. Click **OK** to preview the report.



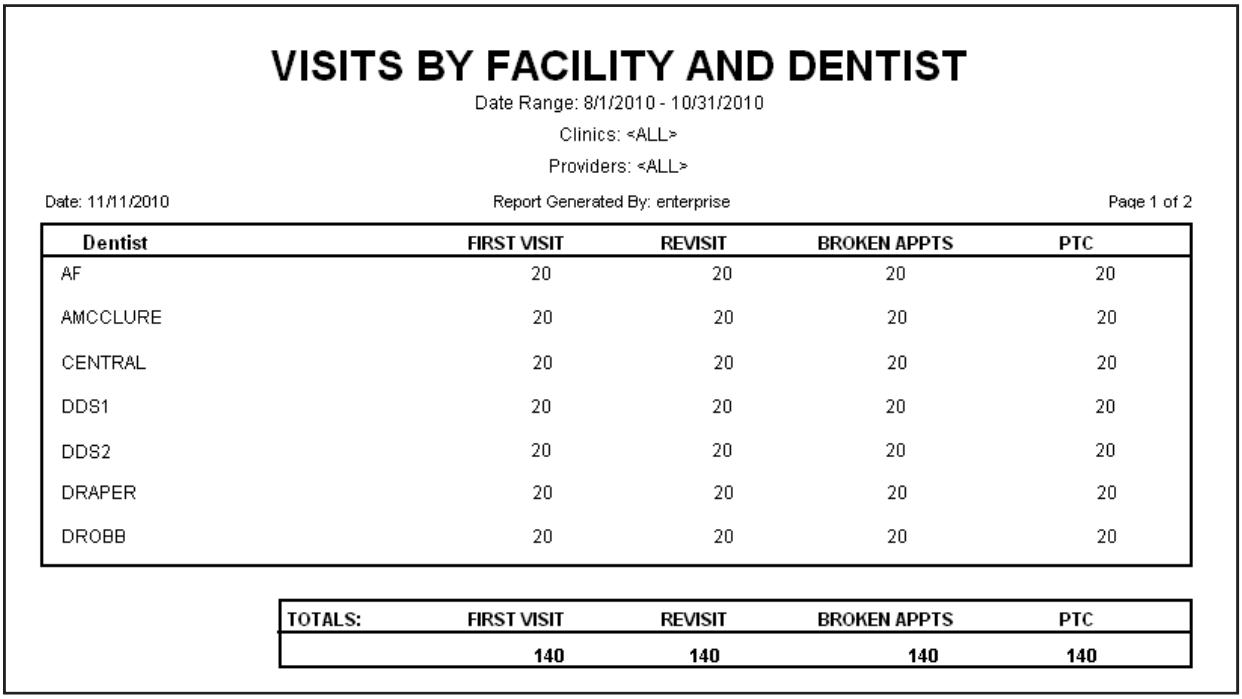
VISITS BY COMMUNITY

Date Range: 8/1/2010 - 10/31/2010
Clinics: <ALL>
Providers: <ALL>

Date: 11/11/2010 Report Generated By: enterprise Page 1 of 1

COMMUNITY	FIRST VISIT	REVISIT	BROKEN APPTS	PTC
WESTERN CREEK	1	1	1	1
DELAWARE	1	0	1	1
NON-INDIAN	3	2	1	3

TOTALS:	FIRST VISIT	REVISIT	BROKEN APPTS	PTC
	5	3	3	5



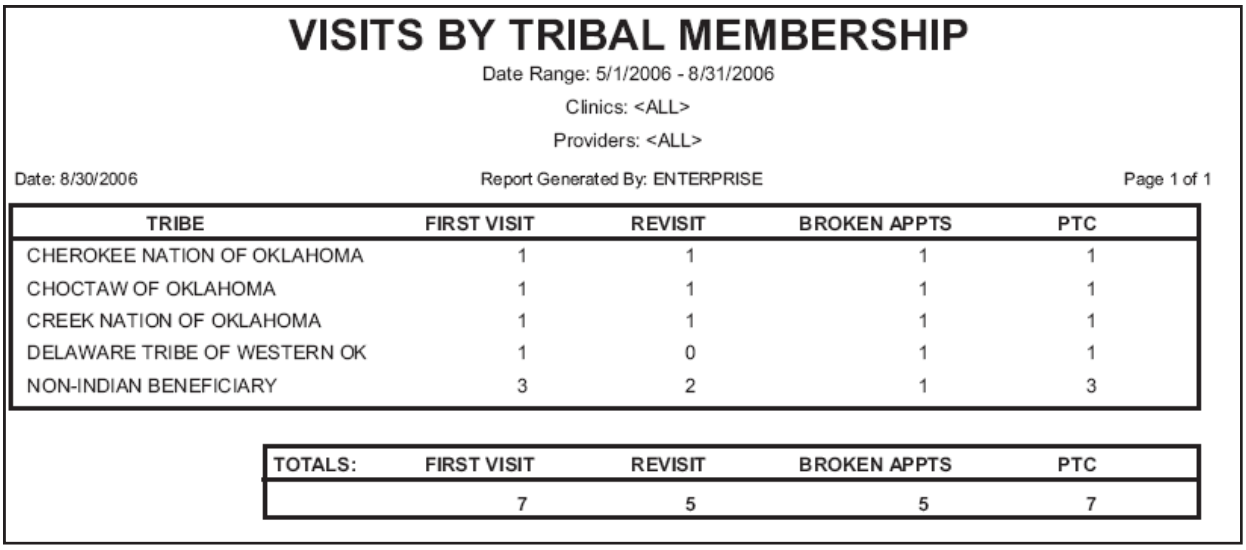
VISITS BY FACILITY AND DENTIST

Date Range: 8/1/2010 - 10/31/2010
Clinics: <ALL>
Providers: <ALL>

Date: 11/11/2010 Report Generated By: enterprise Page 1 of 2

Dentist	FIRST VISIT	REVISIT	BROKEN APPTS	PTC
AF	20	20	20	20
AMCCLURE	20	20	20	20
CENTRAL	20	20	20	20
DDS1	20	20	20	20
DDS2	20	20	20	20
DRAPER	20	20	20	20
DROBB	20	20	20	20

TOTALS:	FIRST VISIT	REVISIT	BROKEN APPTS	PTC
	140	140	140	140



VISITS BY TRIBAL MEMBERSHIP

Date Range: 5/1/2006 - 8/31/2006

Clinics: <ALL>

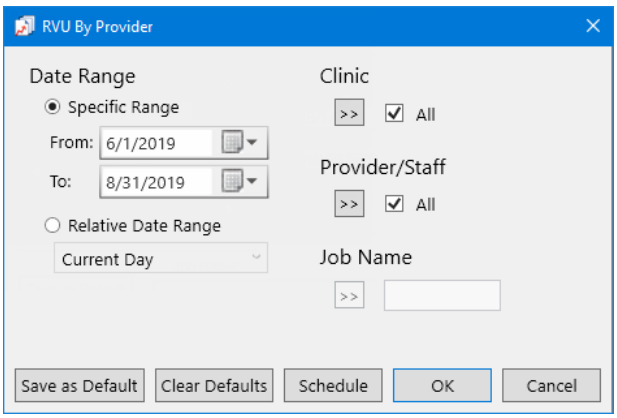
Providers: <ALL>

Date: 8/30/2006 Report Generated By: ENTERPRISE Page 1 of 1

TRIBE	FIRST VISIT	REVISIT	BROKEN APPTS	PTC
CHEROKEE NATION OF OKLAHOMA	1	1	1	1
CHOCTAW OF OKLAHOMA	1	1	1	1
CREEK NATION OF OKLAHOMA	1	1	1	1
DELAWARE TRIBE OF WESTERN OK	1	0	1	1
NON-INDIAN BENEFICIARY	3	2	1	3

TOTALS:	FIRST VISIT	REVISIT	BROKEN APPTS	PTC
	7	5	5	7

RVU by Provider Report



1. Click the **Job Name** search button >> to select a job name from a list of available jobs and templates to apply the corresponding settings. You can leave the settings that are applied or change any of them as needed.
2. Set up the following options:
   - **Date Range** – Select **Specific Range**, and then enter a date range in the **From** and **To** fields; or select **Relative Date Range**, and then select a date range. The report uses the procedure date of Ledger transactions.

     Note: Using a relative date range is ideal when saving your report settings as default. Then, you don't have to manually enter a date range each time you run the report.

   - **Clinic** – Click the search button >> to select the clinics you want to include on the report, or select **All** to include all clinics.
   - **Provider/Staff** – Click the search >> button to select the providers and staff you want to include on the report, or select **All** to include all providers and staff.
3. Do any of the following:
   - To save these settings for future uses of this report, click **Save as Default**.
   - To schedule the report to run at a later time or on a recurring basis, click **Schedule**.

- To clear any changes you have made to the settings and start over, click **Clear Defaults**.

4. Click **OK** to preview the report.

RELATIVE VALUE UNITS BY PROVIDER

Date Range: 8/1/2010 - 10/31/2010
Clinics: <ALL>
Providers: <ALL>

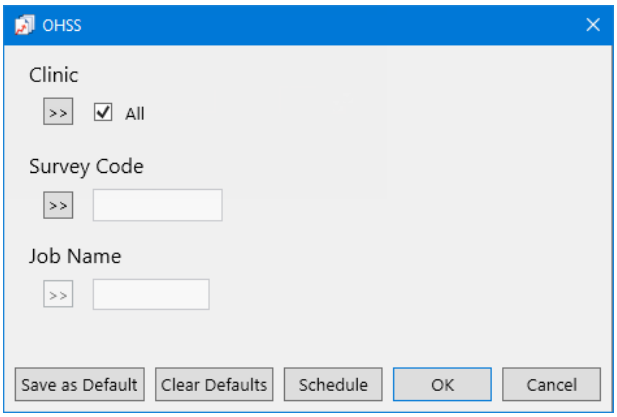
Date: 11/11/2010 Report Generated By: enterprise Page 1 of 3

Brown, Mary D. D.D.S. (DDS2)	SERVICES	RVU's
LEVEL 0:	30	0
LEVEL 1:	47	376
LEVEL 2:	44	868
LEVEL 3:	25	384
LEVEL 4:	0	0
LEVEL 5:	0	0
LEVEL 9:	0	0
TOTAL LEVEL 1-5:	**116**	**1628**

Hayes, Sally H. Hygienist (HYG1)	SERVICES	RVU's
LEVEL 0:	40	0
LEVEL 1:	35	412
LEVEL 2:	59	1544
LEVEL 3:	26	356
LEVEL 4:	0	0
LEVEL 5:	0	0
LEVEL 9:	0	0
TOTAL LEVEL 1-5:	**120**	**2312**

TOTALS:	SERVICES	RVU's
LEVEL 0:	70	0
LEVEL 1:	82	788
LEVEL 2:	103	2412
LEVEL 3:	51	740
LEVEL 4:	0	0
LEVEL 5:	0	0
LEVEL 9:	0	0
TOTAL LEVEL 1-5:	236	3940

OHSS Report



1. Click the **Job Name** search button >> if you want to select a job name from a list of available jobs and templates to apply the corresponding settings. You can leave the settings that are applied or change any of them as needed.
2. Set up the following options:
   - **Clinic** – Click the search button >> to select the clinics you want to include on the report, or select **All** to include all clinics.
   - **Survey Code** – Click the search >> button to select a survey code. These codes are supplied by the Department of Health (DOH).
3. Do any of the following:
   - To save these settings for future uses of this report, click **Save as Default**.
   - To schedule the report to run at a later time or on a recurring basis, click **Schedule**.
   - To clear any changes you have made to the settings and start over, click **Clear Defaults**.
4. Click **OK** to preview the report.

This report prints on three pages with statistics for five age groups:

- The age group 2 - 5 years is on the first page.
- The age groups 6 - 14 years and 15 - 19 years are on the second page.
- The age groups 35 - 44 years and 55 years and older are on the third page.

Be familiar with the following terms before reading this report:

- **Caries Free** – No decayed, missing, or filled teeth
- **CPITN** – Community Periodontal Index of Treatment Needs
- **Dmfs** – Decayed, missing, or filled surfaces on primary teeth
- **DMFS** – Decayed, missing, or filled surfaces on permanent teeth
- **Dmft** – Decayed, missing, or filled primary teeth
- **DMFT** – Decayed, missing, or filled permanent teeth
- **Dentate** – Having teeth (i.e. a patient who does not have a full set of dentures)
- **Fluorosis** – An abnormal condition of the tooth enamel caused by excessive exposure to fluoride

Notes:

- The report considers a condition in its calculations only if that condition is marked as existing, existing other, or completed. Invalidated conditions are not considered.

- The reports is based on the procedure date.
- The report considers a patient in its calculations only if that patient has a valid survey code posted on the same date. Age group counts are based on patients that have a valid survey code posted.

Preschool children (2-5 years)

Preschool children (2-5 years):

dmfs / dmft	20 / 12
Mean dmfs for Max. Incisors & Posterior teeth	133.33
Percent with history of decay on...	
anterior teeth	66.67%
posterior teeth	66.67%
both anterior and posterior teeth	66.67%
Percent with caries history on >= 1 maxillary incisors	33.33%
Percent with caries history on >= 2 maxillary incisors	0.00%
Percent with caries history on >= 1 maxillary incisors or dmft >= 6	66.67%
Percent with dmfs > 0	
maxillary incisor decay only	66.67%
posterior decay only	66.67%
both posterior and incisor decay	66.67%
Percent caries free children by individual ages and age cohorts	
2 Years:	50.00%
3 Years:	0.00%
4 Years:	0.00%
5 Years:	0.00%
2-4 Years:	50.00%
3-5 Years:	0.00%
2-5 Years:	50.00%

- **dmfs** – The sum of the following:
  - The total number of primary tooth surfaces with one or more untreated caries conditions (15104, 15105, 15106, 15107) for every patient in this age group.
  - The total number of primary tooth surfaces with a restorative code posted for that tooth (D1352, D2000 – D4276, D4910, D4999, D6000 – D6079, D6100, D6199 – D7259, D7999) for every patient in this age group.

    The maximum number of filled surfaces per tooth for codes D2930, D2932, D2933, D2934 are as follows: 4 surfaces for anterior teeth (c – h, m – r), and 5 surfaces for posterior teeth (a,b,i,j,k,l,s,t).
  - The total number of primary tooth surfaces that have missing teeth conditions (15100, 15101, 15204 – 15211) or extraction codes (D7111 – D7250) for every patient in this age group.

    The maximum number of surfaces per tooth for missing teeth and extractions are as follows: 4 surfaces for anterior deciduous teeth (c – h, m – r), and 5 surfaces for posterior deciduous teeth (a,b,i,j,k,l,s,t).

  Each patient, tooth, and surface combination is counted only once.
- **dmft** – The sum of the following:
  - The total number of primary teeth with one or more untreated caries conditions (15104, 15105, 15106, 15107) for every patient in this age group.
  - The total number of primary teeth with a restorative code posted for that tooth (D1352, D2000 – D4276, D4910, D4999, D6000 – D6079, D6100, D6199 – D7259, D7999) for every patient in this age group.
  - The total number of primary teeth that have missing teeth conditions (15100, 15101, 15204 – 15211) or extraction codes (D7111 – D7250) for every patient in this age group.

  Each patient and tooth combination is counted only once. If a particular patient has both a caries code as well as a restorative code for the same tooth, the caries code takes precedence.

- **Mean dmfs for Max. Incisors & Posterior teeth** – The dmfs of primary maxillary incisors (c – h) and primary posterior teeth (a, b, i, j, k, l, s, t) for all patients in this age group divided by the number of patients in this age group. A surface with an untreated caries code that has been fixed later is counted only once. An untreated caries is a surface with an untreated caries code that has not had either a procedure that covers the same surface posted after the caries code was
- **Percent with history of decay on anterior and posterior teeth and both**
  - **History of decay on anterior teeth** – The total number of patients with a caries code (15104, 15105, 15106, or 15107), a missing due to caries code (15204), or restorative code (D1352, D2000 – D4276, D4910, D4999, D6000 – D6079, D6100, D6199 – D7259, D7999) on any primary anterior tooth (c – h, m – r) divided by the total number of patients in this age group.

    Each patient is counted only once.
  - **History of decay on posterior teeth** – The total number of patients with a caries code (15104, 15105, 15106, or 15107), a missing due to caries code (15204), or restorative code (D1352, D2000 – D4276, D4910, D4999, D6000 – D6079, D6100, D6199 – D7259, D7999) on any primary posterior tooth (a, b, i, j, k, l, s, t) divided by the total number of patients in this age group.

    Each patient is counted only once.
  - **History of decay on both anterior and posterior teeth** – The total number of patients with a caries code (15104, 15105, 15106, or 15107), a missing due to caries code (15204), or restorative code (D1352, D2000 – D4276, D4910, D4999, D6000 – D6079, D6100, D6199 – D7259, D7999) on any primary anterior tooth (c – h, m – r) and on any primary posterior tooth (a, b, i, j, k, l, s, t) divided by the total number of patients in this age group.

    Each patient is counted only once.
- **Percent with caries history on ≥ 1 maxillary incisors** – The total number of patients with a caries code (15104, 15105, 15106, or 15107), a missing due to caries code (15204), or restorative code (D1352, D2000 – D4276, D4910, D4999, D6000 – D6079, D6100, D6199 – D7259, D7999) on one or more primary maxillary incisors (c – h) divided by the total number of patients in this age group.

  Each patient is counted only once.
- **Percent with caries history on ≥ 2 maxillary incisors** – The total number of patients with a caries code (15104, 15105, 15106, or 15107), a missing due to caries code (15204), or restorative code (D1352, D2000 – D4276, D4910, D4999, D6000 – D6079, D6100, D6199 – D7259, D7999) on two or more primary maxillary incisors (c – h) divided by the total number of patients in this age group.
- **Percent with caries history on ≥ 1 maxillary incisors OR dmft ≥ 6 (severe ECC)** – The total number of patients with either of the following: a caries code (15104, 15105, 15106, or 15107), a missing due to caries code (15204), or restorative code (D1352, D2000 – D4276, D4910, D4999, D6000 – D6079, D6100, D6199 – D7259, D7999) on primary maxillary incisors; or a dmft ≥ 6 divided by the total number of patients in this age group.

  Each patient is counted only once.
- **Percent caries free children by individual ages and age cohorts** – For each age group (2, 3, 4, 5, 2 – 4, 3 – 5, 2 – 5), the total number of patients without caries conditions (15104, 15105, 15106, 15107), restorative codes (D1352, D2000 – D4276, D4910, D4999, D6000 – D6079, D6100, D6199 – D7259, D7999), missing teeth conditions (15100, 15101, 15204-15211) or extraction codes (D7111-D7250) posted on any primary teeth.

- **Percent with dmfs > 0**
  - **Maxillary incisor decay only** – The total number of patients with a caries code (15104, 15105, 15106, or 15107) on any primary maxillary incisor (c – h) divided by the number of patients in this age group.

    Each patient is counted only once.
  - **Posterior decay only** – The total number of patients with a caries code (15104, 15105, 15106, or 15107) on any primary posterior tooth (a, b, i, j, k, l, s, t) divided by the number of patients in this age group.

    Each patient is counted only once.
  - **Posterior and incisor decay** – The total number of patients with a caries code (15104, 15105, 15106, or 15107) on any primary posterior tooth (a,b,i,j,k,l,s,t) or primary maxillary incisor (c – h, m – r).

    Each patient is counted only once.

Ages 6-14 Years

Ages 6-14 Years:

	<----Percent Caries Free---->		<----Percent with---->									
	Prim & Perm Teeth	Perm Teeth Only	Untreated Decay Prim & Perm teeth	Untreated Decay Perm teeth	Using Tobacco	Dental Fluorosis	Sealants	Sealants 1st Molar	Sealants 2nd molar	Sealants 1st or 2nd Molar	Mean # of sealed teeth	Mean dmft / DMFT
6 Years:	0.00	0.00	100.00	100.00	0.00	100.00	100.00	100.00	100.00	100.00	1.00	0.00 / 8.00
7 Years:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00 / 0.00
8 Years:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00 / 0.00
9 Years:	100.00	100.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00 / 0.00
10 Years:	0.00	0.00	100.00	100.00	0.00	100.00	100.00	100.00	100.00	100.00	1.00	0.00 / 2.00
11 Years:	100.00	100.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00 / 0.00
12 Years:	100.00	100.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00 / 0.00
13 Years:	100.00	100.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00 / 0.00
14 Years:	100.00	100.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00 / 0.00
6-8 Years:	0.00	0.00	100.00	100.00	0.00	100.00	100.00	100.00	100.00	100.00	1.00	0.00 / 8.00
9-11 Years:	80.00	80.00	20.00	20.00	0.00	20.00	20.00	20.00	20.00	20.00	0.20	0.00 / 0.40
12-14 Years:	100.00	100.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00 / 0.00
6-14 Years:	86.67	86.67	13.33	13.33	46.67	13.33	13.33	13.33	13.33	13.33	0.13	0.00 / 0.67

- **Percent Caries Free** – For each age or age group (6, 7, 8, 9 , 10, 11, 12, 13, 14, 6 – 8, 9 – 11, 12 – 14, 6 – 14), the following percentages appear:
  - **Primary & Permanent Teeth** – The total number of patients without caries conditions (15104, 15105, 15106, 15107), restorative codes (D1352, D2000 – D4276, D4910, D4999, D6000 – D6079, D6100, D6199 – D7259, D7999), missing teeth conditions (15100, 15101, 15204-15211) or extraction codes (D7111-D7250) posted on any primary (a – t) and permanent teeth (2 – 15, 18 – 31) divided by the number of patients in the age group.

    Each patient is counted only once.
  - **Permanent Teeth Only** – The total number of patients without caries conditions (15104, 15105, 15106, 15107), restorative codes (D1352, D2000 – D4276, D4910, D4999, D6000 – D6079, D6100, D6199 – D7259, D7999), missing teeth conditions (15100, 15101, 15204-15211) or extraction codes (D7111-D7250) posted on any permanent teeth (2 – 15, 18 – 31) divided by the number of patients in the age group.

    Each patient is counted only once.

- **Percent with** – For each age or age group (6, 7, 8, 9 , 10, 11, 12, 13, 14, 6 – 8, 9 – 11, 12 – 14, 6 – 14), the following percentages appear:
  - **Untreated Decay Primary & Permanent Teeth** – The total number of patients that have a caries condition (15104, 15105, 15106, 15107) but not a restorative code (D1352, D2000 – D4276, D4910, D4999, D6000 – D6079, D6100, D6199 – D7259, D7999) posted on the same tooth for both for primary and permanent teeth in the age group divided by the number of patients in the age group.

    Each patient is counted only once.
  - **Untreated Decay Permanent Teeth** – The total number of patients with a caries condition (15104, 15105, 15106, 15107) but not a restorative code (D1352, D2000 – D4276, D4910, D4999, D6000 – D6079, D6100, D6199 – D7259, D7999) posted on the same tooth for permanent teeth in the age group divided by the number of patients in the age group.

    Each patient is counted only once.
  - **Using Tobacco** – The total number of patients with a condition code 15203 Tobacco Use in the age group divided by the total number of patients in the age group.

    Each patient is counted only once.
  - **Dental Fluorosis** – The total number of patients with a condition code 15200 Dental Fluorosis in the age group divided by the total number of patients in the age group.

    Each patient is counted only once.
  - **Sealants** – The total number of patients with a sealant code (D1351) divided by the number of patients in the age group.

    Each patient is counted only once.
  - **Sealants on 1st Molars** – The number of patients with a sealant code (D1351) on tooth numbers 3, 14, 19, or 30 in the age group divided by the total number of patients in the age group.

    Each patient is counted only once.
  - **Sealants on 2nd Molars** – The total number of patients with a sealant code (D1351) on tooth numbers 2, 15, 18, or 31 in the age group divided by the total number of patients in the age group.

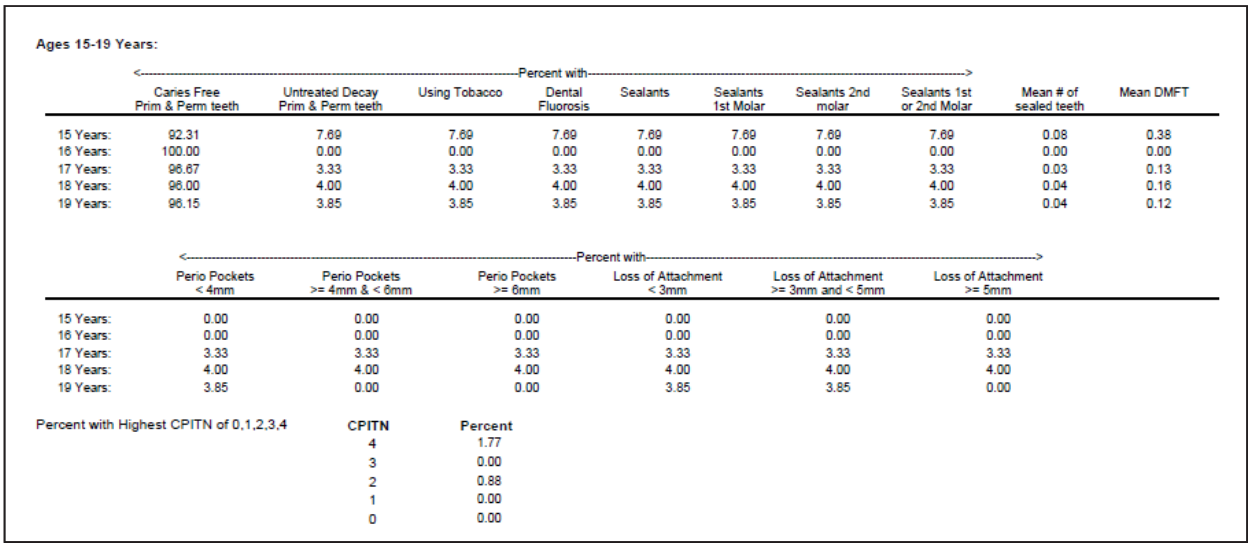
    Each patient is counted only once.
  - **Percent with Sealants 1st or 2nd Molars** – The total number of patients with a sealant code (D1351) on tooth numbers 2, 3, 14, 15, 18, 19, 30, or 31 in the age group divided by the total number of patients in the age group.

    Each patient is counted only once.
  - **Mean Number of Sealed Teeth** – The total number of teeth with a sealant code (D1351) for patients in the age group divided by the total number of patients in that age group.

    Each patient is counted only once.
  - **Mean dmft/DMFT** – The dmft/DMFT of primary/permanent teeth for all patients in the age group divided by the total number of patients in the age group.

    Each patient and tooth combination is counted only once. If a particular patient has both a caries code as well as a restorative code for the same tooth, the caries code takes precedence.

Ages 15-19 Years



Ages 15-19 Years:

	Percent with									
	Caries Free Prim & Perm teeth	Untreated Decay Prim & Perm teeth	Using Tobacco	Dental Fluorosis	Sealants	Sealants 1st Molar	Sealants 2nd molar	Sealants 1st or 2nd Molar	Mean # of sealed teeth	Mean DMFT
15 Years:	92.31	7.69	7.69	7.69	7.69	7.69	7.69	7.69	0.08	0.38
16 Years:	100.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
17 Years:	96.67	3.33	3.33	3.33	3.33	3.33	3.33	3.33	0.03	0.13
18 Years:	96.00	4.00	4.00	4.00	4.00	4.00	4.00	4.00	0.04	0.16
19 Years:	96.15	3.85	3.85	3.85	3.85	3.85	3.85	3.85	0.04	0.12

	Percent with					
	Perio Pockets < 4mm	Perio Pockets >= 4mm & < 6mm	Perio Pockets >= 6mm	Loss of Attachment < 3mm	Loss of Attachment >= 3mm and < 5mm	Loss of Attachment >= 5mm
15 Years:	0.00	0.00	0.00	0.00	0.00	0.00
16 Years:	0.00	0.00	0.00	0.00	0.00	0.00
17 Years:	3.33	3.33	3.33	3.33	3.33	3.33
18 Years:	4.00	4.00	4.00	4.00	4.00	4.00
19 Years:	3.85	0.00	0.00	3.85	3.85	0.00

Percent with Highest CPITN of 0,1,2,3,4	CPITN	Percent
	4	1.77
	3	0.00
	2	0.88
	1	0.00
	0	0.00

- **Percent with** – For each age or age group (6, 7, 8, 9 , 10, 11, 12, 13, 14, 6 – 8, 9 – 11, 12 – 14, 6 – 14), the following percentages appear:
  - **Untreated Decay Primary & Permanent Teeth** – The total number of patients that have a caries condition (15104, 15105, 15106, 15107) but not a restorative code (D1352, D2000 – D4276, D4910, D4999, D6000 – D6079, D6100, D6199 – D7259, D7999) posted on the same tooth for both for primary and permanent teeth in the age group divided by the number of patients in the age group.

    Each patient is counted only once.
  - **Untreated Decay Permanent Teeth** – The total number of patients with a caries condition (15104, 15105, 15106, 15107) but not a restorative code (D1352, D2000 – D4276, D4910, D4999, D6000 – D6079, D6100, D6199 – D7259, D7999) posted on the same tooth for permanent teeth in the age group divided by the number of patients in the age group.

    Each patient is counted only once.
  - **Using Tobacco** – The total number of patients with a condition code 15203 Tobacco Use in the age group divided by the total number of patients in the age group.

    Each patient is counted only once.
  - **Dental Fluorosis** – The total number of patients with a condition code 15200 Dental Fluorosis in the age group divided by the total number of patients in the age group.

    Each patient is counted only once.
  - **Sealants** – The total number of patients with a sealant code (D1351) divided by the number of patients in the age group.

    Each patient is counted only once.
  - **Sealants on 1st Molars** – The number of patients with a sealant code (D1351) on tooth numbers 3, 14, 19, or 30 in the age group divided by the total number of patients in the age group.

    Each patient is counted only once.
  - **Sealants on 2nd Molars** – The total number of patients with a sealant code (D1351) on tooth numbers 2, 15, 18, or 31 in the age group divided by the total number of patients in the age group.

    Each patient is counted only once.

- **Percent with Sealants 1st or 2nd Molars** – The total number of patients with a sealant code (D1351) on tooth numbers 2, 3, 14, 15, 18, 19, 30, or 31 in the age group divided by the total number of patients in the age group.

  Each patient is counted only once.

- **Mean Number of Sealed Teeth** – The total number of teeth with a sealant code (D1351) for patients in the age group divided by the total number of patients in that age group.

  Each patient is counted only once.

- **Mean DMFT** – The DMFT of permanent teeth for all patients in the age group divided by the total number of patients in the age group.

  Each patient and tooth combination is counted only once. If a particular patient has both a caries code as well as a restorative code for the same tooth, the caries code takes precedence.

- **Perio Pockets < 4 mm** – The total number of patients with a probing depth (PD or Pocket Depth) less than 4 mm for any tooth in the age group divided by the total number of patients in the age group.

  To be included, a patient must have a perio exam on the same date the selected survey code for the report was posted.

- **Perio Pockets ≥ 4 mm and < 6 mm** – The total number of patients with a probing depth (PD or Pocket Depth) greater or equal to 4 mm and less than 6 mm for any tooth in the age group divided by the total number of patients in the age group.

  To be included, a patient must have a perio exam on the same date the selected survey code for the report was posted.

- **Perio Pockets > 3 mm and < 6 mm** – The total number of patients with a probing depth (PD or Pocket Depth) greater than 3 mm and less than 6 mm for any tooth in the age group divided by the total number of patients in the age group.

  To be included, a patient must have a perio exam on the same date the selected survey code for the report was posted.

- **Perio Pockets** ≥ 6 mm – The total number of patients with a probing depth (PD or Pocket Depth) for any tooth higher than 6 mm in the age group divided by the total number of patients in the age group.

  To be included, a patient must have a perio exam on the same date the selected survey code for the report was posted.

- **Loss of Attachment < 3 mm** – The total number of patients with a clinical attachment level of less than 3 mm in the age group divided by the total number of patients in the age group.

  To be included, a patient must have a perio exam on the same date the selected survey code for the report was posted.

- **Loss of Attachment ≥ 3 and < 5 mm** – The total number of patients with a clinical attachment level greater than or equal to 3 mm and less than 5 mm in the age group divided by the total number of patients in the age group.

  To be included, a patient must have a perio exam on the same date the selected survey code for the report was posted.

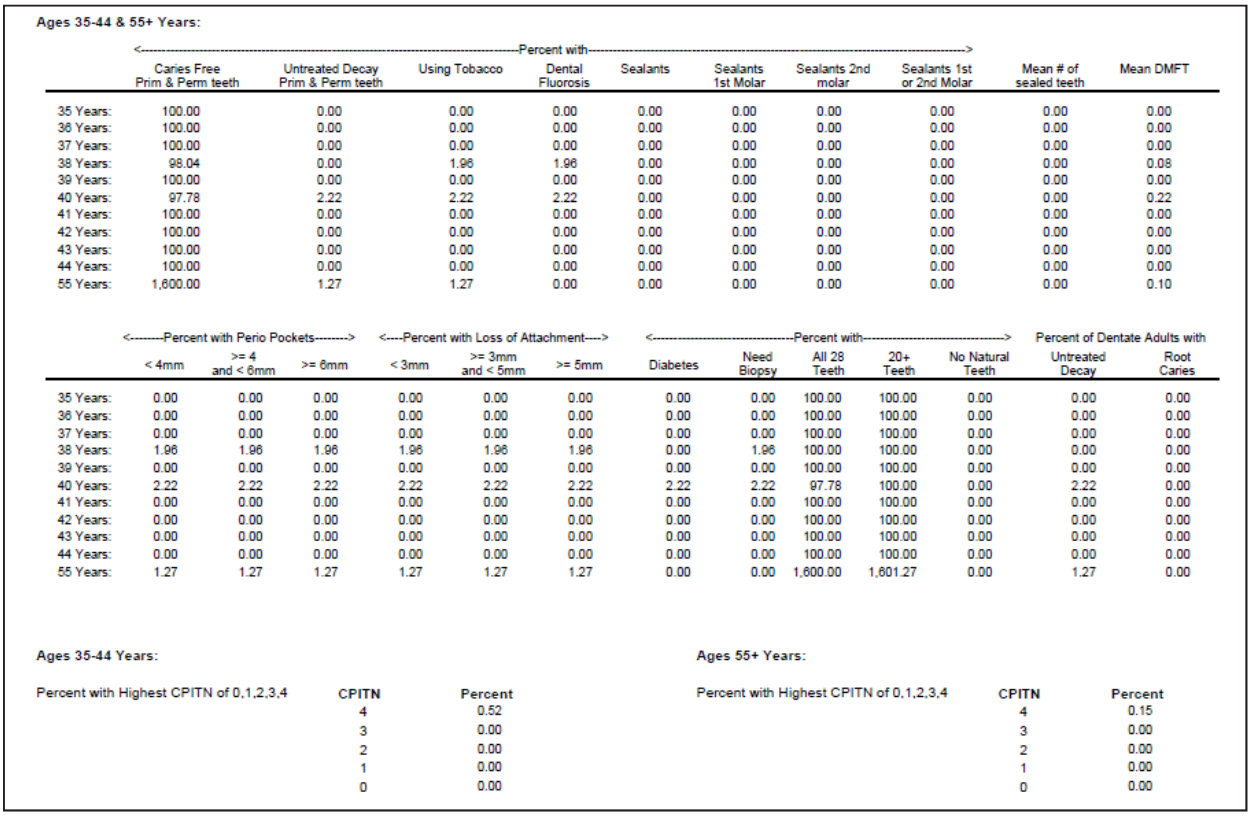
- **Loss of Attachment ≥ 5 mm** – The total number of patients with a clinical attachment level greater than or equal to 5 mm in the age group divided by the total number of patients in the age group.

  To be included, a patient must have a perio exam on the same date the selected survey code for the report was posted.

- **Percent with Highest CPITN of 0, 1, 2, 3, 4** – For each category, the percentage of patients in the age groupe that fall into that category divided by the total number of patients in theage group. Which category a patient corresponds to comes from his or her perio exam, using the following criteria:
  - A patient with a probing depth (PD or Pocket Depth) for any tooth higher than 6 mm pertain to category 4.
  - A patient with a probing depth (PD or Pocket Depth) for any tooth of 4 – 6 mm pertain to category 3.
  - A patient marked as having only calculus (not set to "0 – None") and a probing depth (PD or Pocket Depth) less than 4 mm for any tooth pertain to category 2.
  - A patient marked as having only bleeding for any tooth pertain to category 1.
  - Any remaining patients pertain to category 0.

  To be included, a patient must have a perio exam on the same date the selected survey code for the report was posted.

Ages 35-44 & 55+ Years



Ages 35-44 & 55+ Years:

	Percent with									
	Caries Free Prim & Perm teeth	Untreated Decay Prim & Perm teeth	Using Tobacco	Dental Fluorosis	Sealants	Sealants 1st Molar	Sealants 2nd molar	Sealants 1st or 2nd Molar	Mean # of sealed teeth	Mean DMFT
35 Years:	100.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
36 Years:	100.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
37 Years:	100.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
38 Years:	98.04	0.00	1.96	1.96	0.00	0.00	0.00	0.00	0.00	0.08
39 Years:	100.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
40 Years:	97.78	2.22	2.22	2.22	0.00	0.00	0.00	0.00	0.00	0.22
41 Years:	100.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
42 Years:	100.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
43 Years:	100.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
44 Years:	100.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
55 Years:	1,600.00	1.27	1.27	0.00	0.00	0.00	0.00	0.00	0.00	0.10

	Percent with Perio Pockets			Percent with Loss of Attachment			Percent with					Percent of Dentate Adults with	
	< 4mm	>= 4 and < 6mm	>= 6mm	< 3mm	>= 3mm and < 5mm	>= 5mm	Diabetes	Need Biopsy	All 28 Teeth	20+ Teeth	No Natural Teeth	Untreated Decay	Root Caries
35 Years:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100.00	100.00	0.00	0.00	0.00
36 Years:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100.00	100.00	0.00	0.00	0.00
37 Years:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100.00	100.00	0.00	0.00	0.00
38 Years:	1.96	1.96	1.96	1.96	1.96	1.96	0.00	1.96	100.00	100.00	0.00	0.00	0.00
39 Years:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100.00	100.00	0.00	0.00	0.00
40 Years:	2.22	2.22	2.22	2.22	2.22	2.22	2.22	2.22	97.78	100.00	0.00	2.22	0.00
41 Years:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100.00	100.00	0.00	0.00	0.00
42 Years:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100.00	100.00	0.00	0.00	0.00
43 Years:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100.00	100.00	0.00	0.00	0.00
44 Years:	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100.00	100.00	0.00	0.00	0.00
55 Years:	1.27	1.27	1.27	1.27	1.27	1.27	0.00	0.00	1,600.00	1,601.27	0.00	1.27	0.00

Ages 35-44 Years:

Percent with Highest CPITN of 0,1,2,3,4	CPITN	Percent
	4	0.52
	3	0.00
	2	0.00
	1	0.00
	0	0.00

Ages 55+ Years:

Percent with Highest CPITN of 0,1,2,3,4	CPITN	Percent
	4	0.15
	3	0.00
	2	0.00
	1	0.00
	0	0.00

This section has the same columns as for 15 – 19 year olds plus the following:

- **Percent with diabetes** – The total number of patients with a code 15201 Diabetes in the age group divided by the number of patients in the age group for the report.

  Each patient is counted only once.
- **Percent need biopsy** – The total number of patients with the code 15202 Needs Biopsy or biopsy code (D7255 – D7258) in the age group divided by the number of patients in the age group.

  Each patient is counted only once.

- **Percent with all 28 teeth** – The total number of patients without extractions (existing, existing other, or completed) or with extraction codes (D7111 – D7250) for teeth other than wisdom teeth (1, 16, 17, 32), and without condition codes (15100 Missing Tooth > 1 year or 15101 Missing tooth) in the age group divided by the number of patients in the age group.

  Each patient is counted only once.
- **Percent with 20 or more teeth** – The total number of patients with 8 or less missing teeth (not counting wisdom teeth) in the age group divided by the number of patients in the age group. A missing tooth (15100, 15101) can be posted as an extraction, a condition, or an existing/existing other code.

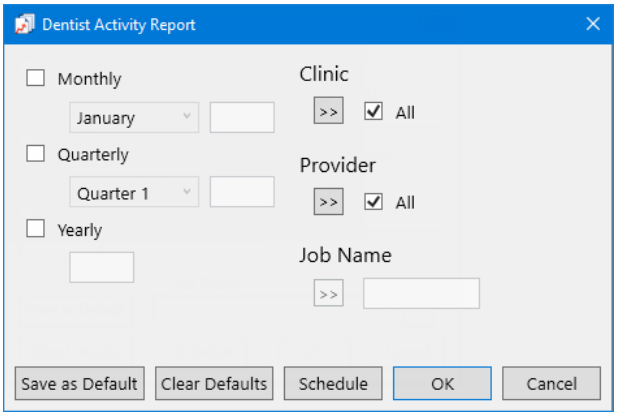
  Each patient is counted only once.
- **Percent with no natural teeth** – The total number of patients missing all 32 teeth int he age group divided by the number of patients in the age group. A missing tooth (15100, 15101) can be posted as an extraction, a condition, or an existing/existing other code.

  Each patient is counted only once.
- **Percent of dentate adults with untreated decay** – The total number of patients who do not have the denture codes D5110 and D5120 posted and have untreated decay (any condition code 15104 – 15107) in the age group divided by the number or patients in the age group.

  Each patient is counted only once. All teeth are considered.
- **Percent of dentate adults with root caries** – The total number of patients who have the deep dentinal/cemental caries condition code 15104 posted in the age groupg divided by the number of patients in the age group.

  Each patient is counted only once. All teeth are considered.

Dentist Activity reports



1. Click the **Job Name** search button >> to select a job name from a list of available jobs and templates to apply the corresponding settings. You can leave the settings that are applied or change any of them as needed.
2. Set up the following options:
   - **Time Periods** – Select any of the following to indicate the time periods for which you want to run the report:
     - **Monthly** – Select a month, and then enter a year. The number of services and the RVUs for the selected month of the specified year will appear on the report.
     - **Quarterly** – Select a quarter, and then enter a year. The number of services and the RVUs for each month of the selected quarter for the specified year will appear on the report.

- **Yearly** – Enter a year. The number of services and the RVUs for each quarter of the specified year will appear on the report.

Each selected item will produce a separate report.

- **Clinic** – Click the search button >> to select the clinics you want to include on the report, or select **All** to include all clinics.
- **Provider** – Click the search >> button to select the providers you want to include on the report, or select **All** to include all providers.

3. Do any of the following:
   - To save these settings for future uses of this report, click **Save as Default**.
   - To schedule the report to run at a later time or on a recurring basis, click **Schedule**.
   - To clear any changes you have made to the settings and start over, click **Clear Defaults**.
4. Click **OK** to preview the report.

Each report provides the following details for the specified time period:

- **Services – MTD / Month 1, Month 2, Month 3 / QTR 1, QTR 2, QTR 3, QTR 4**
  - For each provider listed, services performed by that provider are listed under the corresponding procedure code categories.
  - For each service, the number of times that service was performed is given.
  - For each procedure code category, the number of times all listed services in that category were performed is given.
  - For each provider, the number of times all listed services in all listed categories were performed is given.
- **RVUs**
  - For each provider listed, services performed by that provider are listed under the corresponding procedure code categories.
  - For each service, the number of RVUs is given.
  - For each procedure code category, the number of RVUs for all listed services in that category is given.
  - For each provider, the number of RVUs for all listed services in all listed categories is given.
- **Percent RVUs**

  For each provider listed, the RVU percentage for a procedure code category and for all procedure code categories are given:
  - For each procedure code category, the RVU percentage for all listed services in that category is calculated by dividing the number of RVUs in that category by the total number of RVUs for all categories with services performed by that provider.
  - For each provider, the RVU percentage will always equal 100% (it is the sum of the RVU percentages of each category for that provider).

Dentist Monthly Report for period beginning Nov 2010
Clinics: <ALL>

11/11/2010 12:40:51PM

Series **Total Services**

	MTD	RVUs	Percent RVUs
Robb,David			
Persons Served			
Diagnostic			
D0120	1	25	
D0210	1	60	
Sub-Total	2	85	5.79%
Oral Surgery			
D7140	1	500	
Sub-Total	1	500	34.06%
Prosth, remov			
D5120	1	828	
Sub-Total	1	828	56.40%
Restorative			
D2140	1	55	
Sub-Total	1	55	3.75%
Total	5	1,468	100.00%
Smith,Dennis			
Persons Served			
Diagnostic			
D0120	2	50	
D0210	1	50	
Sub-Total	3	100	4.00%
Oral Surgery			
D7230	1	400	
Sub-Total	1	400	16.00%
Prosth, remov			
D5110	1	2,000	
Sub-Total	1	2,000	80.00%
Restorative			
D2140	1	0	
Sub-Total	1	0	0.00%

Dentist Quarterly Report for period beginning Oct 2010
Clinics: <ALL>

11/11/2010 12:43:47PM

Series **Total Services**

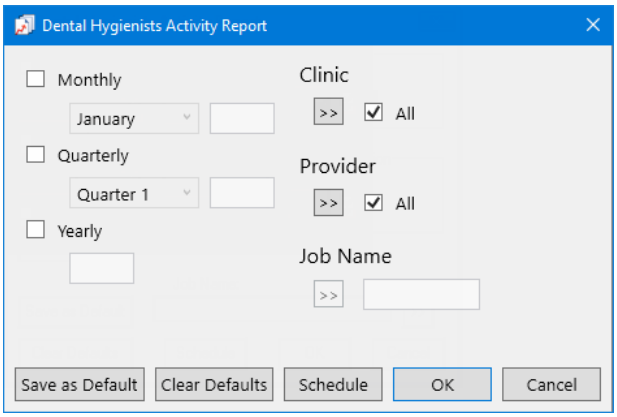
	Month 1	Month 2	Month 3	RVUs	Percent RVUs
Robb,David					
Persons Served					
Diagnostic					
D0120	1	1	1	25	
D0210	1	1	1	60	
Sub-Total	2	2	2	85	5.79%
Oral Surgery					
D7140	1	1	1	500	
Sub-Total	1	1	1	500	34.06%
Prosth, remov					
D5120	1	1	1	828	
Sub-Total	1	1	1	828	56.40%
Restorative					
D2140	1	1	1	55	
Sub-Total	1	1	1	55	3.75%
Total	5	5	5	1,468	100.00%
Smith,Dennis					
Persons Served					
Diagnostic					
D0120	2	2	2	50	
D0210	1	1	1	50	
Sub-Total	3	3	3	100	4.00%
Oral Surgery					
D7230	1	1	1	400	
Sub-Total	1	1	1	400	16.00%
Prosth, remov					
D5110	1	1	1	2,000	
Sub-Total	1	1	1	2,000	80.00%
Restorative					
D2140	1	1	1	0	
Sub-Total	1	1	1	0	0.00%
Total	6	6	6	2,500	100.00%

Dentist Yearly Report for period beginning 2010
Clinics: <ALL>

11/11/2010 12:45:54PM

Series	Total Services					
	QTR 1	QTR 2	QTR 3	QTR 4	RVUs	Percent RVUs
Robb,David						
Persons Served						
Diagnostic						
D0120	1	1	1	1	25	
D0210	1	1	1	1	60	
Sub-Total	2	2	2	2	85	5.79%
Oral Surgery						
D7140	1	1	1	1	500	
Sub-Total	1	1	1	1	500	34.06%
Prosth, remov						
D5120	1	1	1	1	828	
Sub-Total	1	1	1	1	828	56.40%
Restorative						
D2140	1	1	1	1	55	
Sub-Total	1	1	1	1	55	3.75%
Total	5	5	5	5	1,468	100.00%
Smith,Dennis						
Persons Served						
Diagnostic						
D0120	2	2	2	2	50	
D0210	1	1	1	1	50	
Sub-Total	3	3	3	3	100	4.00%
Oral Surgery						
D7230	1	1	1	1	400	
Sub-Total	1	1	1	1	400	16.00%
Prosth, remov						
D5110	1	1	1	1	2,000	
Sub-Total	1	1	1	1	2,000	80.00%
Restorative						
D2140	1	1	1	1	0	
Sub-Total	1	1	1	1	0	0.00%
Total	6	6	6	6	2,500	100.00%

Dental Hygienists Activity reports



1. Click the **Job Name** search button >> to select a job name from a list of available jobs and templates to apply the corresponding settings. You can leave the settings that are applied or change any of them as needed.
2. Set up the following options:
   - **Time Periods** – Select any of the following to indicate the time periods for which you want to run the report:
     - **Monthly** – Select a month, and then enter a year. The number of services and the RVUs for the selected month of the specified year will appear on the report.
     - **Quarterly** – Select a quarter, and then enter a year. The number of services and the RVUs for each month of the selected quarter for the specified year will appear on the report.
     - **Yearly** – Enter a year. The number of services and the RVUs for each quarter of the specified year will appear on the report.

     Each selected item will produce a separate report.
   - **Clinic** – Click the search button >> to select the clinics you want to include on the report, or select **All** to include all clinics.
   - **Provider** – Click the search >> button to select the providers you want to include on the report, or select **All** to include all providers.
3. Do any of the following:
   - To save these settings for future uses of this report, click **Save as Default**.
   - To schedule the report to run at a later time or on a recurring basis, click **Schedule**.
   - To clear any changes you have made to the settings and start over, click **Clear Defaults**.
4. Click **OK** to preview the report.

Each report provides the following details for the specified time period:

- **Services – MTD / Month 1, Month 2, Month 3 / QTR 1, QTR 2, QTR 3, QTR 4**
  - For each secondary provider listed, services performed by that provider are listed under the corresponding procedure code categories.
  - For each service, the number of times that service was performed is given.
  - For each procedure code category, the number of times all listed services in that category were performed is given.
  - For each secondary provider, the number of times all listed services in all listed categories were performed is given.

- **RVUs**
  - For each secondary provider listed, services performed by that provider are listed under the corresponding procedure code categories.
  - For each service, the number of RVUs is given.
  - For each procedure code category, the number of RVUs for all listed services in that category is given.
  - For each secondary provider, the number of RVUs for all listed services in all listed categories is given.
- **Percent RVUs**

  For each provider listed, the RVU percentage for a procedure code category and for all procedure code categories are given:
  - For each procedure code category, the RVU percentage for all listed services in that category is calculated by dividing the number of RVUs in that category by the total number of RVUs for all categories with services performed by that provider.
  - For each secondary provider, the RVU percentage will always equal 100% (it is the sum of the RVU percentages of each category for that provider).

Dental Hygienists Monthly Activity Report for period beginning Nov 2010
Clinics: <ALL>

11/11/2010 12:53:15PM

Series	Total Services		
	MTD	RVUs	Percent RVUs
Hayes,Sally			
Persons Served			
Diagnostic			
D0180	1	40	
Sub-Total	1	40	28.57%
Periodontics			
D4910	1	70	
Sub-Total	1	70	50.00%
Preventive			
D1330	1	30	
Sub-Total	1	30	21.43%
Total	3	140	100.00%
McClure,Angela			
Persons Served			
Diagnostic			
D0140	1	35	
Sub-Total	1	35	26.12%
Periodontics			
D4910	1	78	
Sub-Total	1	78	58.21%
Preventive			
D1204	1	21	
Sub-Total	1	21	15.67%
Total	3	134	100.00%

Dental Hygienists/Dental Auxiliary Quarterly Activity Report for period beginning Oct 2010
Clinics: <ALL>

11/11/2010 12:58:06PM

Series **Total Services**

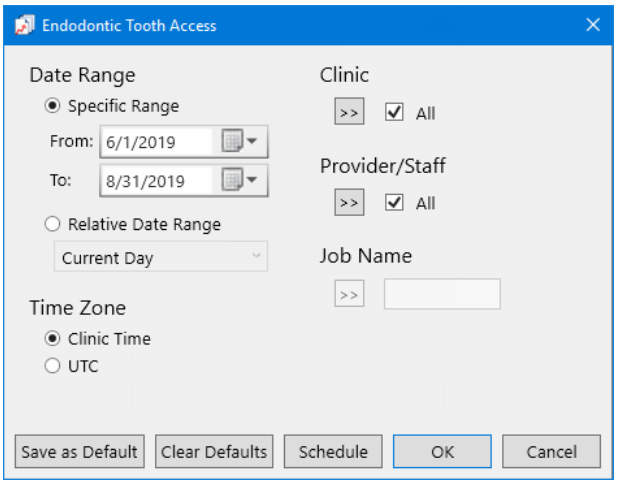
	Month 1	Month 2	Month 3	RVUs	Percent RVUs
Hayes,Sally					
Persons Served					
Diagnostic					
D0180	1	1	1	40	
Sub-Total	1	1	1	40	28.57%
Periodontics					
D4910	1	1	1	70	
Sub-Total	1	1	1	70	50.00%
Preventive					
D1330	1	1	1	30	
Sub-Total	1	1	1	30	21.43%
Total	3	3	3	140	100.00%
McClure,Angela					
Persons Served					
Diagnostic					
D0140	1	1	1	35	
Sub-Total	1	1	1	35	26.12%
Periodontics					
D4910	1	1	1	78	
Sub-Total	1	1	1	78	58.21%
Preventive					
D1204	1	1	1	21	
Sub-Total	1	1	1	21	15.67%
Total	3	3	3	134	100.00%

Dental Hygienists/Dental Auxiliary Yearly Activity Report for period beginning 2010
Clinics: <ALL>

11/11/2010 12:59:35PM

Series	Total Services					
	QTR 1	QTR 2	QTR 3	QTR 4	RVUs	Percent RVUs
Hayes,Sally						
Persons Served						
Diagnostic						
D0180	1	1	1	1	40	
Sub-Total	1	1	1	1	40	28.57%
Periodontics						
D4910	1	1	1	1	70	
Sub-Total	1	1	1	1	70	50.00%
Preventive						
D1330	1	1	1	1	30	
Sub-Total	1	1	1	1	30	21.43%
Total	3	3	3	3	140	100.00%
McClure,Angela						
Persons Served						
Diagnostic						
D0140	1	1	1	1	35	
Sub-Total	1	1	1	1	35	26.12%
Periodontics						
D4910	1	1	1	1	78	
Sub-Total	1	1	1	1	78	58.21%
Preventive						
D1204	1	1	1	1	21	
Sub-Total	1	1	1	1	21	15.67%
Total	3	3	3	3	134	100.00%

Endodontic Tooth Access Report



1. Click the **Job Name** search button >> if you want to select a job name from a list of available jobs and templates to apply the corresponding settings. You can leave the settings that are applied or change any of them as needed.
2. Set up the following options:
   - **Date Range** – Select **Specific Range**, and then enter a date range in the **From** and **To** fields; or select **Relative Date Range**, and then select a date range. The report uses the procedure date of Ledger transactions.

     Note: Using a relative date range is ideal when saving your report settings as default. Then, you don't have to manually enter a date range each time you run the report.

   - **Time Zone** – 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 select **All** to include all clinics.
   - **Provider/Staff** – Click the search >> button to select the providers and staff you want to include on the report, or select **All** to include all providers and staff.
3. Do any of the following:
   - To save these settings for future uses of this report, click **Save as Default**.
   - To schedule the report to run at a later time or on a recurring basis, click **Schedule**.
   - To clear any changes you have made to the settings and start over, click **Clear Defaults**.
4. Click **OK** to preview the report.

The report provides the following details for the specified time period:

- For each provider, the tooth categories are listed: anterior teeth for teeth 6 – 11, 22 – 27; first molars for teeth 3, 14, 19, 30; other molars for teeth 1, 2, 15 – 18, 31, 32; and premolars for teeth 4, 5, 12, 13, 20, 21, 28, 29.
- For each tooth category, the following statistics are given:
  - **Total Accessed** – The number of teeth on which a pulpal debridement has been performed. A tooth is counted as accessed if the ADA code D3221 has been posted on that tooth.

- **Accessed Completed** – The number of teeth on which a pulpal dedridement and endodontic therapy have been performed. A tooth is counted as accessed and completed if the ADA code D3221 and any of the following ADA codes have been posted on that tooth: D3310, D3320, or D3330.
- **Extracted** – The number of teeth on which a pulpal debridement and an extraction have been performed. A tooth is counted as accessed and extracted if the ADA code D3221 and any of the following ADA extraction codes have been posted on that tooth: D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250.
- **Restored** – The number of teeth on which a pulpal debridement and a restoration have been performed. A tooth is counted as accessed and restored if the ADA code D3221 and any restorative ADA code that is not a crown procedure included under "Accessed plus Crowned" have been posted on that tooth.
- **Crowned** – The number of teeth on which a pulpal debridement and a crown placement has been performed. A tooth is counted as accessed and crowned if the ADA code D3221 and any of the following ADA codes have been posted on that tooth: D2390, D2710, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2790, D2791, D2792, D2794, D2799, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6094, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6790, D6791, D6792, D6794, or D6793.

Endodontic Tooth Access
All Sites
08/01/2010 - 10/31/2010

Date: 11/11/2010 Page 1 of 2

Tooth Category	Total Accessed	Accessed Completed	Extracted	Restored	Crowned
Bright, Sally					
Anteriors	10	10	10	10	10
First Molars	10	10	10	10	10
Other Molars	8	8	8	8	8
Premolars	31	31	31	31	31
Brown, Mary					
Anteriors	10	10	10	10	10
First Molars	10	10	10	10	10
Other Molars	8	8	8	8	8
Premolars	31	31	31	31	31
Erickson, Tracy					
Anteriors	10	10	10	10	10
First Molars	10	10	10	10	10
Other Molars	8	8	8	8	8
Premolars	31	31	31	31	31

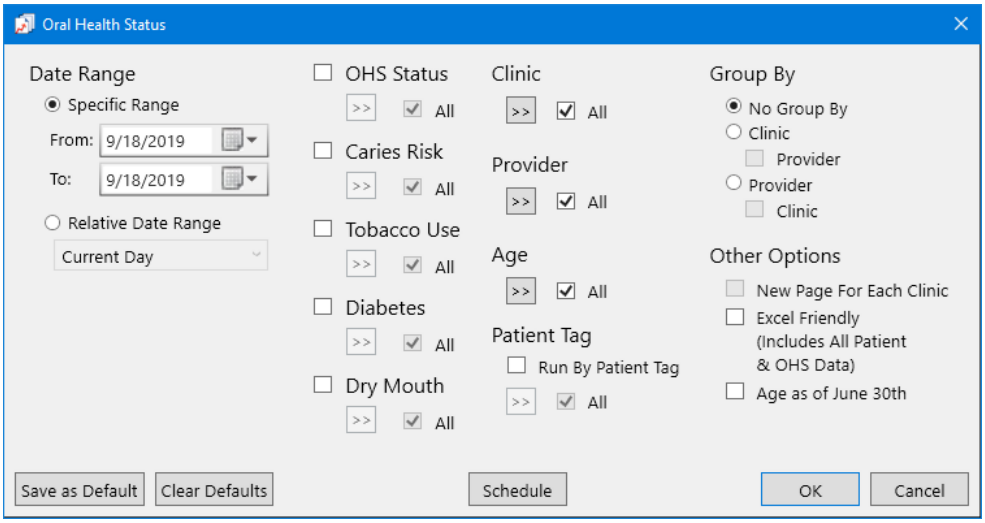
Example scenarios

The following examples explain a few ways tooth counts are calculated for the columns on the report:

- The date range of the report is February 1 through February 28. A provider has performed a D3221 on tooth 11 on the 2nd and then extracted that same tooth on the 20th. On the report, tooth 11 will be counted once in the Total Accessed column and once in the Extracted column.
- The date range of the report is February 1 through February 20. A provider has performed a D3221 on tooth 11 on the 2nd and then a performed a D3310 on the same tooth on the 27th. On the report, tooth 11 will be counted once in the Total Accessed column but not in the Accessed Completed column because the D3310 code was posted outside of the date range of the report.

- The date range of the report is February 1 through February 20. Provider #1 has performed a D3221 on tooth 11 on the 2nd, and then Provider #2 performed a D3310 on the same tooth on the 20th. On the report, the D3221 will be counted once in the Total Accessed column for Provider #1, and the D3310 will be counted once in the Accesed Completed column for Provider #2.

Oral Health Status Report



1. Select any of the following:

   - **OHS Status** – To have the report include patients with a completed OHS survey that has one of the OHS statuses that you specify for the report, select the **OHS Status** check box. Click the search button >> to select the desired OHS statuses, or select the **All** check box to include all OHS statuses. To not filter the report by OHS status, clear the **OHS Status** check box.

     Note: OHS class 5 and 6 are calculated based on the date that you generate the report.

   - **Caries Risk** – To have the report include patients with a completed OHS survey that has one of the caries risk levels that you specify for the report, select the **Caries Risk** check box. Click the search button >> to select the desired caries risk levels, or select the **All** check box to include all caries risk levels. To not filter the report by caries risk level, clear the **Caries Risk** check box.
   - **Tobacco Use** – To have the report include patients with a completed OHS survey that has one of the tobacco uses that you specify for the report, select the **Tobacco Use** check box. Click the search button >> to select the desired tobacco uses, or select the **All** check box to include all tobacco uses. To not filter the report by tobacco use, clear the **Tobacco Use** check box.
   - **Diabetes** – To have the report include patients with a completed OHS survey that has one of the types of diabetes that you specify for the report, select the **Diabetes** check box. Click the search button >> to select the desired types of diabetes, or select the **All** check box to include all types of diabetes. To not filter the report by type of diabetes, clear the **Diabetes** check box.
   - **Dry Mouth** – To have the report include patients with a completed OHS survey that has one of the dry mouth descriptions that you specify for the report, select the **Dry Mouth** check box. Click the search button >> to select the desired dry mouth descriptions, or select the **All** check box to include all dry mouth descriptions. To not filter the report by dry mouth description, clear the **Dry Mouth** check box.

Notes:

- If all these check boxes are clear, the report will include patients with a completed OHS survey within the selected date range (in the OHS 1–6 columns) and patients who do not have a completed OHS survey (in the NO OHS column).
- If at least one of these check boxes is selected, the report will include patients with a completed OHS survey within the selected date range and who meet the specified filter criteria. The report will not include patients who do not have a completed OHS survey (the NO OHS column will not appear on the report).

2. Set up the following options:
   - **Date Range** – Select **Specific Range**, and then enter a date range in the **From** and **To** fields; or select **Relative Date Range**, and then select a date range.
   - **Clinic** – Click the search button ›› to select the clinics you want to include on the report, or select **All** to include all clinics.
   - **Provider** – Click the search button ›› to select the providers you want to include on the report, or select **All** to include all providers.
   - **Age** – Click the search button ›› to select the ages you want to include on the report, or select **All** to include all ages.
   - **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 select the **All** check box to include patients with any patient tag. To not filter the report by a patient tag, clear the **Run By Patient Tag** check box.
   - **Group By** – Select one of the following options:
     - **No Group By** – For no grouping. The summary report will be generated. The overall total numbers of patients will be displayed.
     - **Clinic** – To group the report by clinic. Select the **Provider** check box to group by provider within each clinic grouping. Each provider is listed with totals related to the clinic grouping.
     - **Provider** – To group the report by provider. Select the **Clinic** check box to group by clinic within each provider grouping. Each clinic is listed with totals related to the provider grouping.
   - **Other Options** – Select any additional filters for the report:
     - **New Page For Each Clinic** – To have each clinic appear on a separate page. This option is available only if the **Clinic** option under **Group By** is selected.
     - **Excel Friendly (Includes All Patient & OHS Data)** – To view the report with patient details and OHS data but without groupings and totals. This report format allows you to view the data in a spreadsheet program.

       Note: The report is sorted by last name, then by first name, then by OHS visit. A patient may appear more than once on the report.

     - **Age as of June 30th** – With this check box selected, the age of each patient will be calculated as of June 30 within the specified date range. With this check box clear, the age of each patient will be calculated based on the date that you generate the report.
3. Do any of the following:
   - To save these settings for future uses of this report, click **Save as Default**.
   - To schedule the report to run at a later time or on a recurring basis, click **Schedule**.
   - To clear any changes you have made to the settings and start over, click **Clear Defaults**.

4. Click **OK** to preview the report.

For each age group on the report, the following statistics appear:

- The number of patients who have a completed OHS survey, broken down into columns by OHS status.
- The number of patients who do not have a completed OHS survey. Depending on how you filter the report, this column may not appear on the report.
- The total number of patients.
- The report also displays the total number of patients across all age groups for each column of data on the report.

Note: A patient may be counted more than once on the report.

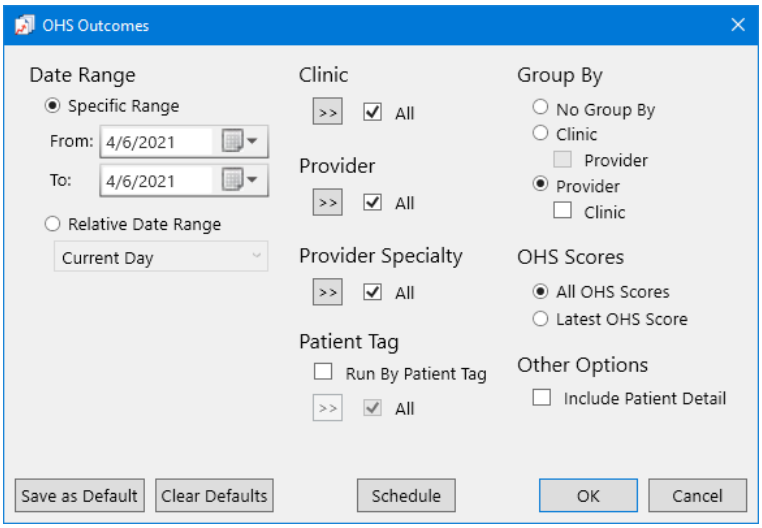
OHS Statistics

Date Range: 5/20/2019 - 5/26/2019
Age: <ALL>
Clinics: <ALL>
Providers: <ALL>

26/05/2019 Report Generated By: ANNAD Page 1 of 1

Age Statistics	OHS 1	OHS 2	OHS 3	OHS 4	OHS 5	OHS 6	NO OHS	Age Total
Patient(s) that are 5 to 6 years old	0	1	0	0	0	0	0	1
Patient(s) that are 7 to 8 years old	0	0	0	0	0	0	1	1
Patient(s) that are 13 to 14 years old	0	0	0	0	0	0	2	2
Patient(s) that are 15 to 16 years old	0	0	0	0	0	0	8	8
Patient(s) that are 17 to 20 years old	0	0	0	0	0	0	413	413
Patient(s) that are 21 to 30 years old	0	0	0	0	0	0	3,610	3,610
Patient(s) that are 31 to 40 years old	0	0	0	0	0	0	3,704	3,704
Patient(s) that are 41 to 50 years old	0	0	0	1	0	0	5,019	5,020
Patient(s) that are 51 to 60 years old	0	0	1	0	0	0	9,660	9,661
Patient(s) that are 61 to 70 years old	0	0	0	0	0	0	10,271	10,271
Patient(s) that are 71 to 80 years old	0	0	0	0	0	0	2,436	2,436
Patient(s) that are 81 years and older	0	0	0	0	0	0	2,036	2,036
Patient(s) without a birthday entered	0	0	0	1	0	0	104	105
Total Number of Patients	**0**	**1**	**1**	**2**	**0**	**0**	**37264**	**37268**

OHS Outcome after Appointment Report



1. Set up the following options:
   - **Date Range** – Either select **Specific Range**, and then enter a date range in the **From** and **To** boxes; or select **Relative Date Range**, and then select a date range.

     Note: For the **Relative Date Range**, there are no future date ranges because they are not relevant for this report.

   - **Clinic** – Click the search button [>>] to select the clinics you want to include on the report, or select the **All** check box to include all clinics. This is based on the clinic where a user was logged in to when an assessment was done. Only the clinics that your user account has permission to access are considered or available for selection.
   - **Provider** – Click the search button [>>] to select the providers you want to include on the report, or select the **All** check box to include all providers. This is based on the provider or staff member who signed a clinical note, which is not necessarily the logged in user. Only the active providers that your user account has permission to access are considered or available for selection.
   - **Provider Specialty** – Click the search button [>>] to select the specialties you want to include on the report, or select the **All** check box to include all specialties.
   - **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 select the **All** check box to include patients with any patient tag. To not filter the report by a patient tag, clear the **Run By Patient Tag** check box.
   - **Group By** – Select one of the following options:
     - **No Group By** – For no grouping. The summary report will be generated. The overall total number of patients will be displayed.
     - **Clinic** – To group the report by clinic. Select the **Provider** check box to group by provider within each clinic grouping. The totals for each provider (in a clinic grouping) and for each clinic appear.
     - **Provider** – To group the report by provider. Select the **Clinic** check box to group by clinic within each provider grouping. The totals for each clinic (in a provider grouping) and for each provider appear.

- **Other Scores** – Select one of the following to select the amount of OHS scores that will be displayed from the amount available during the specified timeframe:
  - **All OHS Scores** – The report will show all the OHS score changes completed during the selected time frame for all patients that had OHS score changes.
  - **Latest OHS Score** – The report will only display the most recent OHS score change within the time frame for each patient that had OHS score changes.
- **Other Options** – Select an additional filter for the report:
  - **Include Patient Detail** – To include patient details.

2. Do any of the following:
   - To save these settings for future uses of this report, click **Save as Default**.
   - To schedule the report to run later or on a recurring basis, click **Schedule**.
   - To clear any changes you have made to the settings and start over, click **Clear Defaults**.
3. Click **OK** to preview the report.

The report displays the following information:

- **Patient Details** – If the report includes patient details, the post-treatment assessments are sorted first by date (in chronological order) and then by patient name (in alphabetical order, by first name and then last name). A post-treatment assessment is included on the report if the assessment was completed within the date range for the report, the assessment is linked to a clinical note, and the other report criteria are met.

  Note: There may be multiple post-treatment assessments for a patient on the same day or across multiple days. Each is listed separately.

  For each post-treatment assessment, the following details appear:

  - **OHS Score Pre-Treatment** – If a pre-treatment assessment was completed prior to the post-treatment assessment, the pre-treatment assessment is linked to a clinical note, and the other report criteria are met (except for the date range), the pre-treatment assessment's score appears. The **OHS Score Pre-Treatment** is different from the pre-treatment assessment's recorded score if one of the following conditions is met:
    - If the score for the pre-treatment assessment was a 1, 2, or 3, and more than 2 years passed until the post-treatment assessment was done, the **OHS Score Pre-Treatment** changes to 6.
    - If the score for the pre-treatment assessment was a 4, and more than 2 years but not more than 3 years passed until the post-treatment assessment was done, the **OHS Score Pre-Treatment** changes to 5.
    - If the score for the pre-treatment assessment was a 4, and more than 3 years passed until the post-treatment assessment was done, the **OHS Score Pre-Treatment** changes to 6.

    Notes:
    - If a pre-treatment assessment does not exist, the **OHS Score Pre-Treatment** is blank, and the assessment is included in the **OHS Score Improved**.
    - The date when a pre-treatment assessment was completed can fall outside of the date range for the report.
  - **OHS Score Post Treatment** – The post-treatment assessment's score.
  - **Assessment Date** – The date when the post-treatment assessment was completed.
  - **Signer** – The user ID of the provider who signed the associated clinical note.
  - **Patient Name** – The patient's name.

- **Chart** – The patient's chart number.
- **Birthdate** – The patient's birth date (if entered in the Family File record).
- **Score change** – An "X" appears in one of the following columns to indicate how the patient's OHS score has changed:
  - **OHS Score Degraded** – If the **OHS Score Post Treatment** is higher than the **OHS Score Pre-Treatment**.
  - **OHS Score No Change** – If the **OHS Score Post Treatment** is the same as the **OHS Score Pre-Treatment**.
  - **OHS Score Improved** – If the **OHS Score Post Treatment** is lower than the **OHS Score Pre-Treatment**, or if the **OHS Score Pre-Treatment** is blank.

- **Totals** – The following subtotals (for each grouping), if applicable, and totals (for the entire report) appear:
  - **Assessments** – The number of post-treatment assessments.
  - **OHS Score Degraded** – The number of post-treatment assessments that have an **OHS Score Degraded**.
  - **% OHS Score Degraded** – The **OHS Score Degraded** divided by the **Assessments**.
  - **OHS Score No Change** – The number of post-treatment assessments that have an **OHS Score No Change**.
  - **% OHS Score No Change** – The **OHS Score No Change** divided by the **Assessments**.
  - **OHS Score Improved** – The number of post-treatment assessments that have an **OHS Score Improved**.
  - **% OHS Score Improved** – The **OHS Score Improved** divided by the **Assessments**.

  Note: There may be multiple post-treatment assessments for a patient on the same day or across multiple days. Each is counted separately toward the applicable totals.

Report examples:

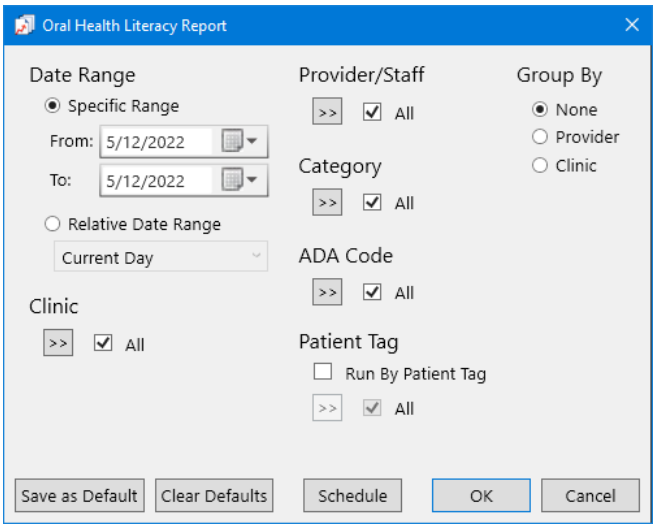
- No grouping, without patient detail

	Assessments	OHS SCORE Degraded	OHS SCORE No Change	OHS SCORE Improved
		%	%	%
TOTALS	11	1	1	9
		9.09%	9.09%	81.82%

- No grouping, with patient detail

Assessment Date	Signer	Patient Name	Chart	Birthdate	Assessments	OHS SCORE Pre-Treatment	OHS SCORE Post Treatment	OHS SCORE Degraded	OHS SCORE No Change	OHS SCORE Improved
								%	%	%
03/15/2015	7BPROV1	Russell Linch	LI0016E	04/04/1944			2			X
03/15/2015	7BPROV1	Rose Loche	LO0002E	04/04/1944			3			X
03/15/2015	7BPROV1	Velma Luna	LU0006E	11/11/1956			4			X
03/15/2015	7BPROV1	Rose Knight	KN0003E	04/04/1943			4			X
03/15/2017	7BPROV1	Russell Linch	LI0016E	04/04/1944		6	3			X
03/15/2017	7BPROV1	Velma Luna	LU0006E	11/11/1956		5	4			X
03/15/2017	7BPROV1	Rose Knight	KN0003E	04/04/1943		4	3			X
03/15/2018	7BPROV1	Rose Loche	LO0002E	04/04/1944		6	3			X
03/15/2019	7BPROV1	Rose Knight	KN0003E	04/04/1943		3	3		X	
03/15/2020	7BPROV1	Rose Knight	KN0003E	04/04/1943		3	1			X
03/15/2020	7BPROV1	Rose Knight	KN0003E	04/04/1943		1	2	X		
TOTALS					11			1	1	9
								9.09%	9.09%	81.82%

Oral Health Literacy Report



1. Set up the following options:
   - **Date Range** – Either select **Specific Range**, and then enter a date range in the **From** and **To** boxes; or select **Relative Date Range**, and then select a date range.

     Note: For the **Relative Date Range**, there are no future date ranges because they are not relevant for this report.

   - **Clinic** – Click the search button >> to select the clinics you want to include on the report, or select the **All** check box to include all clinics. This is based on the clinic where a user was logged in to when an assessment was done. Only the clinics that your user account has permission to access are considered or available for selection.
   - **Provider/Staff** – Click the search button >> to select the providers/staff you want to include on the report, or select the **All** check box to include all providers/staff. This is based on the provider or staff member who was logged in when patient education was provided. Only the active providers that your user account has permission to access are considered or available for selection.
   - **Category** – Click the search button >> to select the procedure code categories you want to include on the report, or select the **All** check box to include all categories.
   - **ADA Code** – Click the search button >> to select the procedure codes you want to include on the report, or select the **All** check box to include all codes.
   - **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 select the **All** check box to include patients with any patient tag. To not filter the report by a patient tag, clear the **Run By Patient Tag** check box.
   - **Group By** – Select one of the following options:
     - **None** – For no grouping. The overall totals appear.
     - **Provider** – To group the report by provider. The totals for each provider appear.
     - **Clinic** – To group the report by clinic. The totals for each clinic appear.

2. Do any of the following:
   - To save these settings for future uses of this report, click **Save as Default**.
   - To schedule the report to run later or on a recurring basis, click **Schedule**.
   - To clear any changes you have made to the settings and start over, click **Clear Defaults**.
3. Click **OK** to preview the report.

The report displays the following information:

- **Patient Education Occurrences**:
  - **Date of Service** – The date of a patient's appointment (which cannot have been canceled) when patient education was provided to that patient.

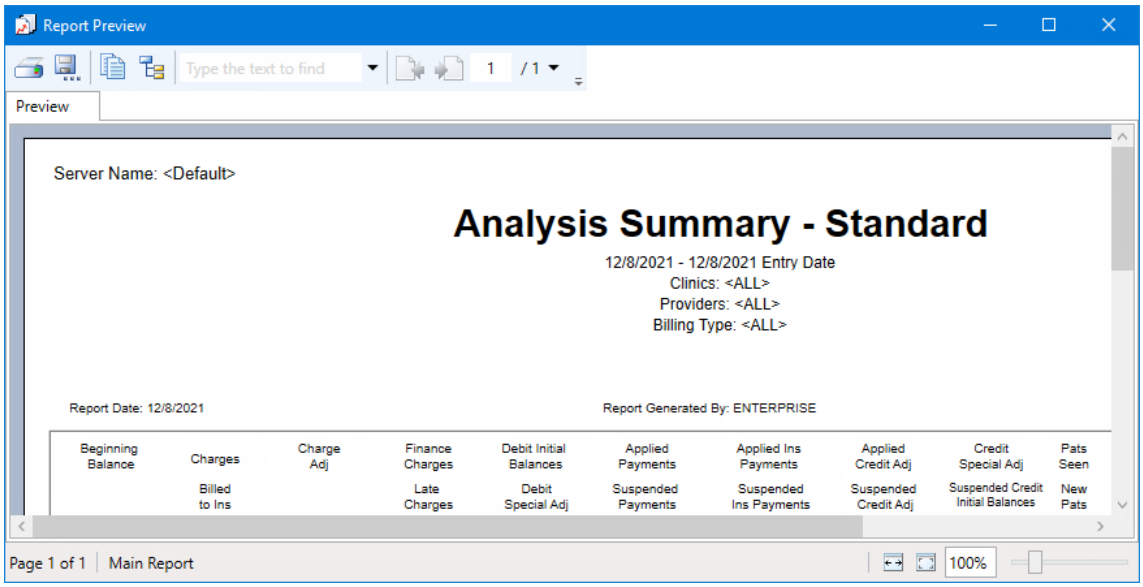
    Patient education can be provided from the following areas of Dentrix Enterprise:
    - The **Education URL** of an eductional topic that was recorded for a patient in the Patient Education module.
    - The **Procedure** link to an educational video that was clicked from the **Edit or Delete Procedure** dialog box of a treatment-planned procedure that was charted for a patient.

    Note: A patient may have more than one patient education occurrence on a given day or days, but the patient is only counted once for the total number of patient visits.
  - **Provider** – The provider or staff member that is logged in to Dentrix Enterprise when patient education was provided.
  - **Patient Name** – The name of the patient who is associated with the appointment and either the recorded patient education topic or the treatment-planned procedure.
  - **OHS Score** – The most recent OHS Score for the patient, if one exists.
  - **Description**:
    - The **Description** that is associated with the recorded patient education topic.
    - The **Description** that is associated with educational video link for the charted procedure.
- **Total Patient Visits** – The number of patients who are associated with at least one patient education occurrence. A patient is only counted once regardless of the number of patient education occurrences during the date range of the report.

  The total number of visits is further broken down by the following:
  - **Medicaid** – The total number of Medicaid patients.
  - **Non-medicaid** – The total number of non-Medicaid patients.

Working with Previewed Reports

When you generate a report from DXOne Reporting, the report appears in the **Report Preview** window.



You can do any of the following with the report being previewed:

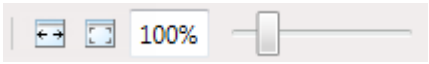
- **Print the report** – To print the displayed report, click the **Print Report** button. The **Print** dialog box appears. All installed Windows printers are listed. The Windows default printer is selected by default, but you can select a different printer. To send the print job to the selected printer, click **Print**.



- **Export the report** – To export the report, click the **Export Report** button. The **Export Report** dialog box appears. Select where you want to save the file, enter a **File name**, select the desired **Save as type** (.rpt, .pdf, .csv, .xls, data-only .xls, data-only .xlsx, .doc, editable Word® .rtf, .rtf, or .xml), and then click **Save**.



- **Change the zoom** – To change the zoom percentage of the report, drag the slider to the desired percentage (the default is 100%). You can also, click the **Fit to Width** or **Full Page** button.



- **Navigate pages** – For a multiple-page report, click the **Go to Previous Page** or the **Go to Next Page** button to navigate one page at a time. To navigate to the first or last page of a multiple-page report, click the down arrow next to the last page number to open a menu, and then click **Go to First Page** or **Go to Last Page**.



- **Search for text** – To specify if you want to perform a case-sensitive or a whole-word search, click the down arrow next to the **Type the text to find** box, and then select **Match Case** and/or **Match Whole Word**. An active filter has a check mark next to it; clicking an option with a check mark removes that filter. Next, in the **Type the text to find** box, enter the text to search for on the page currently being viewed, and then press Enter. The first matching text on the page has a red box around it. Continue pressing Enter to find other matches. If no matches are found, the search box's background color changes to orange.

- **Copy text** – To copy selected text to the Clipboard, search for or click to select some text (a red box appears around it), and then click the **Copy** button.



Using Report Templates

You can have multiple templates for the custom IHS reports. For eachof these reports, you can select a template (a **Job Name**) to run that report without having to change the options for filtering the report when certain variations of the report are frequently required. Also, if an existing scheduled job or template is changed, it can be saved as a different template or job while preserving the original.

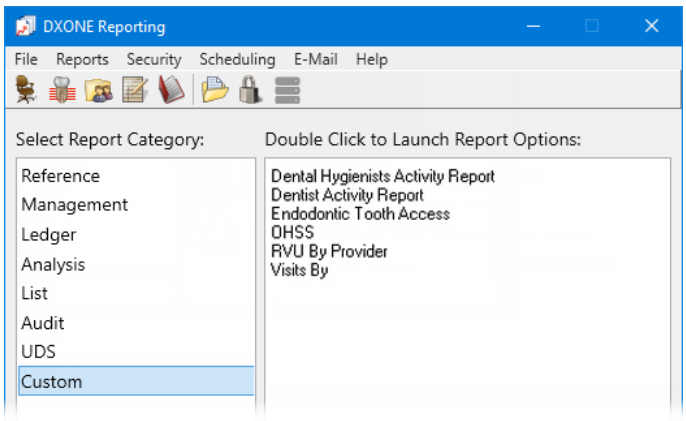
Creating a Report Job Template

You can create a template for running a custom IHS report.

To create a report job template

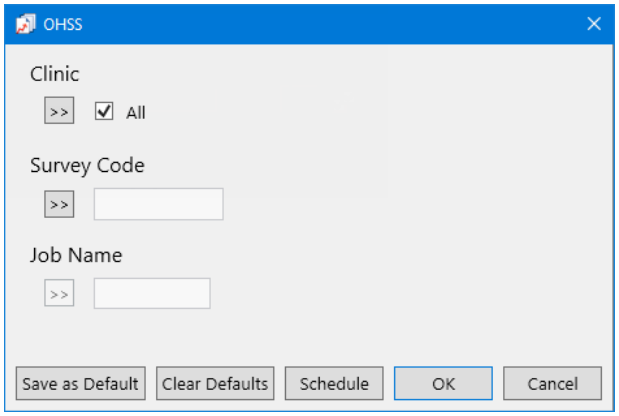
1. In DXOne Reporting, in the **Select Report Category** list box, select **Custom**.

   The custom reports appear in the right list box.



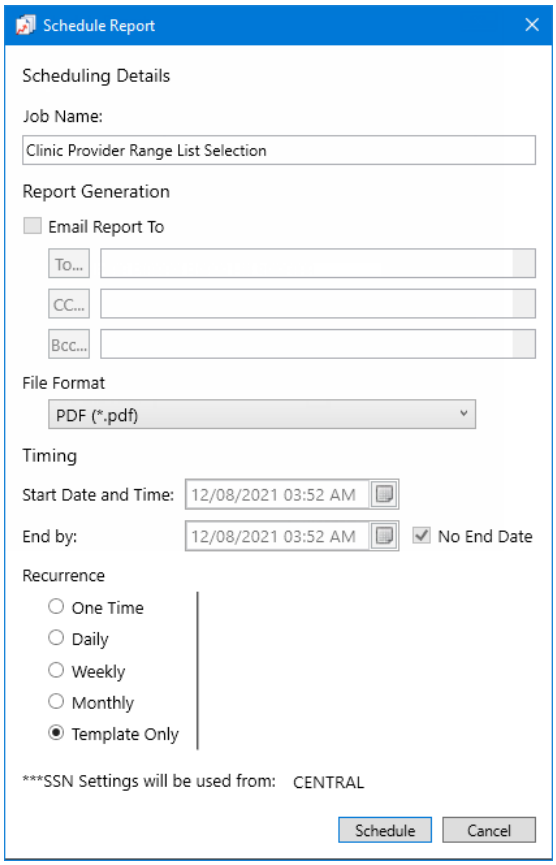
2. Double-click the report for which you want to create a template.

   The corresponding report dialog box appears.



3. Set up the options for filtering the report results.
4. Click **Save as Default** to save the current settings for future uses of the report.
5. Click **Schedule**.

   The **Scheduling Report** dialog box appears.



6. Under **Recurrence pattern**, select **Template Only** to indicate that the report job will serve as a template.
7. Type a **Job Name** for the report job (up to 50 characters in length). The job name will be visible for the scheduled report job in the **Manage Scheduled Jobs** dialog box.
8. Click **Schedule** to save the report job as a template and schedule the report job. The report job will appear in the **Manage Scheduled Jobs** dialog box.

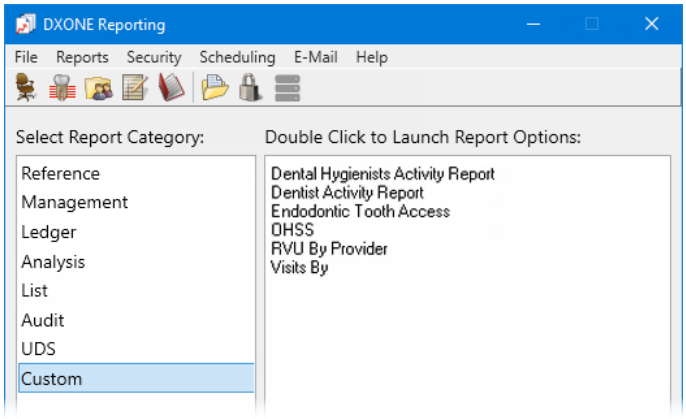
Scheduling a Report Job from a Template

You can schedule a report job from a template for an IHS custom report.

To schedule a report job from a template

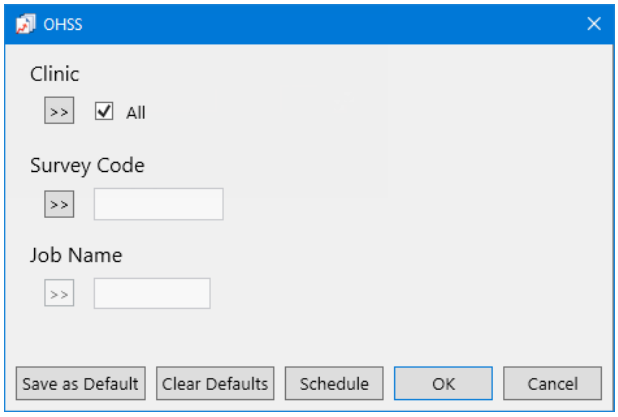
1. In DXOne Reporting, in the **Select Report Category** list box, select **Custom**.

   The custom reports appear in the right list box.



2. Double-click the report you want to schedule from a template.

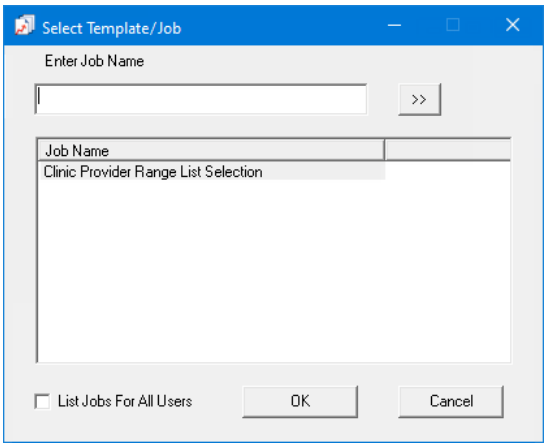
   The corresponding report dialog box appears.



3. Select a template:

   a. Click the **Job Name** search button. The search button is only enabled if templates have been created or jobs have been schedule for this report.

The **Select Template/Job** dialog box appears. Any existing templates/jobs that have been created for the report by the user you are currently logged on as are shown in the list box.



b. Select **List Jobs for all users** if you want to view templates for all users for this report. If this option is selected, a **User ID** column appears to the left of the **Job Name** column and displays the user ID for each job/template. The **List Jobs for all users** check box is available only if the current user has the "Scheduled Jobs – Manage All Users" DXOne Reporting security right enabled; in other words, the current user has rights to view reports or jobs for other users.

c. The templates are listed alphabetically in ascending order by default. To reverse the order, click the **Job Name** column header of the list box. Then, to change the order from descending to ascending, click the list box's **Job Name** column header again.

d. Select the appropriate report job template in the list box (if more templates exist than can be displayed at one time in the list box, you might have to click and drag the list box's scroll bar slider down to find the template). Or, type all or part of the template name for which you want to search in the **Enter Job Name** field, click the search button to show the closest matching template(s) in the list box, and then select the appropriate report job template.

e. Click **OK** to assign the selected template to the report job. The filter options associated with the selected template are applied to the report job.

4. Click **Save as Default** to save the current settings for the next time the report options are accessed. The current job name will not be saved as the deafult.
5. Click **OK** to schedule the report. The report job will appear in the **Manage Scheduled Jobs** dialog box.

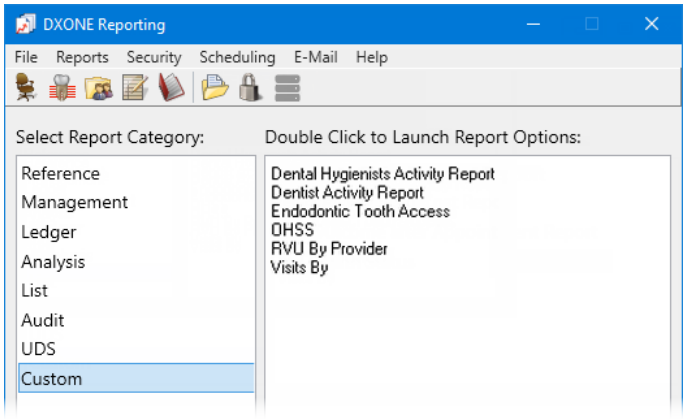
Editing a Report Job Template

You can edit a report job template for an IHS custom report.

To edit a report job template

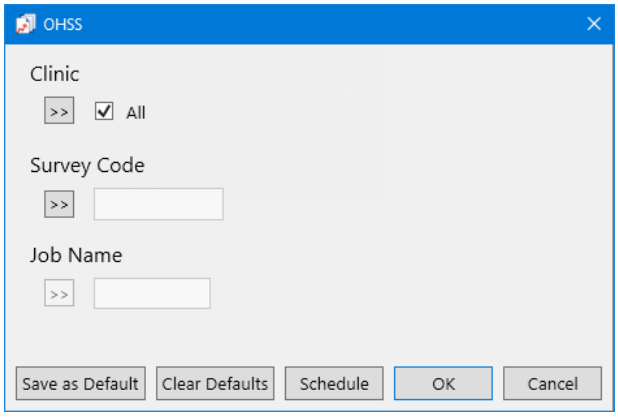
1. In DXOne Reporting, in the **Select Report Category** list box, select **Custom**.

   The custom reports appear in the right list box.



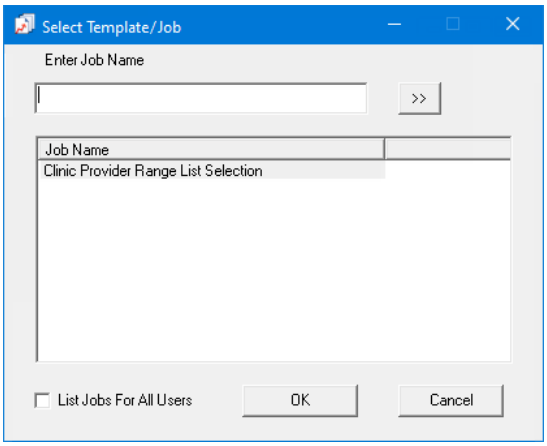
2. Double-click the report you want to schedule from a template.

   The corresponding report dialog box appears.



3. Select a template:

   a. Click the **Job Name** search button. The search button is only enabled if templates have been created or jobs have been schedule for this report. The **Select Template/Job** dialog box appears. Any existing templates/jobs that have been created for the report by the user you are currently logged on as are shown in the list box.



b. Select **List Jobs for all users** if you want to view templates for all users for this report. If this option is selected, a **User ID** column appears to the left of the **Job Name** column and displays the user ID for each job/template. The **List Jobs for all users** check box is available only if the current user has the "Scheduled Jobs – Manage All Users" DXOne Reporting security right enabled; in other words, the current user has rights to view reports or jobs for other users.

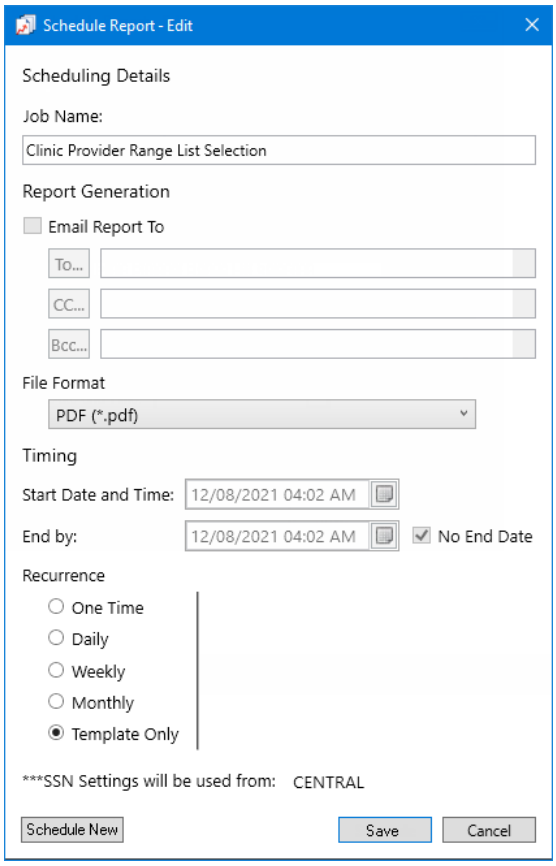
c. The templates are listed alphabetically in ascending order by default. To reverse the order, click the **Job Name** column header of the list box. Then, to change the order from descending to ascending, click the list box's **Job Name** column header again.

d. Select the appropriate report job template in the list box (if more templates exist than can be displayed at one time in the list box, you might have to click and drag the list box's scroll bar slider down to find the template). Or, type all or part of the template name for which you want to search in the **Enter Job Name** field, click the search button to show the closest matching template(s) in the list box, and then select the appropriate report job template.

e. Click **OK** to assign the selected template to the report job. The filter options associated with the selected template are applied to the report job.

4. Edit the options for filtering the report results as necessary.
5. Click **Save as Default** to save the current settings for the next time the report options are accessed. The current job name will not be saved as the deafult.
6. Click **Schedule**.

The **Schedule Report - Edit** dialog box appears.



7. Edit the **Job Name**.
8. Do one of the following:
   - Click **Save** to save any changes to the template (its job name and report filters).
   - Click **Schedule New** to save the changes as a new report job that will appear in the **Manage Scheduled Jobs** dialog while preserving the original template (its job name and report filters). The new job name must be different than the original to add the template as a new template.

Chapter 10: Document Center

Document Center can help your office become paperless. You can scan, capture, and import documents (such as patient letters, EOBs, 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 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 Document Center).

This chapter covers the following topics:

- Opening Document Center
- The Document Center Window
- Setting up the Document Center
- Acquiring Documents and Images
- Printing to the Document Center
- Working with Unfiled Documents
- Entering Document Information
- Importing MiPACS Images
- Working with Documents
- Signing Documents
- Signing Consent Forms
- Printing and Exporting Documents

Opening Document Center

You can open Document Center from Family File, Ledger, Chart, Appointment Book, Treatment Planner, Collections Manager, and Office Manager.

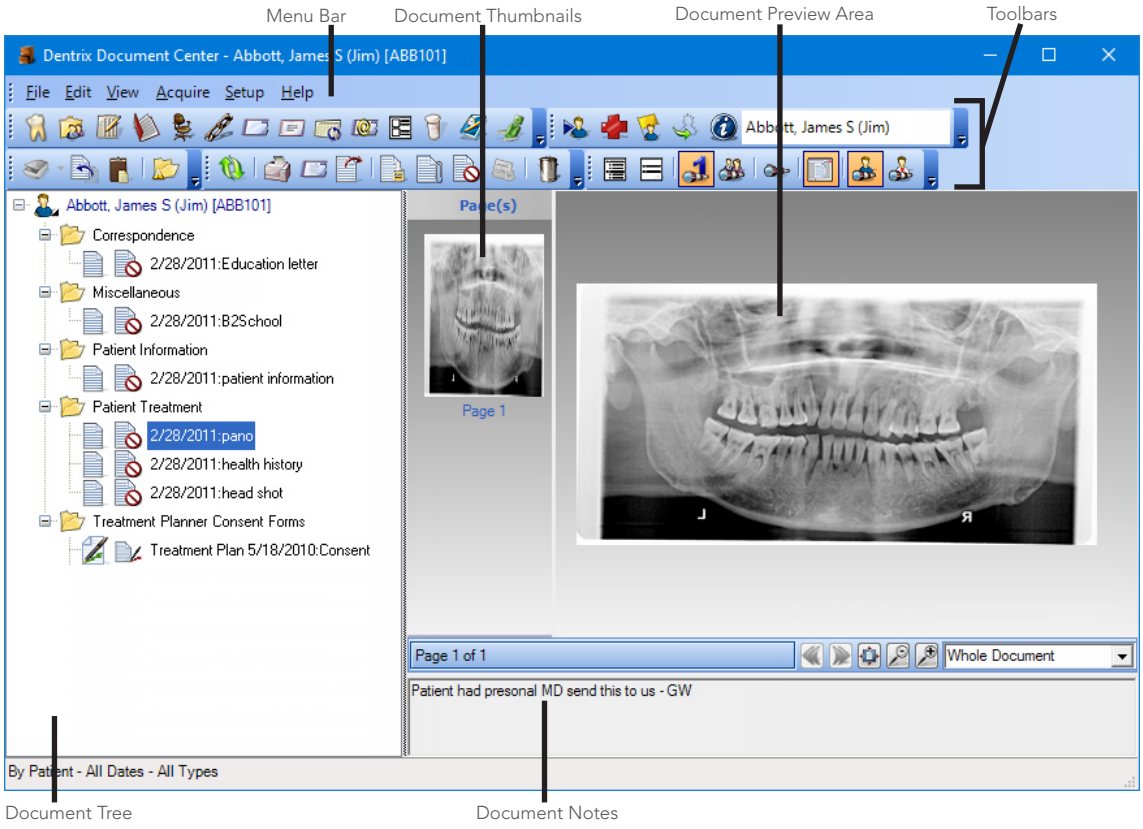
To open Document Center

In a Dentrix Enterprise module, click the **Document Center** button  .

When opened from Family File, Ledger, Chart, Appointment Book, Treatment Planner, or Collections Manager, the Document Center module displays the selected patient's attached documents. When opened from Office Manager, the Document Center module gives you the option to select a provider to view his or her attached documents.

The Document Center Window

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.

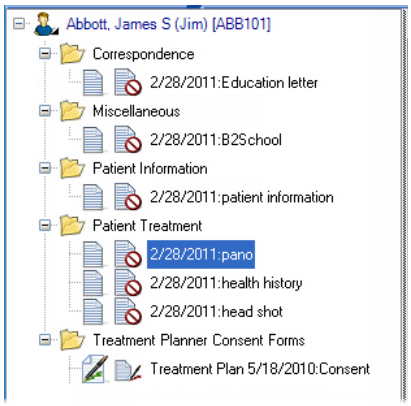


This section covers the following topics to help you understand how to use the **Document Center** window:

- The Document Tree
- The Document Thumbnails
- The Document Preview Area
- The Document Center Toolbars
- Viewing Documents

The Document Tree

The document tree displays the document source (patient, provider/staff, employer, referral, or insurance), the document types in use under that source, and the documents associated with each of those types. The plus (+) or minus (-) sign next to a document type folder indicates whether the list item is expanded or collapsed. Click the plus sign to view the contents of the document type folder. Click the minus sign to hide the contents of the document type folder. The document tree is where you will select documents for viewing, editing, printing, and so forth.



The Document Thumbnails

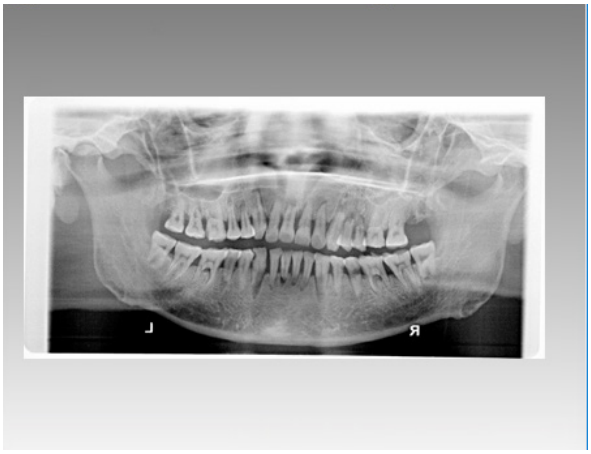
For a selected document, thumbnails (miniature images) may appear for each page of the imported document. Click any of the thumbnails to preview the corresponding page. If you want to view an OLE document (one that has been imported using Object Linking and Embedding), you must have the appropriate program or viewer installed on the computer (for example, Microsoft Word is required to view a DOC file).



The Document Preview Area

The document preview area displays the document selected in the document tree. If the document has multiple pages, Document Center displays the first page initially, but you can view the other pages:

- By clicking a thumbnail.
- By clicking the Previous Page and Next Page buttons on the preview toolbar.
- By scrolling.



Note: In Document Center, you can store files of any type supported by Windows. However, you can preview only the files that are of the types supported for previewing in Document Center (such as .pdf, .png, .jpg, .doc, .xls, and .ppt).

The Document Center Toolbars

Document Center includes toolbars with buttons to access certain areas or features of Dentrix Enterprise. The toolbars specific to Document Center and some of the available buttons are explained in the following table.

Patient Information Toolbar



	Click the **Select Patient** button to open the Select Patient dialog box and select a patient to view in Document Center.

Acquire Toolbar



	Click the **From Device** button to acquire documents from a WIA- or TWAIN-compliant device, such as a digital camera or scanner. You can also click the down arrow to select the acquisition source.
	Click the **Import From File** button to copy a file from your computer's hard drive, removable media, or another computer on the network into Document Center.
	Click the **Paste From Clipboard** button to create a document from text and/or graphics on the Windows Clipboard.
	Click the **Unfiled Documents** button to import an unfiled document to the Document Center of the patient, provider, employer, referral, or insurance plan currently being viewed.

Document Toolbar



	Click the **Print Document(s)** button to send the selected documents to a printer.
	Click the **Send Document(s)** button to compose an email message to send to a patient, provider, employer, referral, or insurance plan with any selected documents included as attachments.
	Click the **Export Document(s)** button to save a copy of the selected documents in an alternate location (for example, a USB drive).
	Click the **Document Information** button to view or change the date, type, description, or notes of the selected document.
	Click the **Modify Document Attachments** button to change the source to which the selected document is attached.
	Click the **Sign Document** button to sign the selected document.
	Click the **Modify Document** button to change the color of, crop, rotate, or add a page to the selected document.
	Click the **Delete Selected Document(s)** button to delete the selected documents.

View Toolbar



	Click the **Expand List** button to expand all the document type folders to view their contents in the document tree.
	Click the **Collapse List** button to hide all the document type folders in the document tree.
	Click the **By Single** button to view documents of the selected patient, provider, employer, referral, or insurance plan.
	Click the **By Family** button to view documents of the selected patient's family. This button is available only if a patient is selected.
	Click the **Filters** button to filter the types of documents being viewed and to view documents within a specified date range.
	Click the **Show Preview** button to show and hide document preview area.
	Click the **By Patient** button to view the documents of a patient you select.
	Click the **By Provider/Staff** to view the documents of a provider you select.

Viewing Documents

In Document Center, you can view documents by patients, family, providers/staff, employers, referrals, and insurance plans. You can also apply filters to view documents acquired within a certain date range and assigned a certain document type.

To change the view

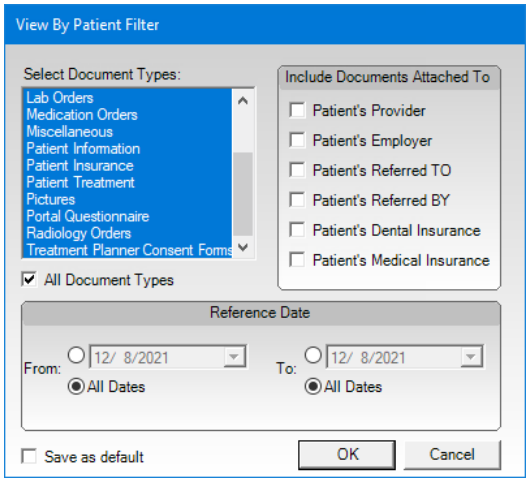
In Document Center, from the **View** menu, click one of the following options:

- **By Patient** – A dialog box appears, allowing you to select a patient.
- **By Provider/Staff** – A dialog box appears, allowing you to select a provider or staff member.
- **By Employer** – A dialog box appears, allowing you to select an employer.
- **By Referred BY** – A dialog box appears, allowing you to select a referral.
- **By Referred TO** – A dialog box appears, allowing you to select a referral.
- **By Dental Insurance Plan** – A dialog box appears, allowing you to select a plan.
- **By Medical Insurance Plan** – A dialog box appears, allowing you to select a plan.
- **By Single** – To view documents of the selected patient, provider, employer, referral, or insurance plan.
- **By Family** – To view documents of the selected patient's family. This option is available only if a patient is selected.

To filter the list in the document tree

1. From the **View** menu, click **Filters**.

   The **View By [Source] Filter** (the name varies, depending on the selected view) dialog box appears.



2. Set up the following options:
   - **Select Document Types** – Select the document types you want to view, or select **All Document Types** to view all types.
   - **Include Documents Attached To** – Select the sources for which you want to view attached documents.
   - **Reference Date** – Enter a date range in the **From** and **To** boxes to view documents that were acquired during the specified range; select **All Dates** for both **From** and **To** to view documents regardless of the acquisition date; or enter a date for either **From** or **To**, and select **All Dates** for the other option to use an open-ended date range.

- **Save as default** – To save the current filter settings for the next time you open the Document Center, select this check box.

3. Click **OK**.

Setting up the Document Center

This section covers the following topics about what to set up before you start using the Document Center:

- Selecting a Document Center Printer
- Customizing Document Types

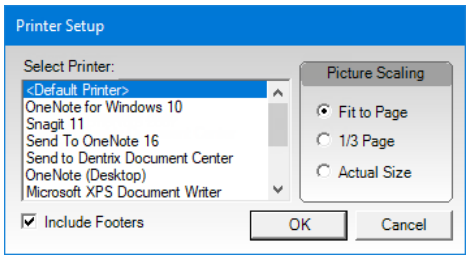
Selecting a Document Center Printer

You can print documents, images, and the Document Center List. Select the printer you want to use for printing from Document Center.

To select a printer

1. In Document Center, from the **Setup** menu, click **Printer**.

   The **Printer Setup** dialog box appears.



2. Set up the following options:
   - **Select Printer** – From the list, select the printer you want to use.
   - **Picture Scaling** – Select how you want the Document Center to scale images when printing:
     - **Fit to Page** – To fit the image on a single page.
     - **1/3 Page** – To have the image scaled to fit on 1/3 of a page.
     - **Actual Size** – To print the image in the actual size that it was imported.
   - **Include Footers** – To include footers on a printed page, select this check box. The information in the footer will vary slightly based on the Document Center source selected (patient, provider/staff, employer insurance plan, or referral) but may include the reference date, the patient's last name, first name, middle initial, preferred name, and chart number, and the page number.
3. Click **OK**.

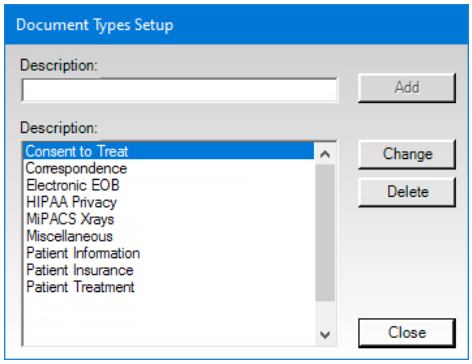
Customizing Document Types

All documents in Document Center must be assigned to a document type. These types are used to categorize as well as describe the type of document. You can add, edit, and delete document types as needed if the pre-set ones do not meet your practice's needs.

To customize a document type

1. In Document Center, from the **Setup** menu, click **Document Types**.

   The **Document Types Setup** dialog box appears.



2. Perform any of the following functions:
   - **Add** – Enter a unique description for the type you want to add, and then click **Add**.
   - **Change** – Select the type you want to change, enter a new description, and then click **Change**.
   - **Delete** – Select the type you want to delete (it cannot be assigned to a signed document), and then click **Delete**.
3. Click **Close**.

Acquiring Documents and Images

You can import documents and images into Document Center with a scanner or digital camera. You can also import documents and images from a file on your computer, another computer on your office's network, a disc, an external drive, or a saved email attachment. Also, using the Windows Clipboard copy and paste functionality, you can import any image or plain text.

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 acquire a document or image from

In Document Center, from the **Acquire** menu, do one of the following:

- Point to **From Device**, and then click the appropriate device. The corresponding third-party program opens. 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.
- Click **Import from File**. The **Import** dialog appears. Locate the directory where the file is stored, select the desired file, and then click **Open**.
- Click **Paste from Clipboard**. If nothing is on the Windows Clipboard, this option is not available.

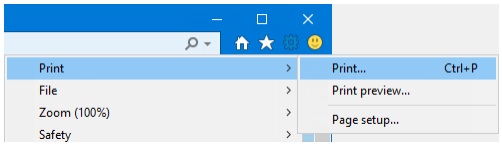
When the acquisition is complete, the **Document Information** dialog box appears. Enter the appropriate document information as explained in "Entering Document Information" in this chapter.

Printing to the Document Center

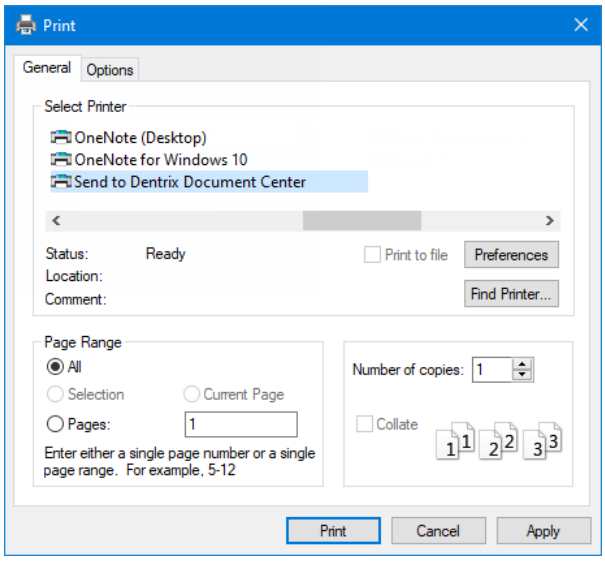
Dentrix Enterprise has a printer driver that allows you to save a copy of a document from any program that allows printing, such as a word processing program or a Web browser, as a .pdf file in Document Center. You can use this tool even without any Dentrix Enterprise modules open.

To print to the Document Center

1. Use the desired program's print capabilities to print a copy of whatever it is you are viewing (for example, in your browser, with a Web page being viewed, right-click anywhere on that page, and then click **Print**).

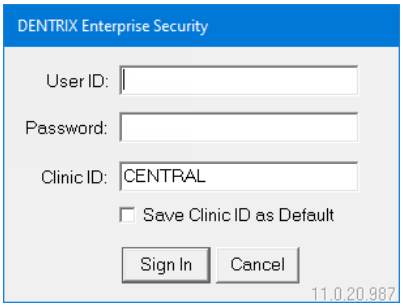


   A **Print** dialog box appears (the look and functionality may vary).



2. From the list of available printers, select **Send to Dentrix Document Center**, and set up any other options as needed.
3. Click **Print**.

   If you are not already logged on to Dentrix Enterprise, a login dialog box appears.



4. Enter your credentials, and then click **Sign In**.

   When the acquisition is complete, the **Document Information** dialog box appears. Enter the appropriate document information as explained in "Entering Document Information" in this chapter.

Working with Unfiled Documents

Sometimes you have a bunch of documents to scan or import or multiple image files to import, and it would be nice to just do them all at once. Instead of having to acquire each item and attach it to an entity (such as a patient or a provider) one at a time, you can acquire a batch of related or unrelated documents and images for the same entity or various patients, providers, staff members, insurance carriers, employers, and/or referrals. Then, as you have time, you can attach these "unfiled" documents to the appropriate entities.

A document as considered unfiled if it was acquired using one of the following methods:

- By printing with the Document Center Printer Driver from another program. The printed document will be imported as a .pdf file into the **Document Center Unfiled Documents** window.
- By acquiring a new document from a file, a device, or the Windows Clipboard in the **Document Center Unfiled Documents** window.
- By removing all attachments from a document, thus making it an unfiled document.

This section covers the following topics about working with unfiled documents:

- Attaching Unfiled Documents
- Combining Documents

For information about the features of the **Document Center Unfiled Documents** window, see the "Working with unfiled documents" topic in the Dentrix Enterprise Help.

Attaching Unfiled Documents

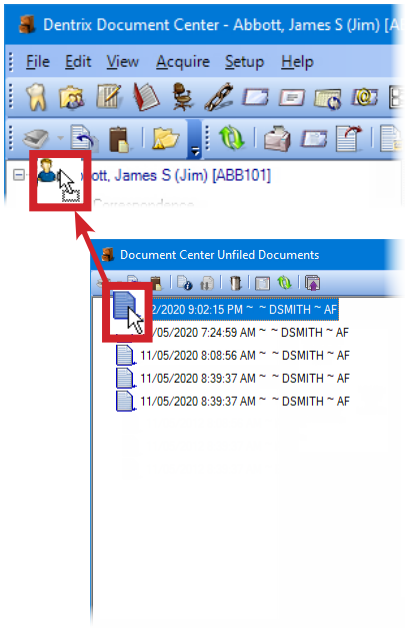
You can assign an unfiled document to one or more entities: patients, providers, referrals, employers, and/or insurance plans.

To quickly attach an unfiled document to one entity

1. With the desired patient, provider/staff, employer, referral, or insurance plan being viewed in the main **Document Center** window, from the **Acquire** menu, click **Unfiled Documents**.

   The **Document Center Unfiled Documents** window opens.

2. Drag the desired unfiled document from the **Document Center Unfiled Document** window to the document tree in Document Center.

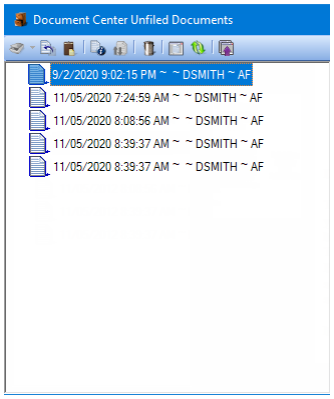


   If the document does not have a type and a description assigned to it, the **Document Information** dialog box appears. Enter the appropriate document information as explained in "Entering Document Information" in this chapter.

To attach an unfiled document to one or more entities

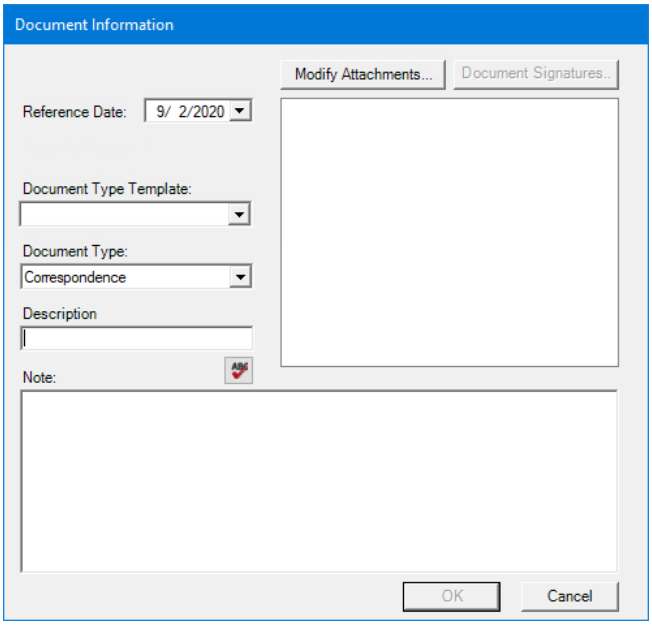
1. In Document Center, from the **Acquire** menu, click **Unfiled Documents**.

   The **Document Center Unfiled Documents** window appears.



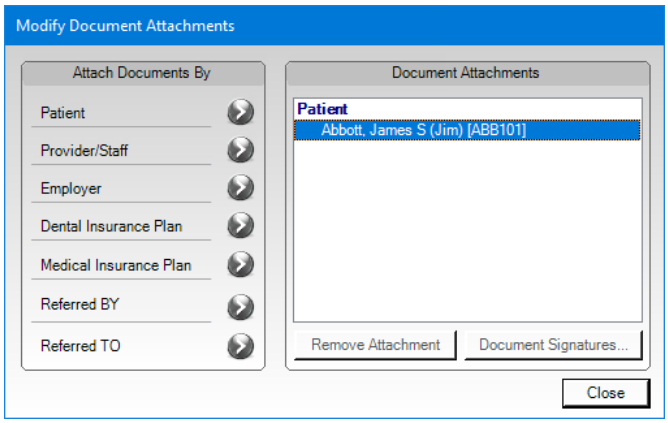
2. Select a document.
3. Click the **Document Information** button to view the document information.

   The **Document Information** dialog box appears.



4. **Click Modify Attachments**.

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



5. Under **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.
   - **Employer** – In the **Select Employer** dialog box that appears, select the desired employer.
   - **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.
   - **Referred TO** – In the **Select Referred To** dialog box that appears, select the desired referral destination.

   The attachment associations appear in the **Document Attachments** list box.

   Note: To remove an attachment association, select it in the **Document Attachments** list box, and then click **Remove Attachment**.

6. Click **Close** to return to the **Document Information** dialog box.

   Enter the appropriate document information as explained in "Entering Document Information" in this chapter.

Combining Documents

You can quickly combine multiple images that you want to be stored in Document Center as multiple pages of the same document. For example, you may want to combine a series of intraoral or extraoral images taken during a single visit.

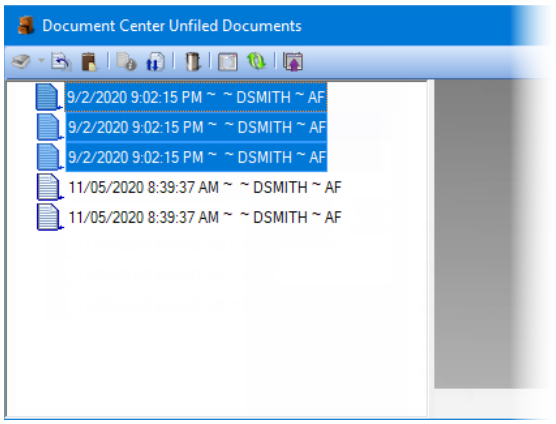
Notes:

- You can combine images only in the **Document Center Unfiled Documents** window. You cannot combine images that are attached to an entity (such as a patient or provider).
- You can only combine image files (such as .png or .jpg files). You cannot combine .pdf files or other non-image files (such as .doc or .xls files).

To combine documents

1. In Document Center, from the **Acquire** menu, click **Unfiled Documents**.

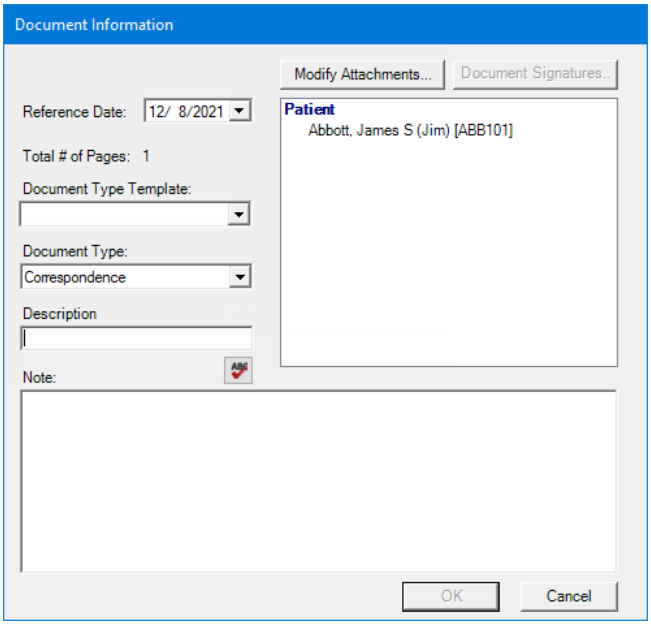
   The **Document Center Unfiled Documents** window opens.



2. Select the desired images. The first one selected will be on the first page of the new document; the second, on the second page; and so on.
3. Click the **Combine Documents** button .

Entering Document Information

Once the document has been captured, scanned, imported, or pasted into Document Center, the **Document Information** dialog box appears so that you can attach information and categorize the document.



To enter the document information

1. In the **Document Information** dialog box, set up the following options:
   - **Reference Date** – By default, the date of the document is the current system date, but you can change it as needed. This date will appear for this document in the document tree and when it is printed.
   - **Document Type** – Select the type you want to assign the document.
   - **Description** – Enter a description for the document. 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.
   - **Note** – Enter 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 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.
2. Click **OK**.

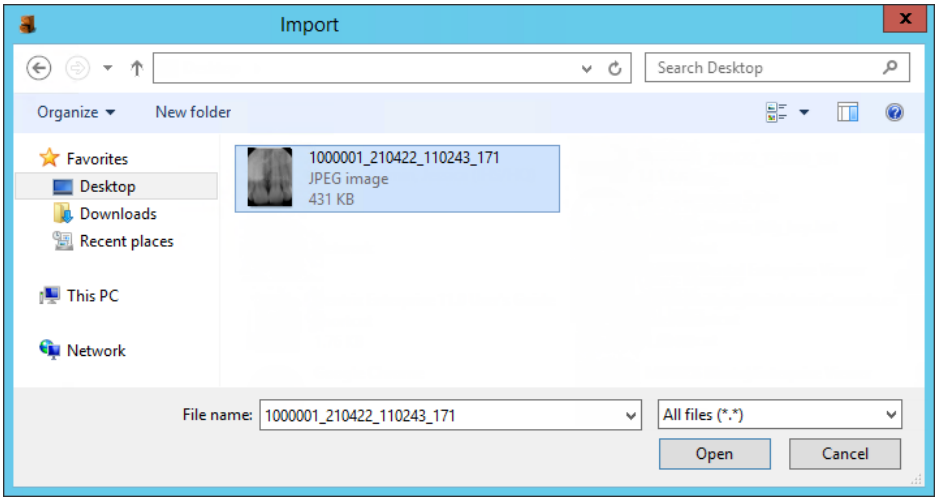
Importing MiPACS Images

To attach digital X-ray images that were acquired using MiPACS to insurance claims, you must first import the images that have been exported from MiPACS into the patient's Document Center. For information about exporting images from MiPACS, see "Exporting Images from MiPACS" on page 812 in the Other Features chapter.

To import image

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

   The **Import** dialog appears.

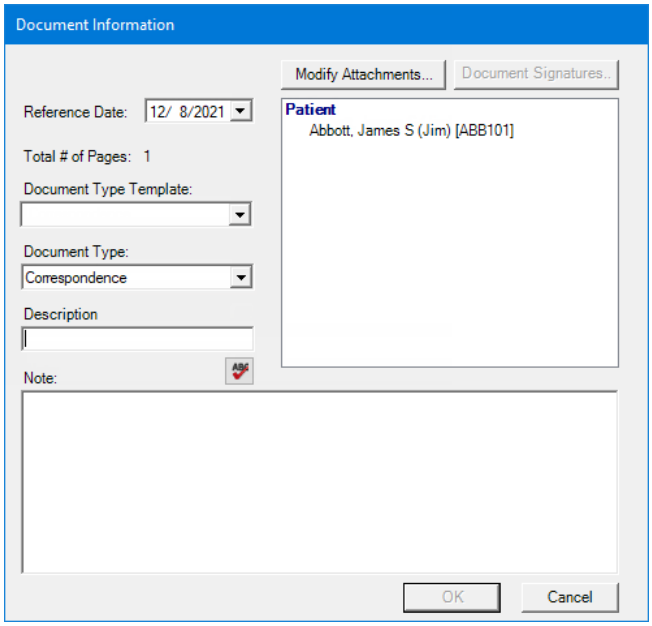


2. To navigate to the directory where the image file that was exported from MiPACS is located, in the address box at the top of the dialog box, enter **\\[EDR server name]\Doc_Center\MiPACS Export\[patient Name_ description_date]**.

   Note: Replace **[EDR server name]** with a server name. Replace **[patient Name_ description_date]** with a folder name, such as JohnDoe_PA8_080821.

3. Select the image file.
4. Click **Open**.

   The **Document Information** dialog box appears.



5. Enter the appropriate document information as explained in "Entering Document Information" in this chapter. For example, you might specify something similar to the following:
   - **Document Type Template** – Imported Images for Insurance.
   - **Document Type** – MiPACS Image.
   - **Description** – pa of tooth #12.
6. Click **OK**.
7. Now, delete the image file that was exported from MiPACS:
   a. On your computer, open File Explorer.
   b. In the address box at the top of the window, enter **\\[EDR server name]\Doc_Center\MiPACS Export**.

      Note: Replace **[EDR server name]** with a server name.

   c. Select the folder that contains the exported image, such as JohnDoe_PA8_080821.

      Note: If the folder contains multiple files, and you want to delete only one image, open the folder, and then select the image file to be deleted.

   d. Click **Delete**.
8. Now, you can attach the image that was imported into the patient's Document Center to an insurance claim for that patient. For information on how to attach a Document Center image to a claim, see "Including Attachments with Dental Insurance Claims" on page 393 in the Ledger chapter.

Working with Documents

In Document Center, you can view attached documents by patients, providers, insurance carriers, and referral sources. You can select filters to view documents acquired within a certain date range and assigned to a certain document type. From Document Center, you can perform functions such as adding more pages to documents, adjusting the brightness and color of an image, and rotating a document.

This section covers the following topics about working with documents:

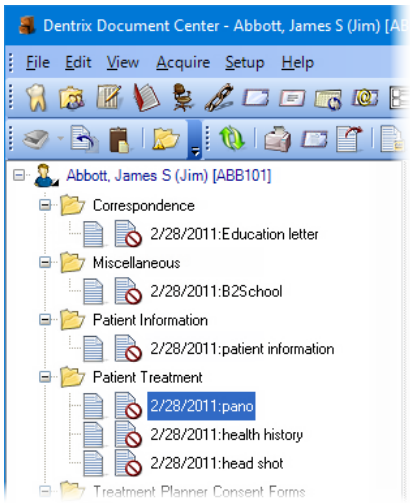
- Editing Document Information
- Modifying Document Attachments
- Deleting Documents
- Modifying Documents

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.

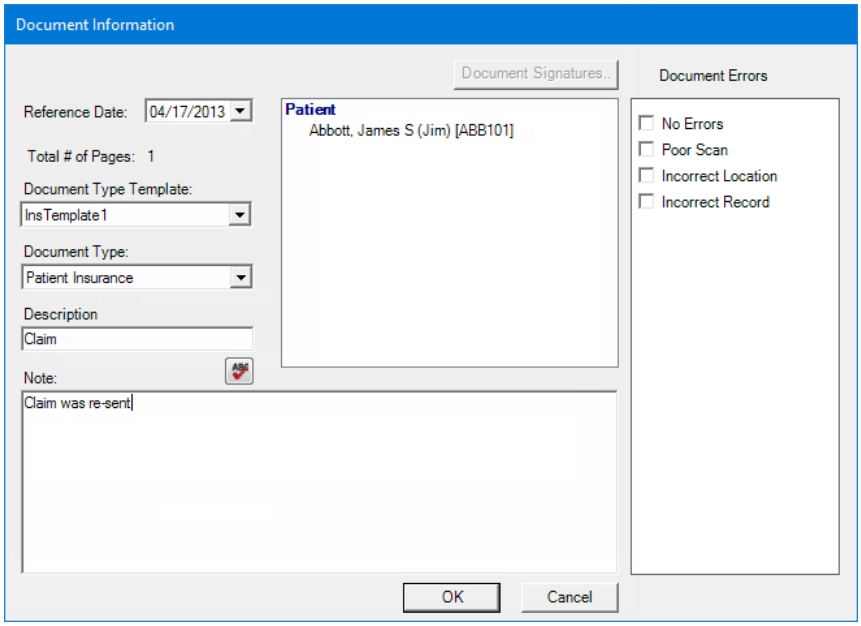
To edit document information

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



2. From the **Edit** menu, click **Document Information**.

   The **Document Information** dialog box appears.



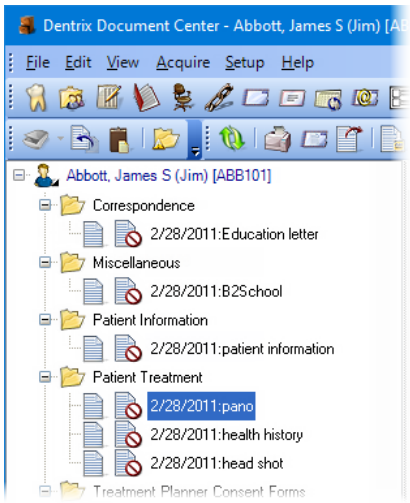
3. Make the necessary changes to any of the options. For details about each available option, see "Entering Document Information" in this chapter.
4. Under **Document Errors**, do one of the following to "audit" the document (specify whether there are errors or not):
   - Select the **No Errors** check box.
   - Select the check box of each applicable error type (**Poor Scan**, **Incorrect Location**, **Incorrect Record**, and any user-defined error type).
5. Click **OK**.

Modifying Document Attachments

You can modify attachment sources for a specific document. 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.

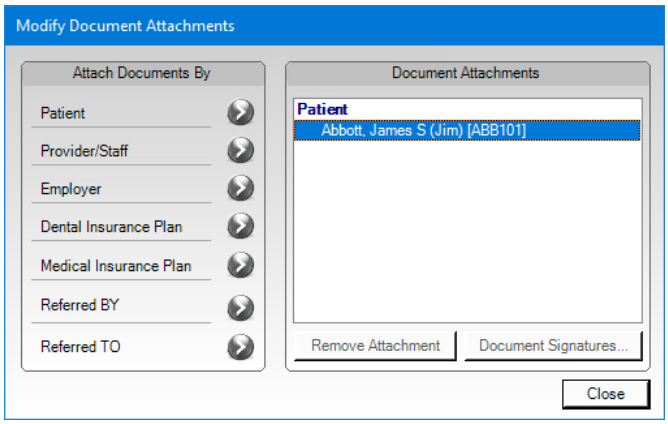
To modify a document's attachments

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



2. From the **Edit** menu, click **Modify Document Attachments**.

   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.
     - **Employer** – In the **Select Employer** dialog box that appears, select the desired employer.
     - **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.
- **Referred TO** – In the **Select Referred To** dialog box that appears, select the desired referral destination.

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**.

Tip: To view the signatures attached to a document, click **Document Signatures**. This button is available only if the document has one or more electronic signatures.

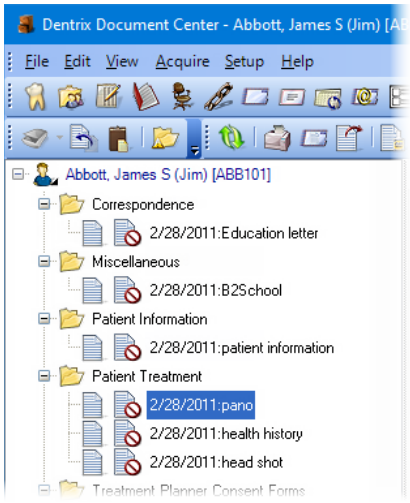
4. Click **Close**.

Deleting Documents

You can delete a document that has not been signed. Dentrix Enterprise will not delete the original document from the computer but will remove it from Document Center.

To remove a document

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



2. From the **Edit** menu, click **Delete Selected Document(s)**.

   Do one of the following:

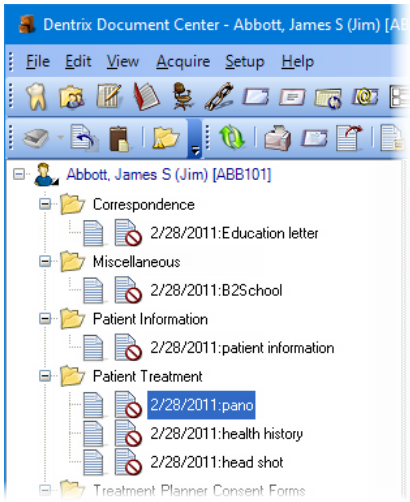
   - If the document has multiple attachment sources, a dialog box appears. Select whether you want to delete the document for only the current attachment source being viewed in Document Center or delete the document for all attachment sources, and then click **OK**.
   - If the document is attached to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

Modifying Documents

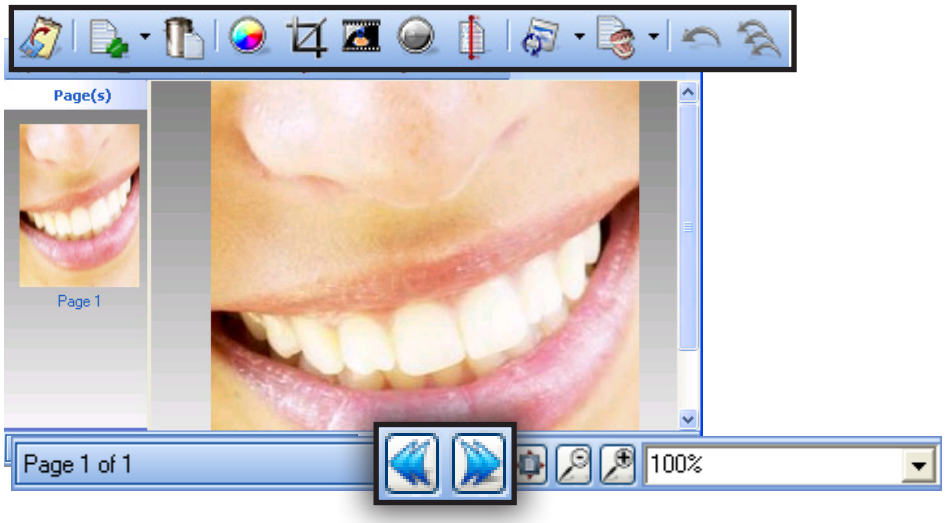
With the Document Center, you can add pages to, make color adjustments to, crop, sharpen, rotate, and assign an orientation to a document being previewed. You can make these modifications only to documents of an image file type (such as .jpg or .png).Also, you cannot modify a document that has been signed.

To modify a document

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



2. From the **Edit** menu, click **Modify Document** (the icon next to this menu item is highlighted if the document is already in modify mode).
3. If the document being previewed has multiple pages, select the page you want to edit.



Tip: You can click the **Previous Page** or **Next Page** button on the Preview toolbar to navigate between the pages of a multi-page document.

4. The Modify Document toolbar appears at the top of the preview area. Make any necessary changes to the document. The function of each button on the Modify Document toolbar is explained in the following table.

	Click the **Add Page** button to import an image as another page of the image being previewed.
	Click the **Delete Page** button to delete the selected page of the image being previewed.
	Click the **Image Adjustments** button to adjust the sharpness, saturation, contrast, and/or brightness of the image being previewed.
	Click the **Crop Image** button to crop the image being previewed to the area you select.
	Click the **Invert Colors** button to invert the colors of the image being previewed.
	Click the **Convert To Grayscale** button to change the image being previewed to a grayscale image.
	Click the **Remove Spots** button to sharpen the image being previewed.
	Click the **Rotate** button to rotate or flip the image being previewed.
	Click the **Orientation** button to specify the point of view used to acquire the image being previewed. Click **<None>**, **No Orientation**, **Right Side of Mouth**, **Left Side of Mouth**, **Entire Mouth**, **Inner**, or **Outer**. A watermark appears in the lower-right corner of the document to indicate the orientation of the document: R for right side, L for left side, M for mouth, I for inner, O for outer. 
	Click the **Undo** button to undo the last operation performed on the image being modified.
	Click the **Undo All** button to undo all edits made to the image being modified since the last time it was saved.

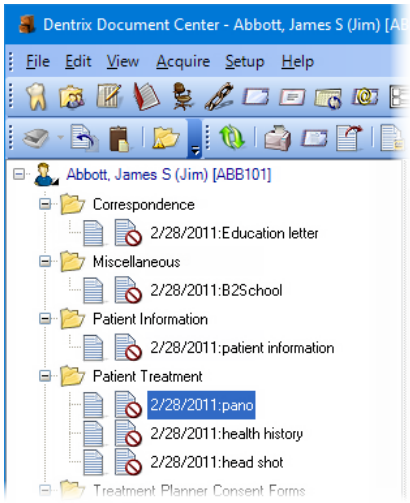
Signing Documents

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.

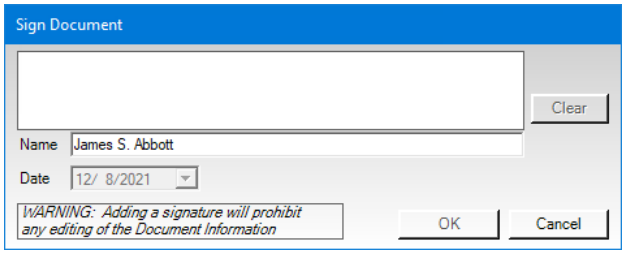
To sign a document

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



2. From the **Edit** menu, click **Sign Document**. (This option reads, "View Signatures," if the selected document already has a signature.)

   The **Sign Document** dialog box appears.



3. The **Name** box 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**.

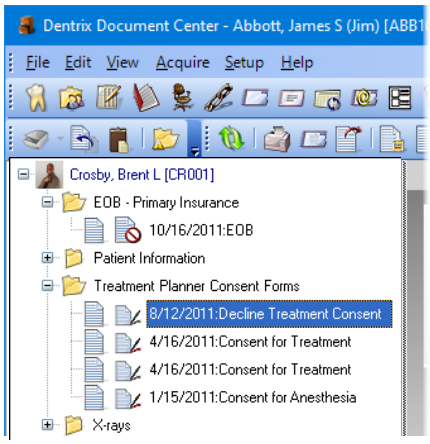
Signing Consent Forms

If you are viewing the Document Center of a patient who has consent forms in the Treatment Planner, the "Treatment Planner Consent Form" document type folder appears in the document tree.

The patient and/or provider can sign a consent form from Document Center. Also, as with other document types, you can only edit unsigned consent forms.

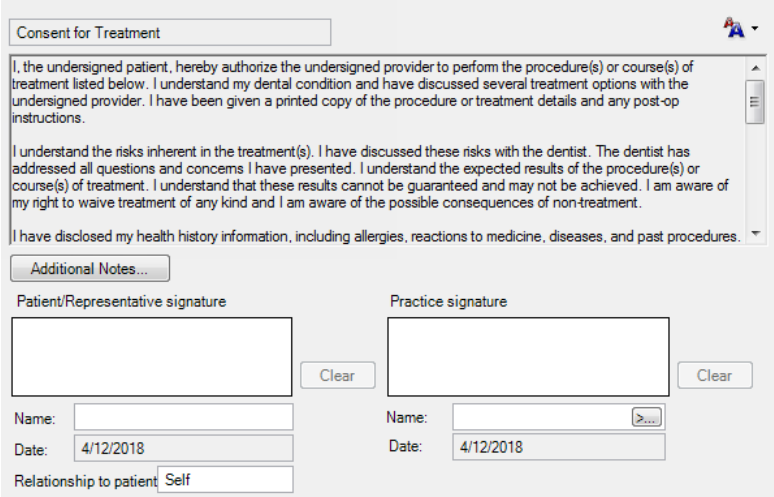
To sign a consent form

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



2. From the **Edit** menu, click **Modify Document**.

   The consent form appears.



3. Enter the name of the patient and provider or staff member in the appropriate **Name** boxes.
4. Use a mouse or other supported device to add the signatures in the **Signature** boxes. If you need to erase a signature so that you can re-sign, click **Clear**.
5. From the **Edit** menu, click **Modify Document** to save the signatures.

Printing and Exporting Documents

Document Center provides the following ways to print or export 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)**.
- **Send documents** – You can send a document or multiple documents electronically as email attachments. In the Document Center document tree, select the documents you want to send. Then, from the **File** menu, click **Send Document(s)**.

  Tip: HIPAA constraints make it unwise for you to include patient information and provider/practice information within the same message for security/privacy. Be mindful of this when sending documents through email.

- **Export documents** – You can export documents to your computer's hard drive, a shared network location, or any removable media or hard drive. In the Document Center document tree, select the documents you want to export. Then, from the **File** menu, click **Export Document(s)**.
- **Attach documents to insurance claims** – For instruction on how to attach Document Center documents to a dental insurance claim, see "Including Attachments with Dental Insurance Claims" in Chapter 7: Ledger.

Chapter 11: Other Features

Dentrix Enterprise provides the following additional features:

- Viewing More Patient Information
- Viewing or Editing OHS Surveys
- Viewing OHS Graphs
- Sending Email Messages
- Quick Labels
- Quick Letters
- Continuing Care
- Patient Questionnaire
- Prescriptions
- Patient Alerts
- Office Journal
- Collections Manager
- Exporting Images from MiPACS

Viewing More Patient Information

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, treatment requests, and aged balances. You can add a picture to a patient's profile. You can customize the patient information view to suit your preferences. Also, you can quickly switch between viewing information for a patient and that patient's family members.

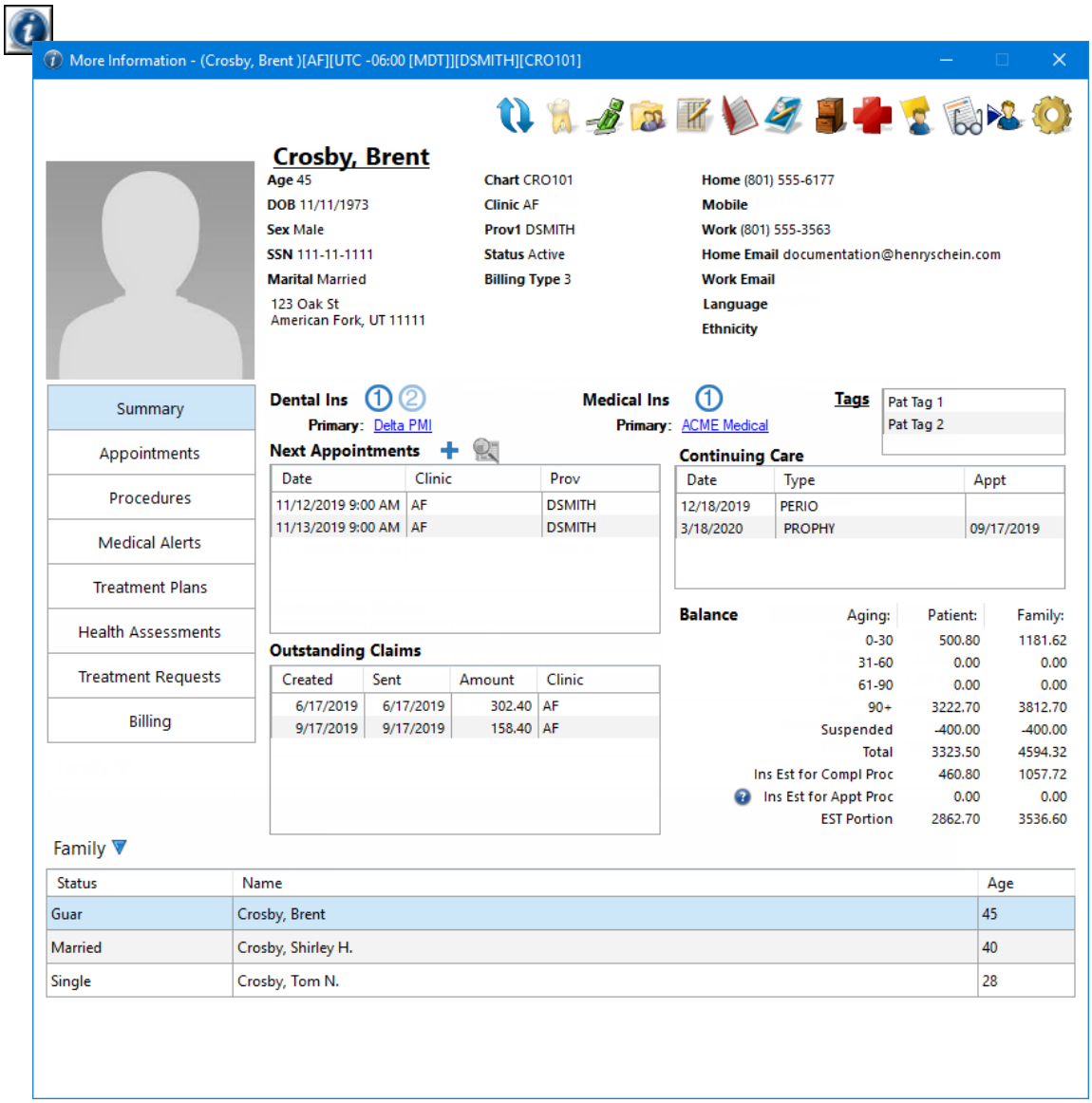
To use the More Information window

1. Do one of the following:
   - In the Treatment Planner, with the correct patient selected, from the **File** menu, click **More Information**.
   - In the Patient Chart, Ledger, or Family File, with the correct patient selected, from the **File** menu, click **More Information**.

- In the Appointment Book, with the correct patient's appointment selected, from the **File** menu, click **More Information**.
- In the Document Center, with the correct patient selected, click the **More Information** button on the Patient Information toolbar.
- In the Office Manager, from the **File** menu, click **More Information**. When the **Select Patient** dialog box appears, select a patient.

Note: There is also a **More Information** button on the Patient Information toolbar in the Treatment Planner, and on the toolbar of the Patient Chart, Ledger, Family File, Appointment Book, and Office Manager.

The **More Information** window appears.

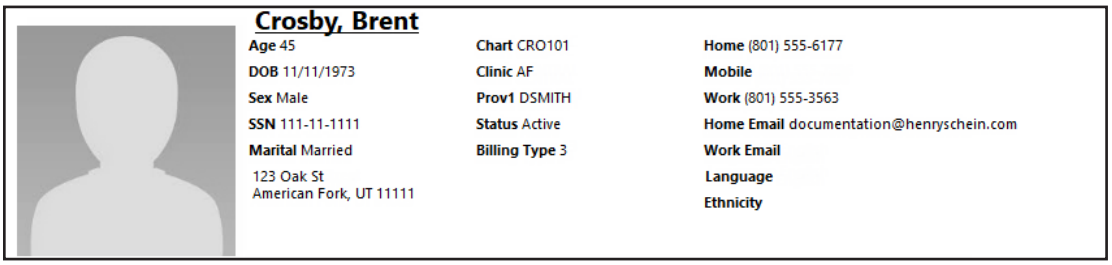


2. Use or view any of the following options and features as needed:

- **Toolbar** – The toolbar provides the following buttons:

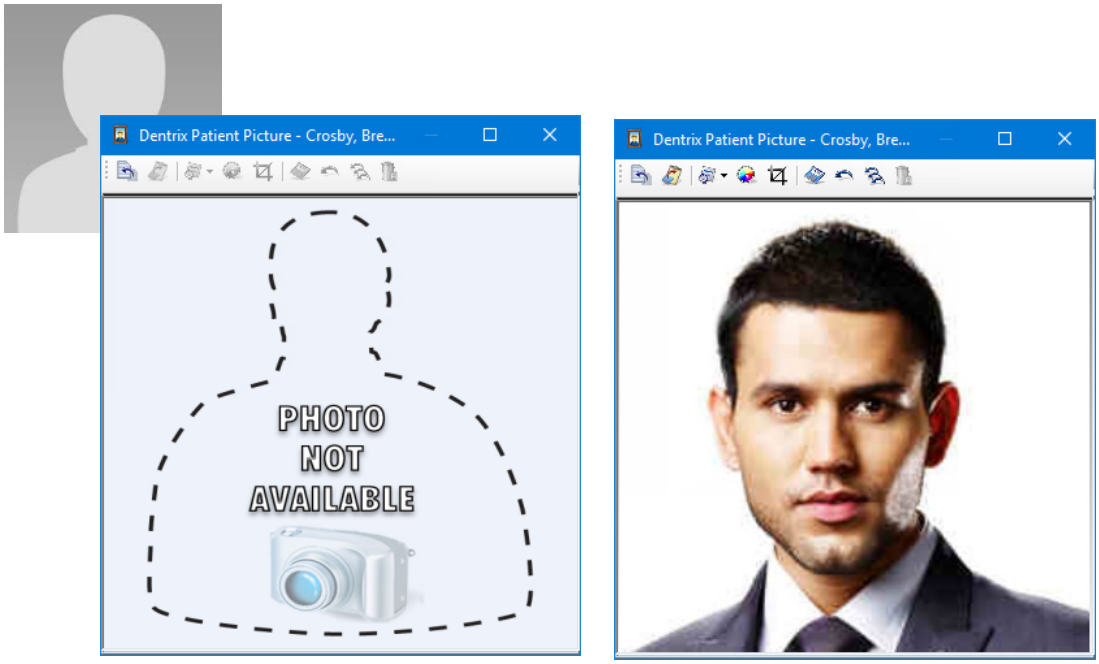
	To access the Patient Chart, Family File, Ledger, Appointment Book, Office Journal, or Document Center, click the corresponding button. When a patient-specific module (not the Appointment Book) opens, the patient will be selected automatically. Also, if you have an appointment selected on the **Appointments** tab or under **Next Appointments** on the **Summary** tab, and then you click the **Patient Chart** button, the provider attached to that appointment will be selected automatically as the provider for the charting session.
	To manage the patient's medical alerts, click the **Medical Alerts/Problems** button.
	To create a patient alert for the patient, click the **Patient Alerts** button.
	To select a different patient in the **More Information** window, click the **Select Patient** button.
	To select which tabs you want to include on or exclude from the window, and to select which buttons you want to include on or exclude from the toolbar of the window, click the **Settings** button.

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

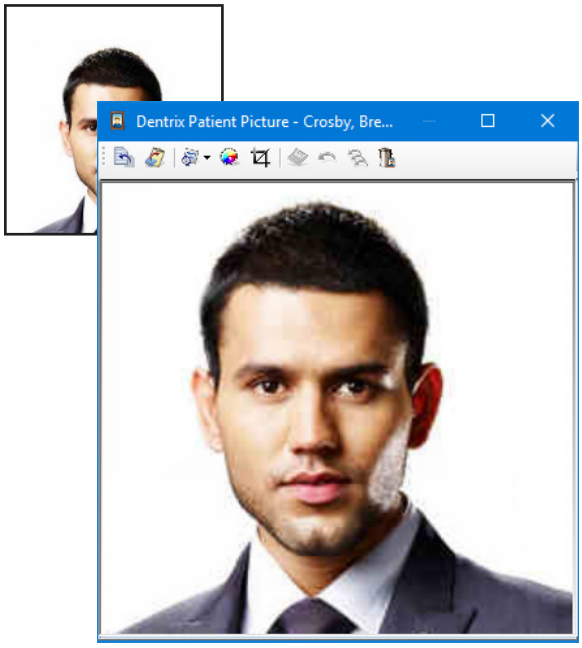


  - To open the **Patient Information** dialog box (without having to open the Family File first) to edit the patient's information, click the patient's name (which is a link).

- **Patient picture**:
  - To add a picture, click the box, click the **Import from File** button to select an image file (such as a .jpg file), use the available tools to make any necessary modifications to the picture, click the **Save** button, click **Yes** to confirm the changes, and then close the dialog box.

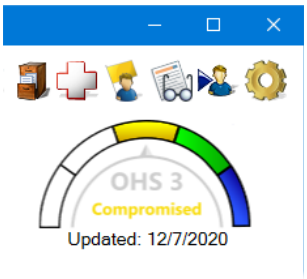


  - To edit the picture, click the picture in the box, use the available tools to make any necessary modifications to the picture, click the **Save** button, click **Yes** to confirm the changes, and then close the dialog box.

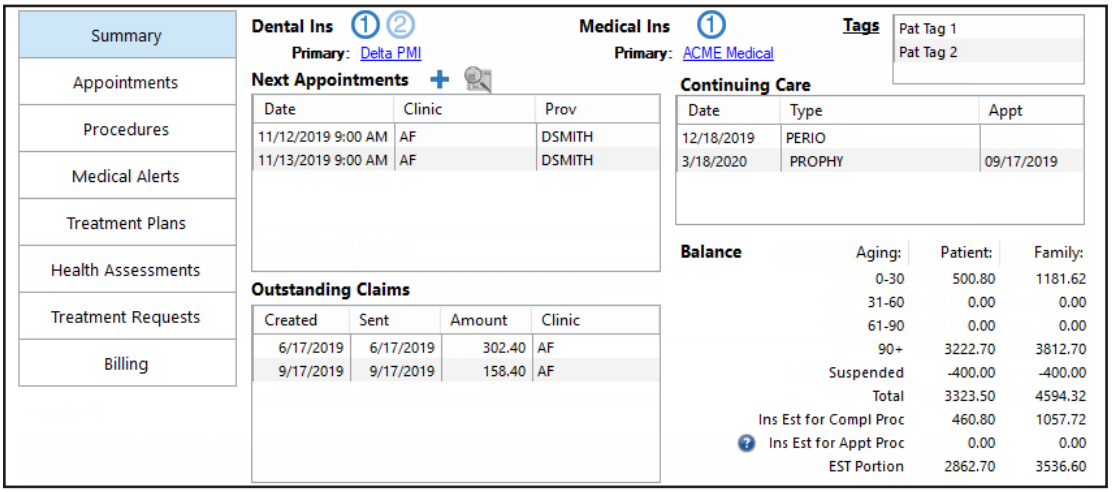


  - To remove the picture, click the picture in the box, click the **Delete Image** button, click **Yes** to confirm the deletion, and then close the dialog box.

- **OHS meter** – With a certain global setting enabled, an OHS meter appears in the upper-right corner. By default, the OHS meter displays the patient's most recent OHS score. If you select a different OHS survey (only one), on the **OHS** tab, the OHS meter displays the score that corresponds to that survey.

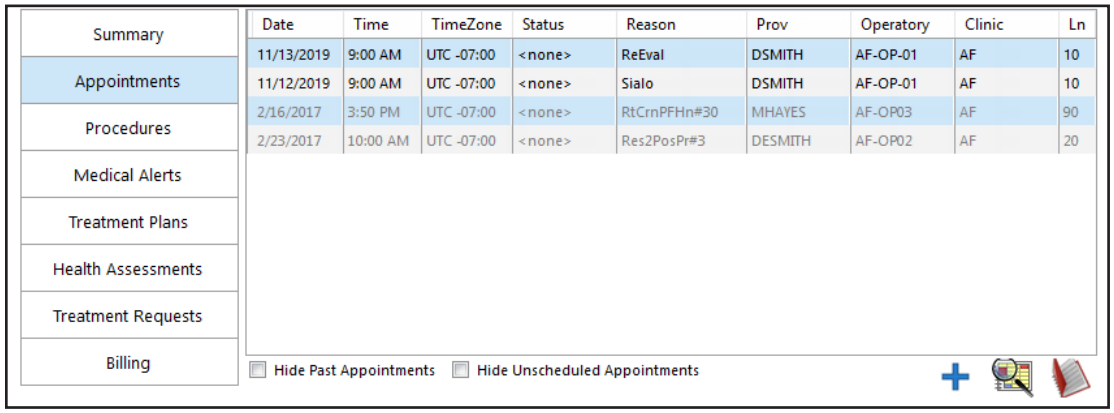


- **Summary tab** – This tab displays the following: the dental insurance plans that are attached to the patient (if there are multiple, click a circled number icon to view the name of the corresponding carrier), the medical insurance plans that are attached to the patient (if there are multiple, click a circled number icon to view the name of the corresponding carrier), the patient tags that are attached to the patient, the patient's future appointments, the continuing care types attached to the patient, the patient's outstanding claims, the aged balances and suspended credits for the patient and family, the estimated insurance portion and patient portion of completed procedures for the patient and family, and the estimated insurance portion for the selected appointments in the **Next Appointments** list.

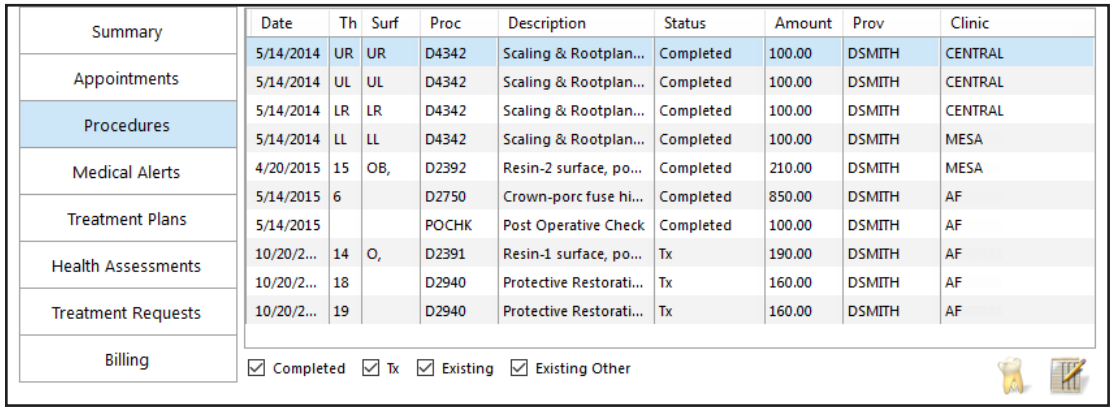


- To view or edit the patient's dental or medical insurance information, click the corresponding carrier link.
- To edit the patient tags that are attached to the patient, click the **Tags** link.
- To schedule an appointment for the patient, click the **New Appointment** button +.
- To open the Appointment Book and view one of the patient's upcoming appointments, select that appointment in the **Next Appointments** list, and then click the **Locate Appointment** button .

- **Appointments tab** – This 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).

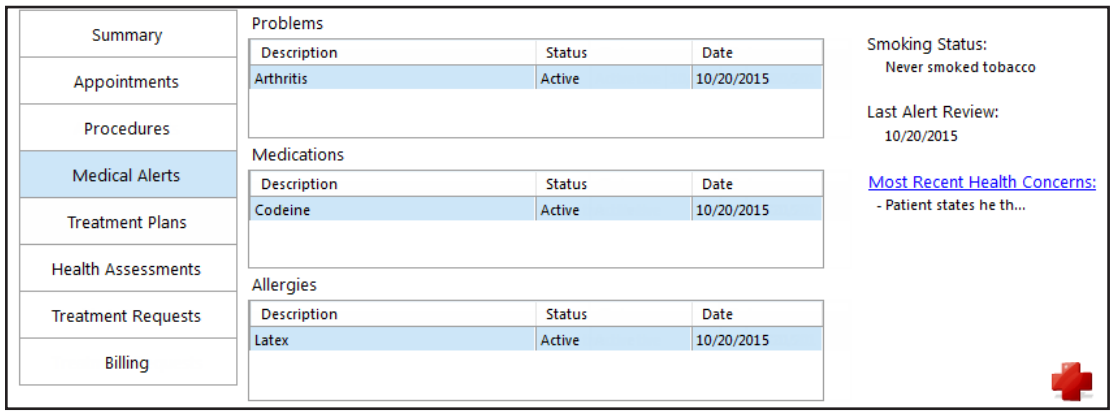


  - To schedule an appointment for the patient, click the **New Appointment** button +.
  - To open the Appointment Book and view one of the patient's appointments, select that appointment in the list, and then click the **Locate Appointment** button .
  - To open the Appointment Book, click the **Appointments** button .
- **Procedures tab** – This tab displays the completed, treatment-planned, existing, and/or existing-other procedures for the patient, according to which check boxes are selected.



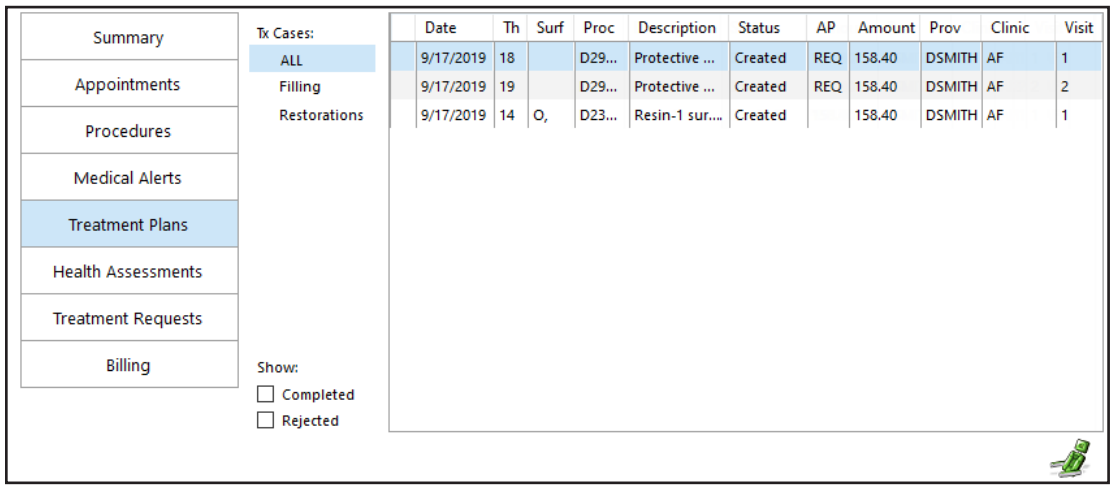
  - To open the patient's Chart, click the **Patient Chart** button .
  - To open the patient's Ledger, click the **Ledger** button .

- **Medical Alerts tab** – This tab displays the patient's problems, medications, allergies, and smoking status. The date of the last time medical alerts were marked as having been reviewed appears. You mark medical alerts as having been reviewed by selecting the second or third option under **Medical Alert Review** in the **Medical History Review** dialog box. Any health concerns entered also appear.



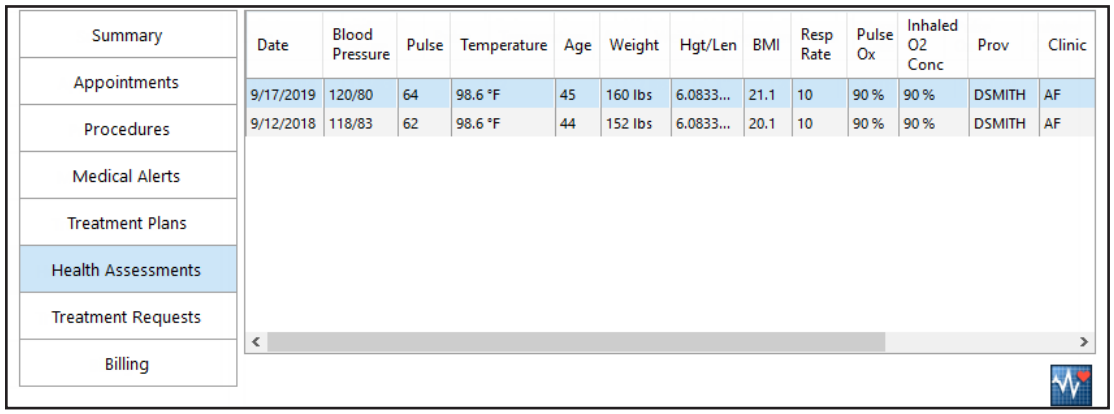
  - To manage the patient's medical alerts, click the **Medical Alerts/Problems** button .
  - To manage the patient's health concerns, click the **Most Recent Health Concerns** link.

- **Treatment Plans tab** – This tab displays all the patient's treatment-planned procedures. Or, you can click the name of a treatment plan to view only the treatment-planned procedures that are part of that case. You can also choose to show completed and/or rejected procedures by selecting the corresponding check boxes.



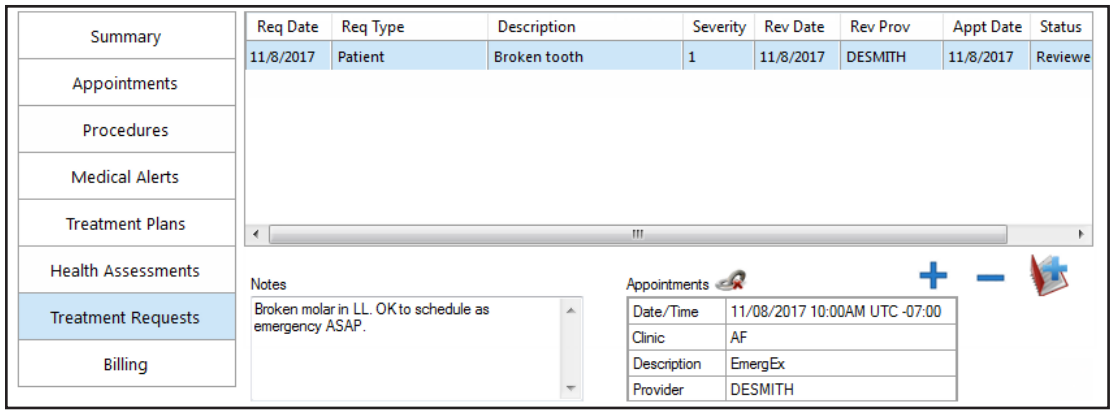
  - To open the patient's Treatment Planner, click the **Treatment Planner** button .

- **Health Assessments tab** – This tab displays the health assessments that were entered for the patient.

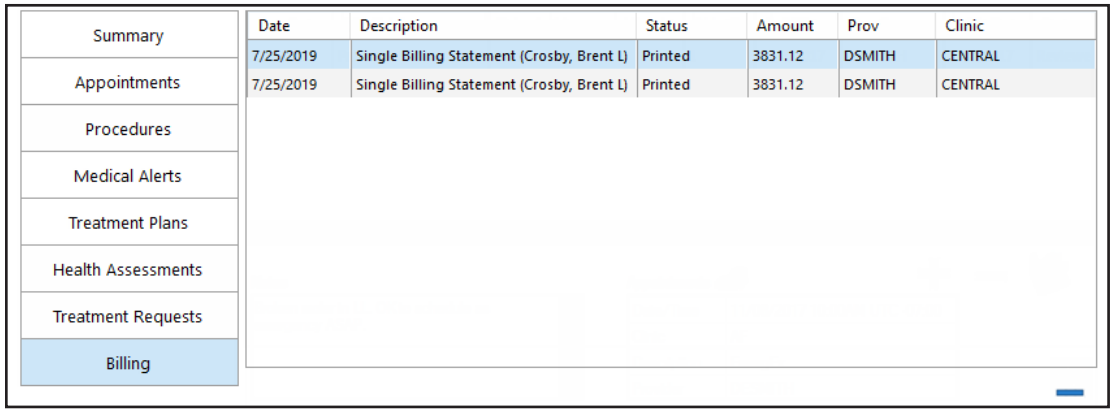


  - To manage the patient's health assessments, click the **Patient Health Assessment** button .

- **Treatment Requests tab** – This tab displays the treatment requests that were entered for the patient. For information about managing a patient's treatment requests and linked appointments, see the "Managing treatment requests from the More Information window" topic in the Dentrix Enterprise Help.



- **Billing tab** – This tab displays a history of billing statements that have been printed for the patient, and you can view any of the statements as needed. Dentrix Enterprise only saves single billing statements that are printed from the Ledger or that are sent to the batch processor from the Ledger and then printed from the Office Manager.



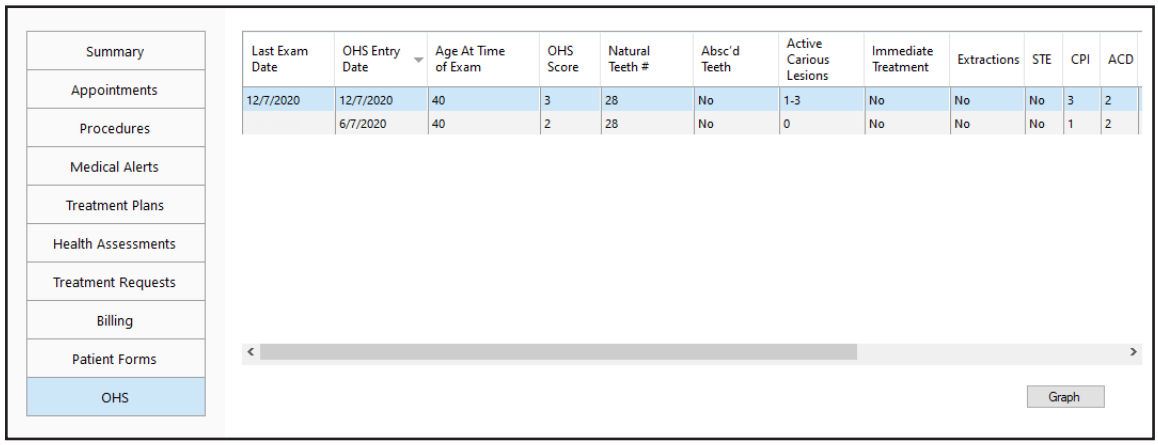
  - To view a statement, double-click the corresponding statement history entry.
  - To sort the statement history list, click the desired column header.

- To copy the history list to the Windows Clipboard (in an Excel-friendly format), while pressing the Ctrl key, press P.
- To delete a billing statement, select the desired entry, and then click the **Delete** button −.

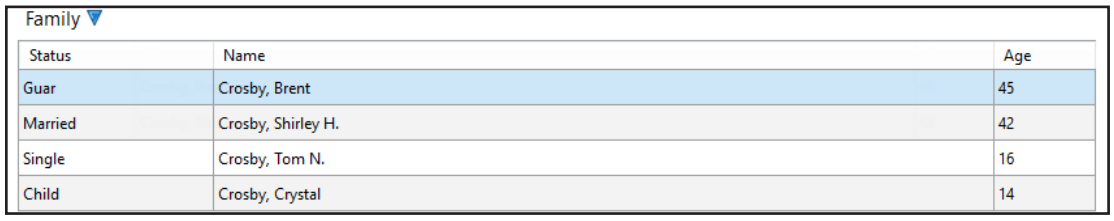
  Notes:

  - To select multiple, drag over the desired entries; select a desired entry, and then select the others while pressing the Ctrl key; or select the first entry of desired range, and then select the last entry of the desired range while pressing the Shift key.
  - You can delete a billing statement only if your user account is allowed to do so (according to a security right). However, if you are not allowed to delete it, Dentrix Enterprise asks for a user who does have rights to delete statements to enter his or her credentials. If you are attempting to delete multiple statements, the overriding user must enter his or her credentials for each statement being deleted.

- **OHS** – With a certain global setting enabled, an **OHS** tab is available. The **OHS** tab lists the patient's OHS surveys.



- **Family list** – To view patient information for any of the current patient's family members, select that family member from the list. You can expand and collapse the **Family** list as needed.

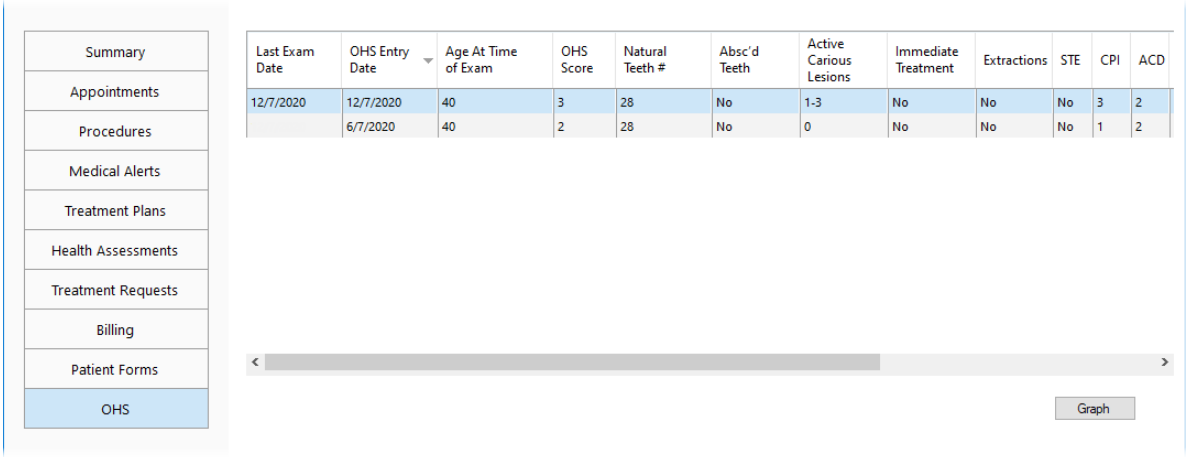


Viewing or Editing OHS Surveys

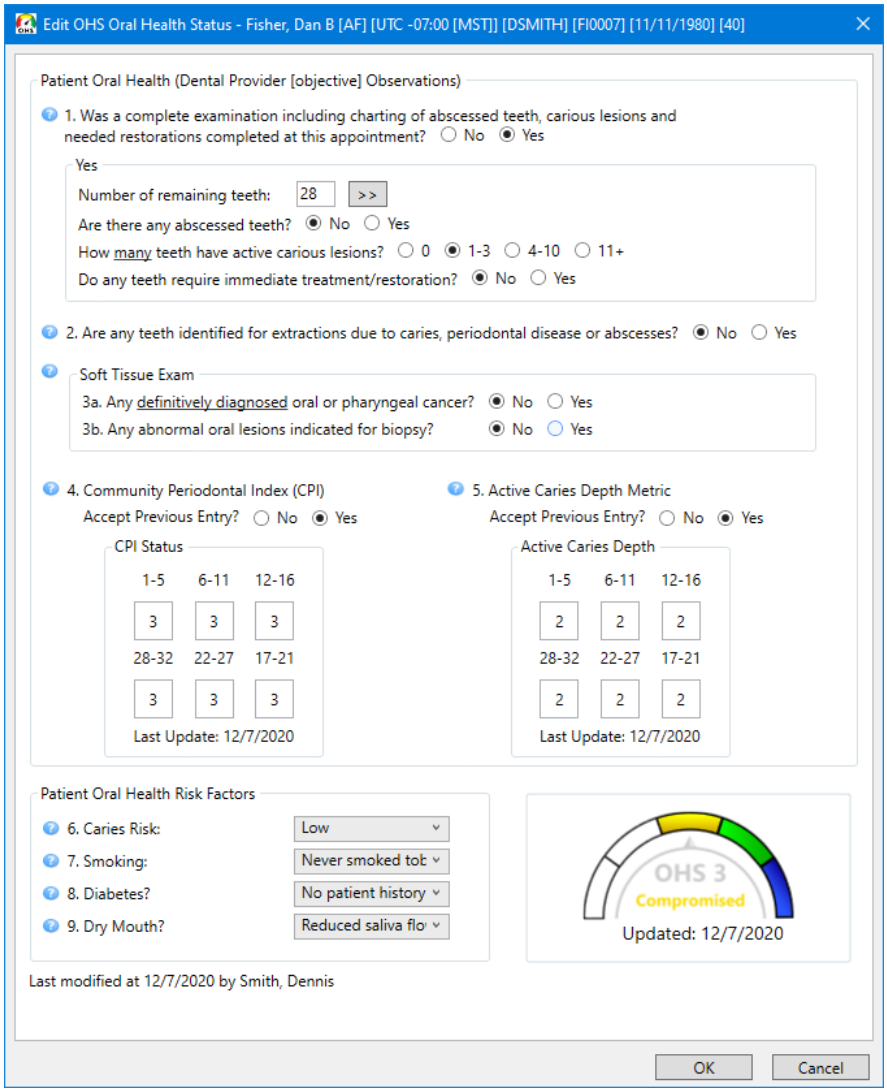
You can view all the details of an OHS survey. If the security rights assigned to your user account allow it, you can edit an OHS survey.

To view or edit an OHS survey

1. In the **More Information** window, on the **OHS** tab, double-click a survey.



The **Edit OHS Oral Health Status** dialog box appears.



2. If allowed, make any necessary changes. For an explanation of the various options, see "Completing Oral Health Status Surveys" in the Patient Chart chapter.
3. If you have made changes, click **OK**; otherwise, click **Cancel**.

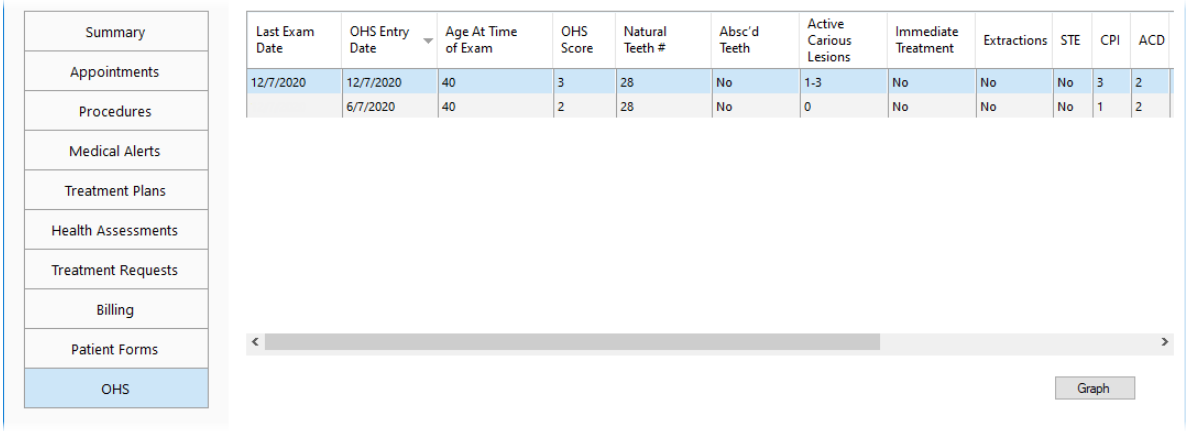
   Note: Whether or not you have made changes to the survey, if you click **OK**, the **Last Exam Date** for the survey will be updated to today's date.

Viewing OHS Graphs

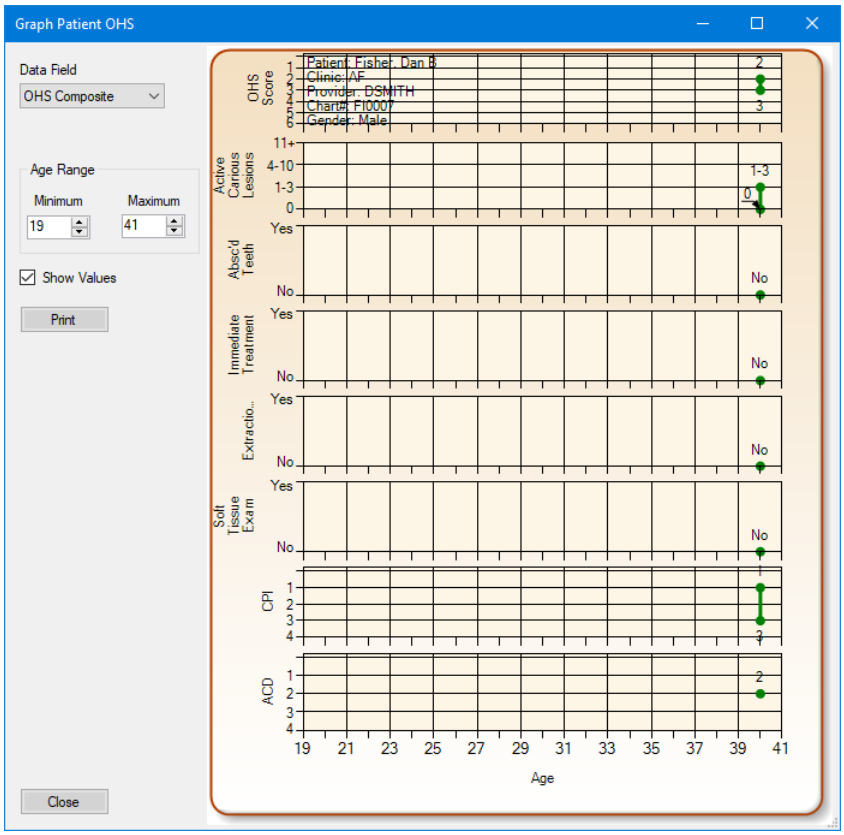
You can view OHS data over time as graphs.

To view OHS graphs

1. In the **More Information** window, on the **OHS** tab, click **Graph**.



The **Graph Patient OHS** dialog box appears. By default, the OHS Composite graph is displayed.



2. Do any of the following:
   - To change which graph is being displayed, from the **Date Field** list, select any of the following graphs:
     - **OHS Composite**
     - **OHS score**
     - **Natural teeth #**
     - **Active Carious lesions**
     - **Absc'd teeth**
     - **Immediate Treatment**
     - **Extractions**
     - **Soft Tissue Exam**
     - **CPI** (6 line graphs; one for each sextant)

       Note: An X indicates that all teeth are missing, so the graph line ends. If, for example, the placement of an implant is done later, the graph line will start again after a gap.

     - **ACD** (6 line graphs; one for each sextant)

       Note: An X indicates that all teeth are missing, so the graph line ends. The graph line may start again after a gap.

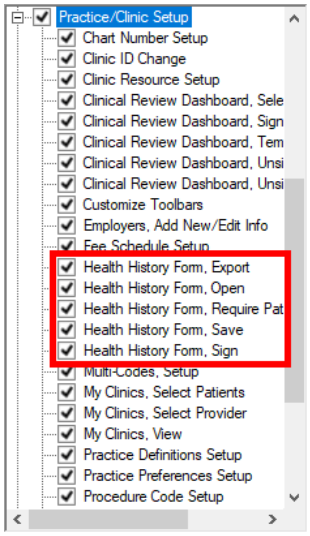
     - **Caries Risk**
     - **Smoking tobacco use**
     - **Diabetes**
     - **Dry Mouth**
   - To view values for specific range of ages, under **Age Range**, enter the **Minimum** and **Maximum** ages. The maximum age must be at least one year after the minimum age.
   - To have an exact value appear next to each point on the graph, select the **Show Values** check box.
   - To print the graph that is being displayed currently, click **Print**. Then, in the **Print Preview** dialog box that appears, click the **Print** button  .

Dental Patient Medical History

In the **Dental Patient Medical Assessment** window, you can record a patient's medical history using an electronic form. The form consists of several sections that a provider goes through with the patient. All required questions on the form must be answered. Then, a provider or staff member and, if required, a patient or guardian must sign the form. Also, you can save a copy of the completed form as a .pdf file in a folder and/or in the patient's Document Center record.

Prerequisites:

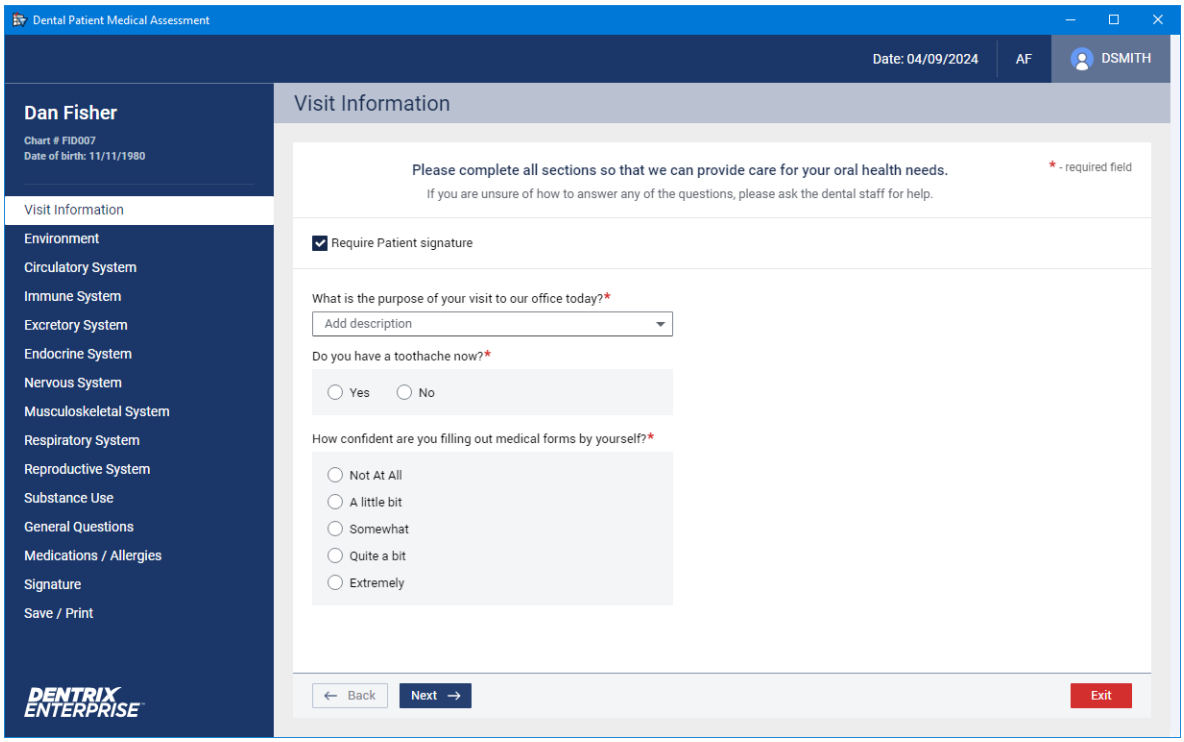
- On each client computer that connects to the Dentrix Enterprise database, in the SQL Server Configuration Manager, TCP/IP must be enabled, and the alias for Dentrix must use that protocol.
- There is a global setting that controls the availability of the health history features. The following are available if "IHS only" is selected for that global setting:
  - The **Dental Patient Medical Assessment** window.
  - The "Health History Form, Require Patient Signature" security right (in the "Practice/Clinic Setup" category) determines whether the **Require Patient signature** checkbox is available or not on the form for a given user. The "Health History Form, Open," "Health History Form, Sign", "Health History Form, Export," and "Health History Form, Save" security rights (in the "Practice/Clinic Setup" category) determine if a user can open, sign, export, and save assessments, respectively.



To complete an assessment

1. In the Family File, Patient Chart, or Ledger, with a patient selected, click the **Patient Health History Wizard** button on the toolbar.

   The **Dental Patient Medical Assessment** window opens.



   This window includes the following:

   - The current date, the clinic that you are logged in to, and your user ID.
   - The patient's name, chart number, and birthdate.
   - The sections of the assessment. With a section selected on the navigation bar, the corresponding options are available.

   Notes:

   - To navigate between sections of the assessment, click **Next** or **Back** as needed, or select a section on the navigation bar.
   - If you attempt to navigate to another section before answering all required questions in the section that you are currently viewing, Dentrix Enterprise helps you easily identify missing required information.

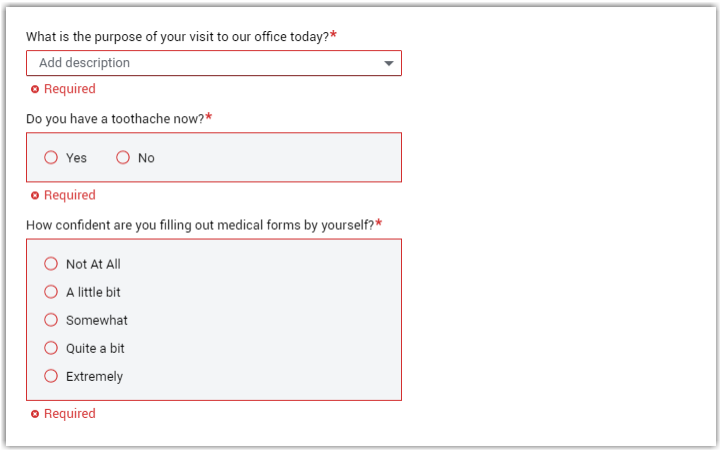
- If you click **Next** or **Back**.



- If you click another section and then click **No** on the message (or **X** to close the message) that appears.

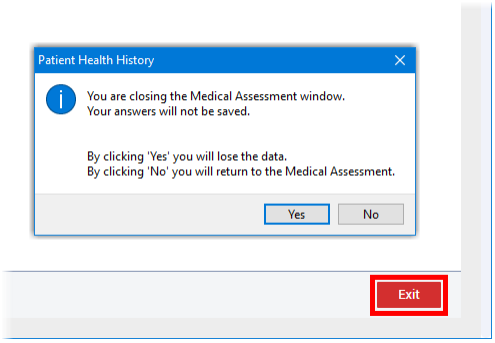


You stay on the current section, the fields are outlined in red, and red text "Required" appears. Additionally, if the first unanswered required question is not visible, the form scrolls automatically to that field.



- If you leave an incomplete section, you can return later to continue where you left off without losing information.
- All required questions must be answered; otherwise, you and the patient (if applicable) cannot sign the assessment.

- If you click **Exit** to close an assessment, and there are unsaved changes, a confirmation message appears and allows you to either exit without saving or return to the assessment.

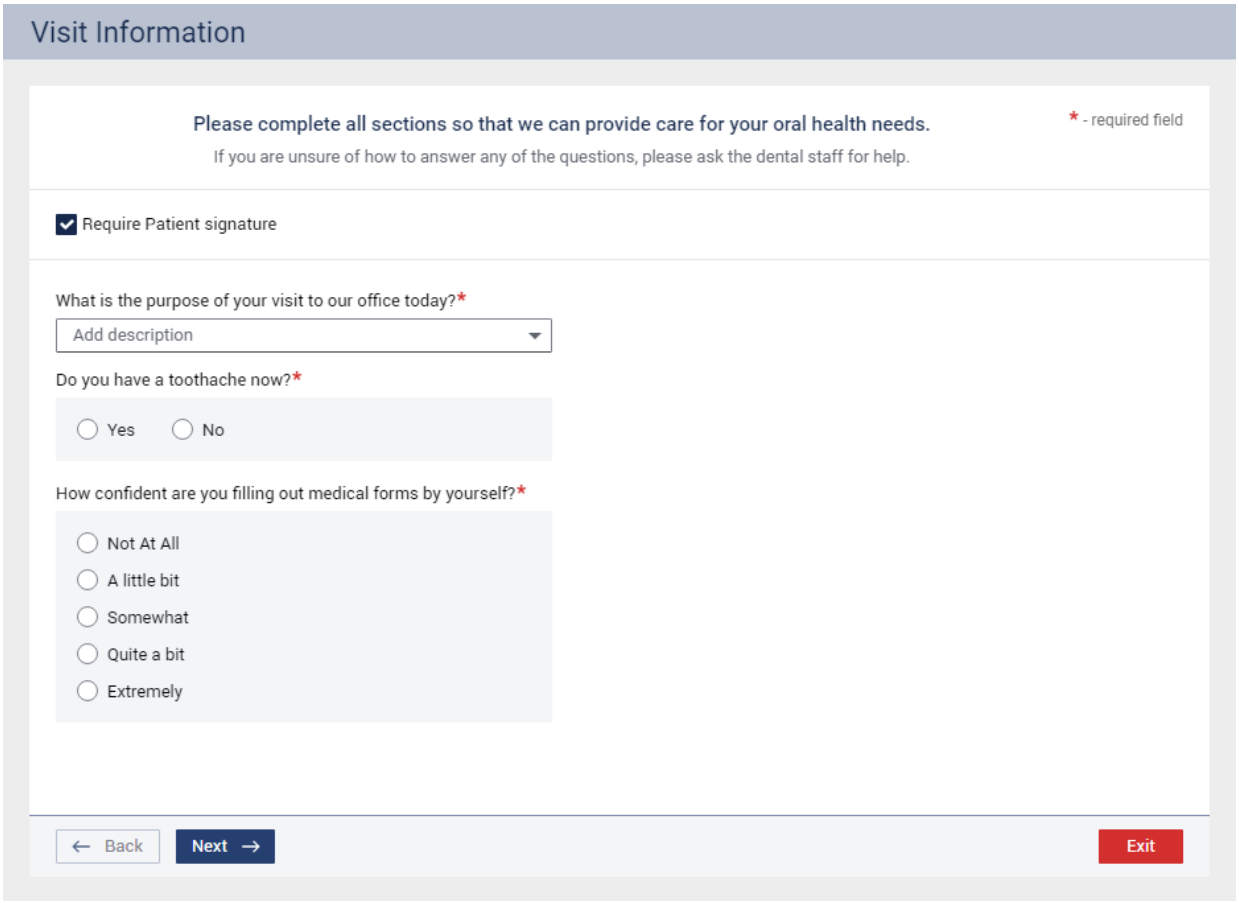


2. Complete the **Visit Information** section, and then click **Next**.
3. Complete the **Environment** section, and then click **Next**.
4. With the Circulatory System section, do one of the following:
   - If this is the first assessment being completed for the patient, or if there are changes in the patient's health history since his or her previous assessment, complete the **Circulatory System** section, and then click **Next**. Then, proceed to the next step.
   - If an assessment has been completed previously for the patient, and there are not changes in the patient's health history since his or her previous assessment, click **No Updates** to load the data from the previous visit's form into the **Circulatory System** section and the remaining sections (except **Signature**). You are automatically taken to the **Signature** section. Skip to step 15.

     Note: Even if you click **No Updates**, before signing the form, you can navigate to any of the sections as needed to make changes.
5. Complete the **Immune System** section, and then click **Next**.
6. Complete the **Excretory System** section, and then click **Next**.
7. Complete the **Endocrine System** section, and then click **Next**.
8. Complete the **Nervous System** section, and then click **Next**.
9. Complete the **Musculoskeletal System** section, and then click **Next**.
10. Complete the **Respiratory System** section, and then click **Next**.
11. Complete the **Reproductive System** section, and then click **Next**.
12. Complete the **Substance Use** section, and then click **Next**.
13. Complete the **General Questions** section, and then click **Next**.
14. Complete the **Medications / Allergies** section, and then click **Next**.
15. Complete the **Signature** section, and then click **Next**.
16. In the **Save / Print** section, save a copy of the assessment as a .pdf file in a folder and/or in the patient's Document Center record, and then click **Finish**.

Note: Detailed instruction for completing each section of the assessment appear on the following pages.

Visit Information

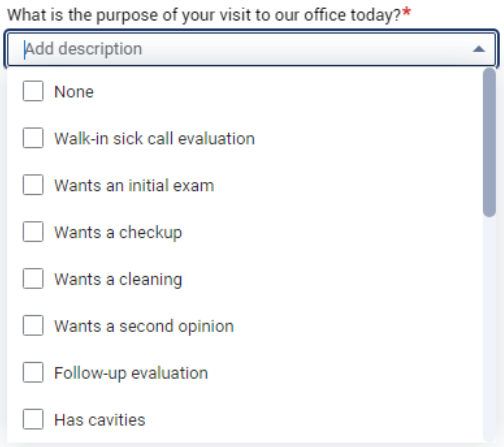


The following options are available:

- **Require Patient signature** – Select or clear the check box.

  Note: This check box is available only if your user account has the "Health History Form, Require Patient Signature" security right enabled.

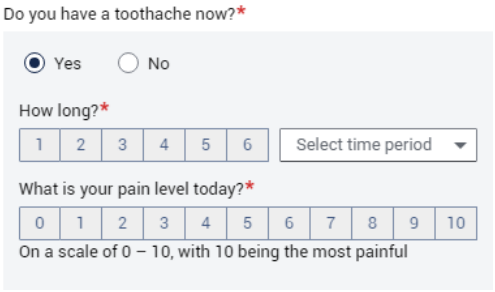
- **What is the purpose of your visit to our office today?** – Click in the **Add description** box, begin typing a description if you want to search for visit reasons that match what you type, select the checkbox of each visit reason that applies to the patient's visit, or select the **None** checkbox if a visit reason is not applicable.



- **Do you have a toothache now?** – Select **Yes** or **No**.

  With **Yes** selected, the following questions are available:

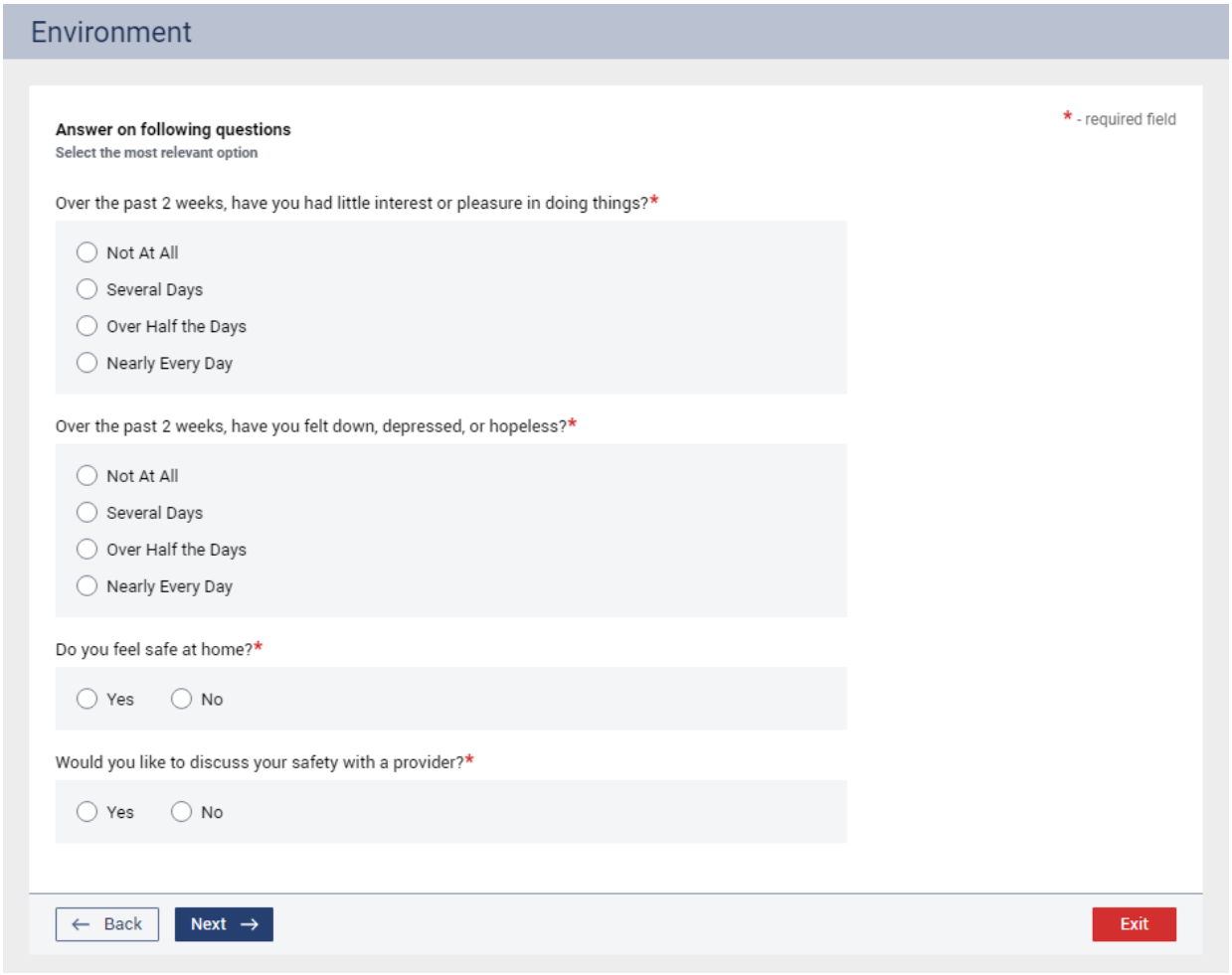
  - **How long?** – Select a number (1–6). From the list, select **Days**, **Weeks**, or **Months**.
  - **What is your pain level today?** – On a scale of 0–10, with 10 being the most painful, select a number.



- **How confident are you filling out medical forms by yourself?** – Select **Not at all**, **A little bit**, **Somewhat**, **Quite a bit**, or **Extremely**.

  Note: This question is available only if the **Require patient signature** check box is selected.

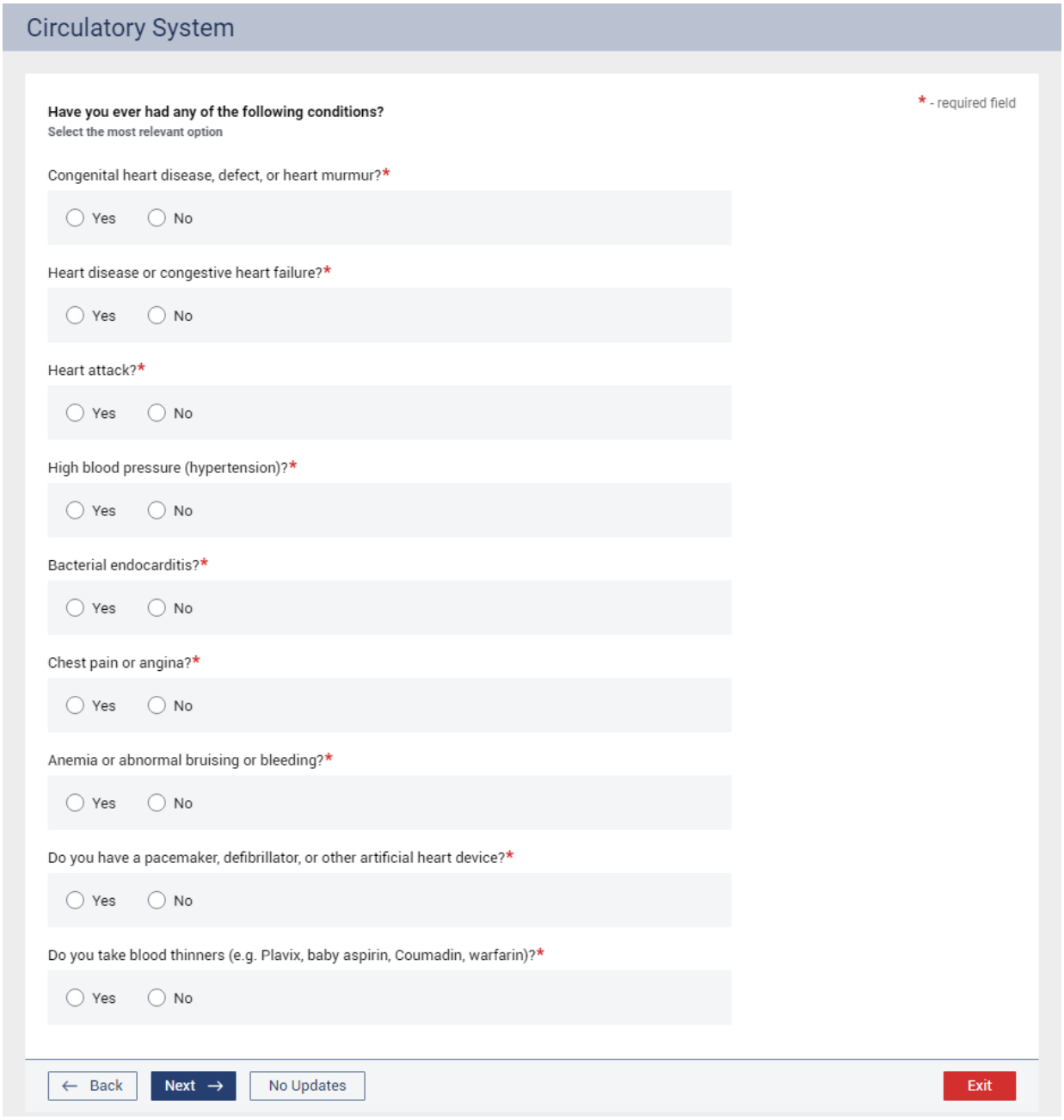
Environment



The following options are available:

- **Over the past 2 weeks, have you had little interest or pleasure in doing things?** – Select **Not At All**, **Several Days**, **Over Half the Days**, or **Nearly Every Day**.
- **Over the past 2 weeks, have you felt down, depressed, or hopeless?** – Select **Not At All**, **Several Days**, **Over Half the Days**, or **Nearly Every Day**.
- **Do you feel safe at home?** – Select **Yes** or **No**.
- **Would you like to discuss your safety with a provider?** – Select **Yes** or **No**.

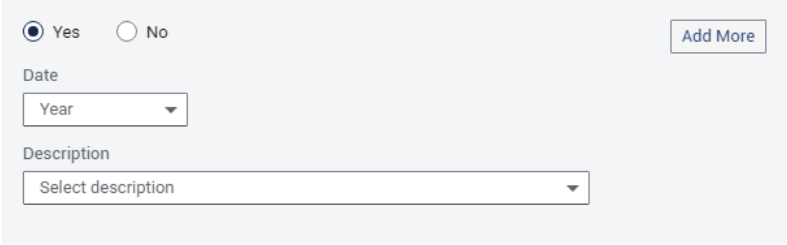
Circulatory System



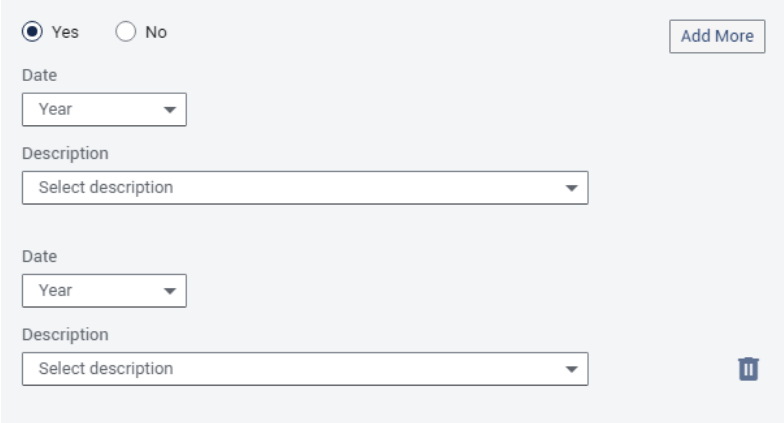
Specify if the patient has ever had any of the following conditions:

- **Congenital heart disease, defect, or heart murmur?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



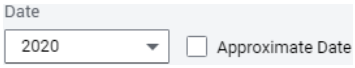
For each additional set of responses you want to add, click **Add More**. You can add up to four additional sets of responses.



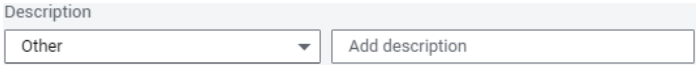
Note: To delete an additional set of responses, click the corresponding **Delete** button .

Optionally, select a year and/or description for each set of responses:

- **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



- **Description** – Select one of the following descriptions:
  - **Heart Defect: Atrial Septal Defect**.
  - **Heart Defect: Ventricular Septal Defect**.
  - **Heart Defect: Atrioventricular Septal Defect**.
  - **Heart Defect: Ventricular Defect**.
  - **Heart Defect: Patent Ductus Arteriosus**.
  - **Stenosis: Aortic Valve Stenosis**.
  - **Stenosis: Mitral Valve Stenosis**.
  - **Stenosis: Pulmonary Valve Stenosis**.
  - **Heart Structure Defects: Coarctation of Aorta**.
  - **Heart Structure Defects: Tetralogy of Fallot**.
  - **Heart Structure Defects: Pulmonary Atresia**.
  - **Heart Structure Defects: Transposition of the Great Arteries**.
  - **Heart Murmur: Innocent Heart Murmur (No follow up by MD)**.
  - **Heart Murmur: Abnormal Heart Murmur (Monitored by MB)**.
  - **Other** – With this option selected, an Add description box is available. Optionally, enter up to 60 characters.

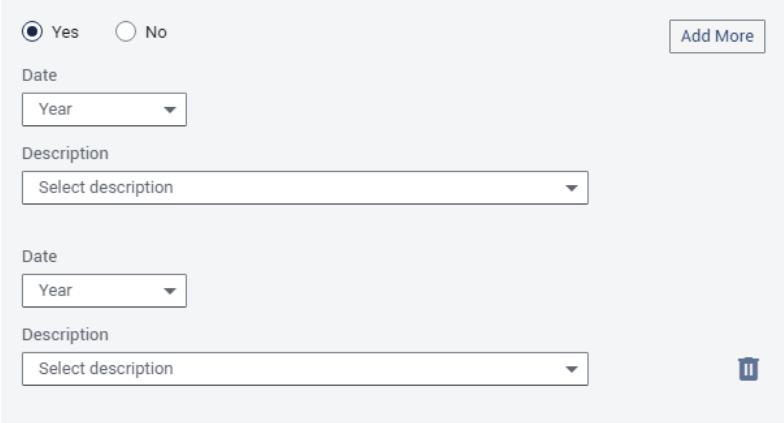


- **Heart disease or congestive heart failure?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



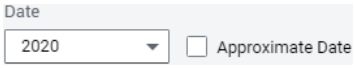
  For each additional set of responses you want to add, click **Add More**. You can add up to four additional sets of responses.



  Note: To delete an additional set of responses, click the corresponding **Delete** button.

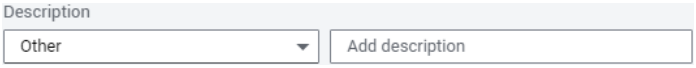
  Optionally, select a year and/or description for each set of responses:

  - **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



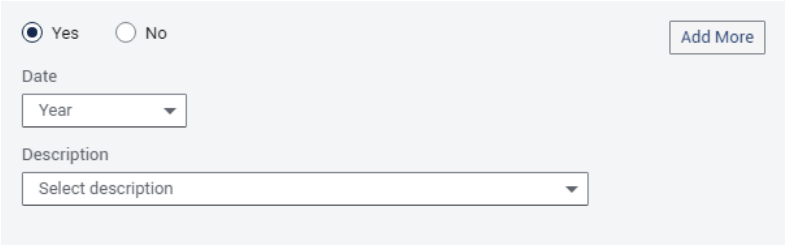
  - **Description** – Select one of the following descriptions:
    - **Heart Valve Abnormality: Aortic Valve (Regurgitation, Stenosis, etc...)**.
    - **Heart Valve Abnormality: Mitral Valve (Regurgitation, Stenosis, etc...)**.
    - **Heart Valve Abnormality: Pulmonary Valve (Regurgitation, Stenosis, etc...)**.
    - **Heart Arrythmia: Adams-Stokes Disease**.
    - **Heart Arrythmia: Premature Ventricular Contractions (PVC)**.
    - **Heart Arrythmia: Premature Atrial Contractions (PAC)**.
    - **Heart Arrythmia: Atrial Fibrillation**.
    - **Heart Arrythmia: Atrial Flutter**.
    - Heart Arrythmia: Sick Sinus Syndrome.
    - **Heart Arrythmia: Heart or Branch Block**.
    - **Heart Arrythmia: Wolff-Parkinson White Syndrome**.
    - **Heart Arrythmia: Bradycardia (Slow HR)**.

- **Heart Arrythmia: Tachycardia (Fast HR)**.
- **Heart Arrythmia: Long QT syndrome**.
- **Heart Transplant**.
- **Cardiac Stent**.
- **Congestive Heart Failure**.
- **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.

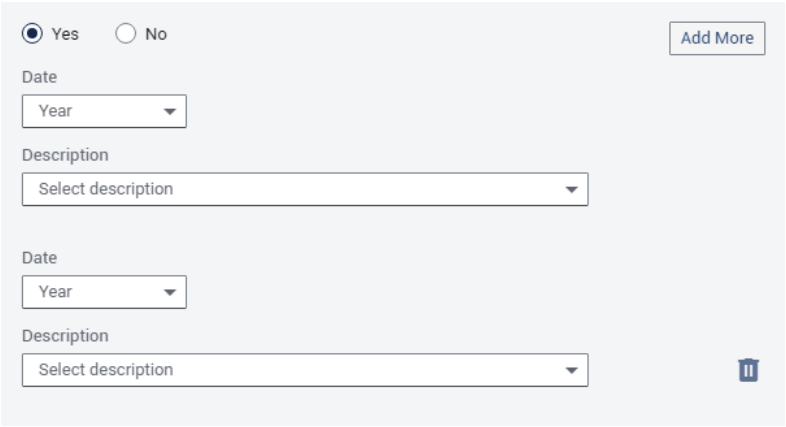


- **Heart attack?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



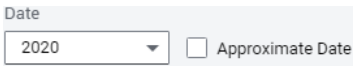
  For each additional set of responses you want to add, click **Add More**. You can add up to four additional sets of responses.



  Note: To delete an additional set of responses, click the corresponding **Delete** button.

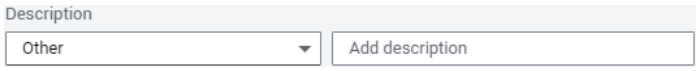
  Optionally, select a year and/or description for each set of responses:

  - **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



  - **Description** – Select one of the following descriptions:
    - **STEMI**.
    - **NSTEMI**.
    - **Silent Heart Attack (CAS)**.
    - **Unknown**.

- **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.

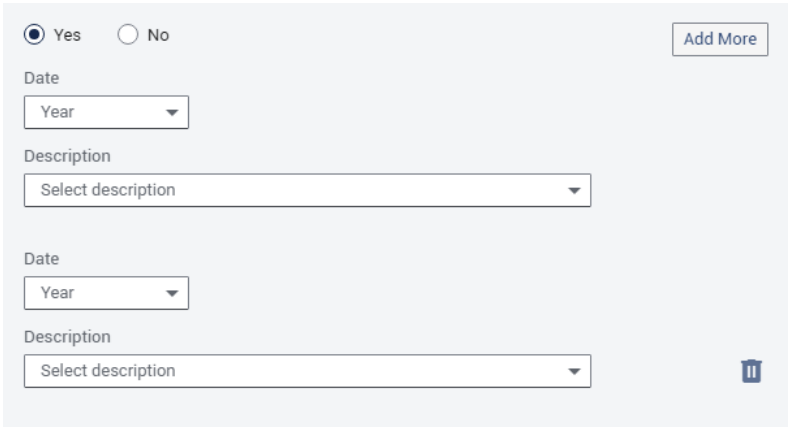


- **High blood pressure (hypertension)?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



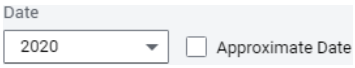
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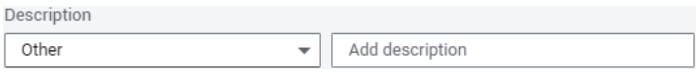
  Note: To delete an additional set of responses, click the corresponding **Delete** button  .

  Optionally, select a year and/or description for each set of responses:

  - **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



  - **Description** – Select one of the following descriptions:
    - **Uncontrolled (Not taking medications)**.
    - **Controlled (Taking medications as directed.)**.
    - **Controlled by diet or other means**.
    - **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.

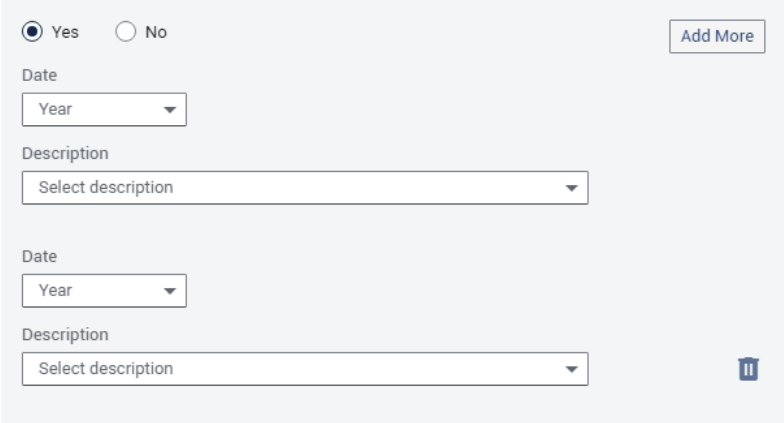


- **Bacterial endocarditis?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



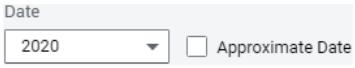
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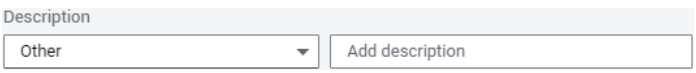
  Note: To delete an additional set of responses, click the corresponding **Delete** button  .

  Optionally, select a year and/or description for each set of responses:

  - **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



  - **Description** – Select one of the following descriptions:
    - **Have experienced one episode**.
    - **Have had more than one episode**.
    - **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.

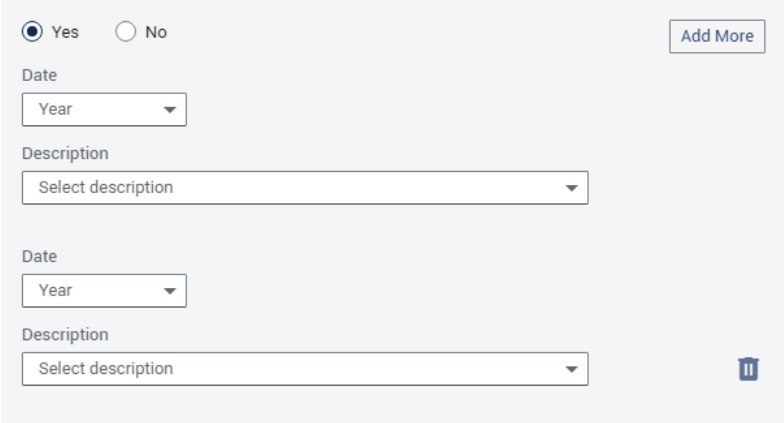


- **Chest pain or angina?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



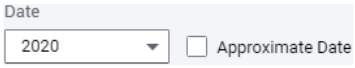
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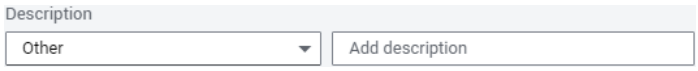
  Optionally, select a year and/or description for each set of responses:

  - **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



  - **Description** – Select one of the following descriptions:
    - **Provoked (only with activity/anger/anxiety)**.
    - **Spontaneous (with no activity/anger/anxiety)**.
    - **Taking medication to control**.
    - Have been hospitalized with chest pain.
    - **Have shortness of breath with chest pain**.
    - **Chest pain frequency: Every Day**.
    - **Chest pain frequency: Once or several times a week**.
    - **Chest pain frequency: Once or several times a month**.
    - **Chest pain frequency: Less than once a month**.
    - **Chest pain frequency: Several times a year**.

- **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.

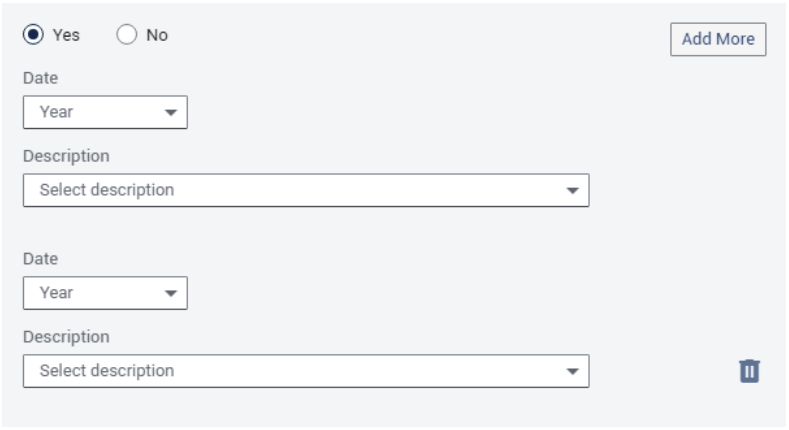


- **Anemia or abnormal bruising or bleeding?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



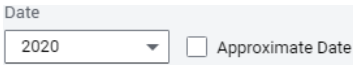
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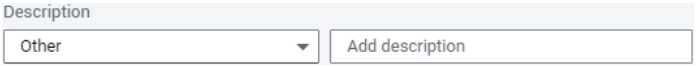
  Optionally, select a year and/or description for each set of responses:

  - **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



  - **Description** – Select one of the following descriptions:
    - **Anemia: Pernicious Anemia**.
    - **Anemia: Iron Deficiency Anemia**.
    - **Anemia: Hemolytic Anemia**.
    - **Anemia: Sickle Cell Anemia**.
    - **Anemia: Thalassemia**.
    - **Anemia: Aplastic Anemia**.
    - **Anemia: Fanconi Anemia**.
    - **Anemia: Bone Marrow Anemia**.
    - **Leukemia**.

- **Bruising**.
- **Hemophilia A or B**.
- **Factor Deficiency (II, V, VII, X, XII)**.
- **Von Willebrand's Disease**.
- **Blood disorders**.
- **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.

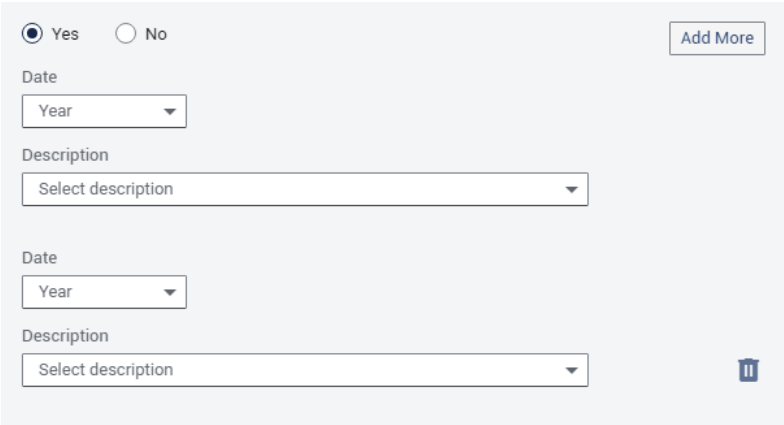


- **Do you have a pacemaker, defibrillator, or other artificial heart device?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



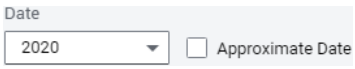
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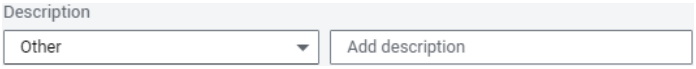
  Optionally, select a year and/or description for each set of responses:

  - **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



  - **Description** – Select one of the following descriptions:
    - **Heart Valve Replacement (Porcine)**.
    - **Heart Valve Replacement (Artificial)**.
    - **Implantable Pacemaker: Single Chamber**.
    - **Implantable Pacemaker: Dual Chamber**.

- **Implantable Pacemaker: Biventricular**.
- **Implantable Defibrillator: Single Chamber**.
- **Implantable Defibrillator: Dual Chamber**.
- **Implantable Defibrillator: Biventricular**.
- **Implantable Defibrillator: Subcutaneous**.
- **Implantable Cardioverter Defibrillator**.
- **Implantable Pacemaker/Defibrillator**.
- **Artificial Heart**.
- **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.

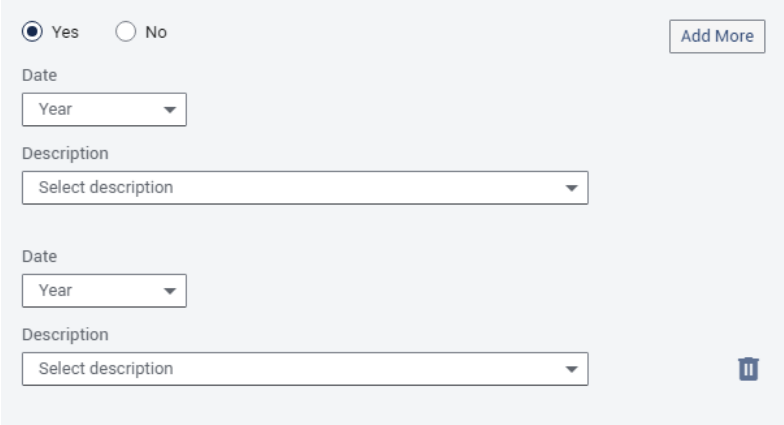


- **Do you take blood thinners (e.g. Plavix, baby aspirin, Coumadin, warfarin)?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



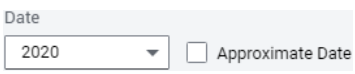
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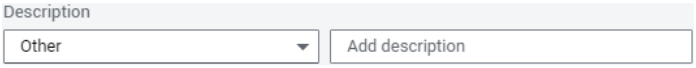
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  Optionally, select a year and/or description for each set of responses:

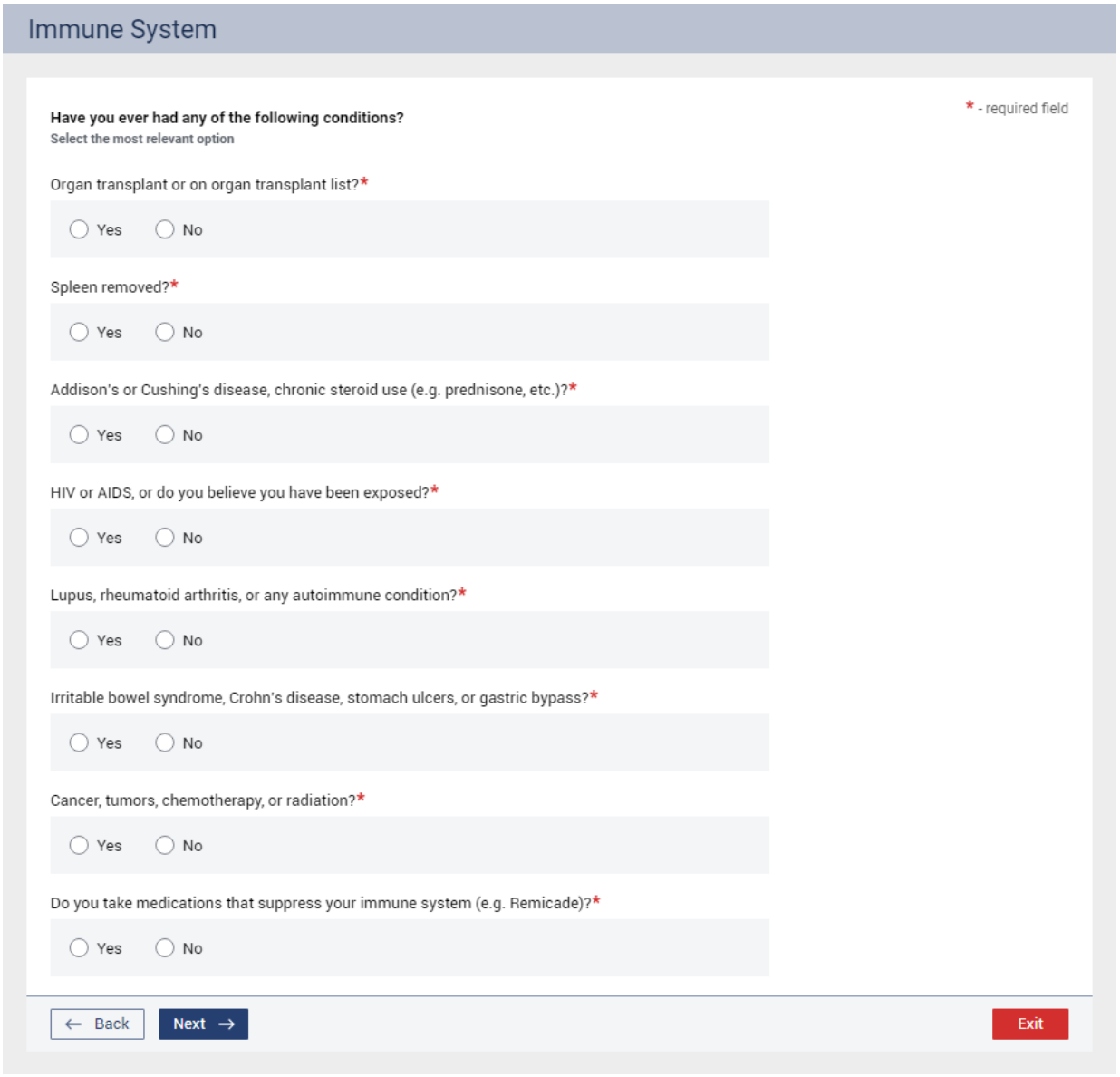
  - **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



- **Description** – Select one of the following descriptions:
  - **Aspirin**.
  - **Plavix (clopidogrel)**.
  - **Coumadin (warfarin)**.
  - **Xarelto (rivaroxaban)**.
  - **Eliquis (apixaban)**.
  - **Pradaxa (dabigatran)**.
  - **Bevyxxa (betrixaban)**.
  - **Savaysa (edoxaban)**.
  - **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.



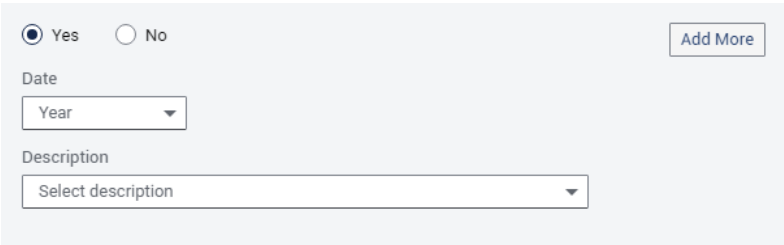
Immune System



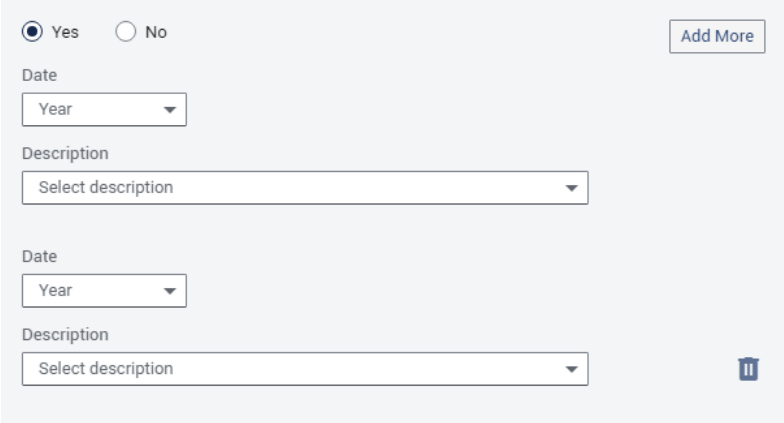
Specify if the patient has ever had any of the following conditions:

- **Organ transplant or on organ transplant list?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



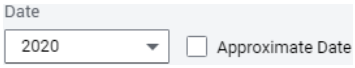
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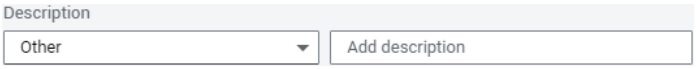
Note: To delete an additional set of responses, click the corresponding **Delete** button .

Optionally, select a year and/or description for each set of responses:

- **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.

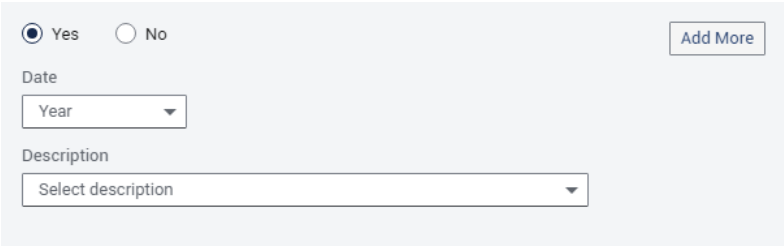
  

- **Description** – Select one of the following descriptions:
  - **Liver**.
  - **Kidney**.
  - **Heart**.
  - **Lung**.
  - **Pancreas**.
  - **Intestine**.
  - **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.

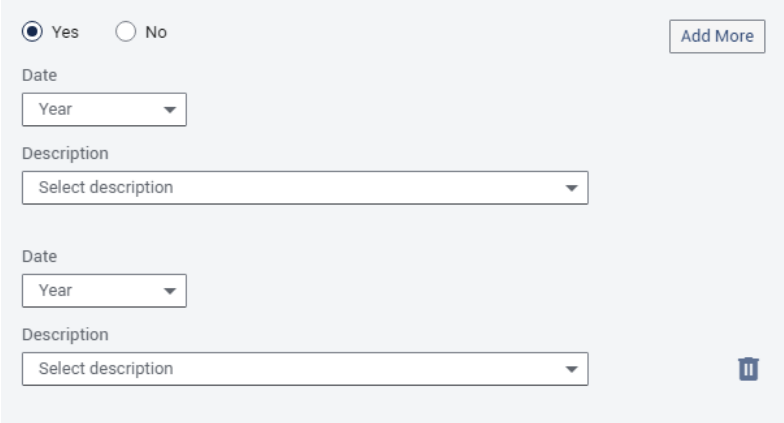
    

- **Spleen removed?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.

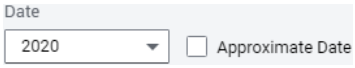
For each additional set of responses you want to add, click **Add More**. You can add up to four additional sets of responses.



Note: To delete an additional set of responses, click the corresponding **Delete** button.

Optionally, select a year and/or enter a description for each set of responses:

- **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



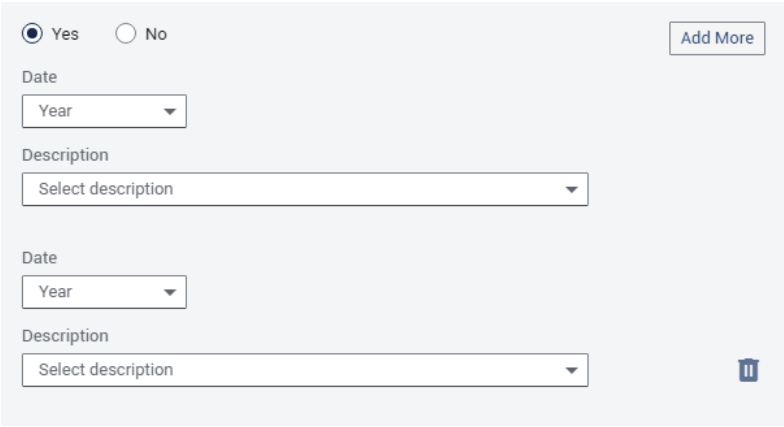
- **Description** – Optionally, enter up to 60 characters for the description.

- **Addison's or Cushing's disease, chronic steroid use (e.g. prednisone, etc.)?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



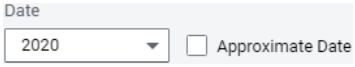
For each additional set of responses you want to add, click **Add More**. You can add up to four additional sets of responses.



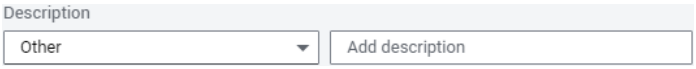
Note: To delete an additional set of responses, click the corresponding **Delete** button.

Optionally, select a year and/or description for each set of responses:

- **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.

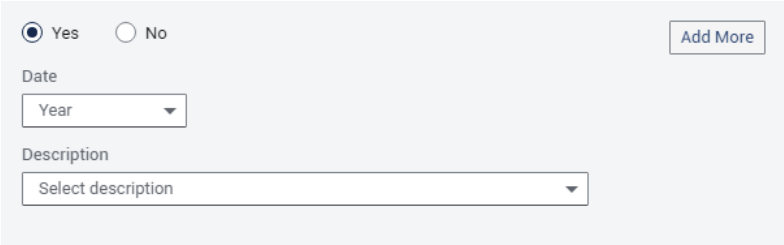


- **Description** – Select one of the following descriptions:
  - **Addison's Disease**.
  - **Cushing's Disease**.
  - **Chronic Steroid Use: Hydrocortisone**.
  - **Chronic Steroid Use: Prednisone**.
  - **Chronic Steroid Use: Dexamethasone**.
  - **Chronic Steroid Use: Triamcinolone**.
  - **Chronic Steroid Use: Celestone**.
  - **Chronic Steroid Use: Prelone**.
  - **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.

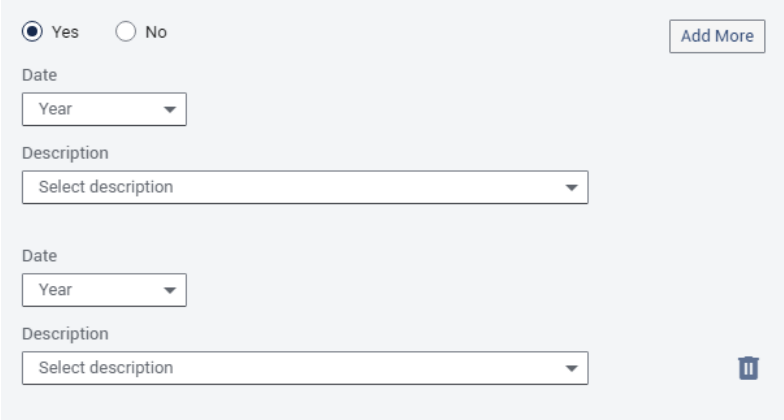


- **HIV or AIDS, or do you believe you have been exposed?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



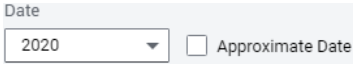
For each additional set of responses you want to add, click **Add More**. You can add up to four additional sets of responses.



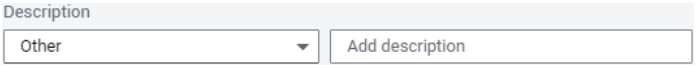
Note: To delete an additional set of responses, click the corresponding **Delete** button  .

Optionally, select a year and/or description for each set of responses:

- **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



- **Description** – Select one of the following descriptions:
  - **HIV**.
  - **AIDS**.
  - **Possible Exposure**.
  - **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.

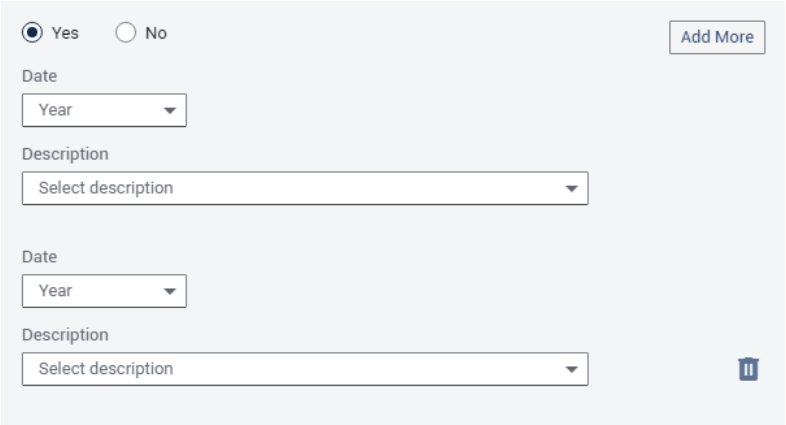


- **Lupus, rheumatoid arthritis, or any autoimmune condition?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



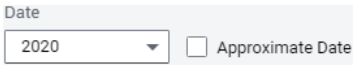
For each additional set of responses you want to add, click **Add More**. You can add up to four additional sets of responses.



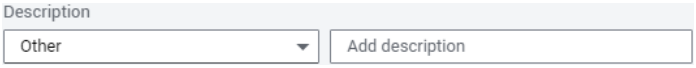
Note: To delete an additional set of responses, click the corresponding **Delete** button .

Optionally, select a year and/or description for each set of responses:

- **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



- **Description** – Select one of the following descriptions:
  - **Lupus**.
  - **Rheumatoid arthritis**.
  - **Hashimoto's Thyroiditis**.
  - **Celiac disease**.
  - **Graves' disease**.
  - **Vitiligo**.
  - **Rheumatic fever**.
  - **Pernicious anemia**.
  - **Immune Thrombocytopenic Purpura (ITP)**.
  - **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.

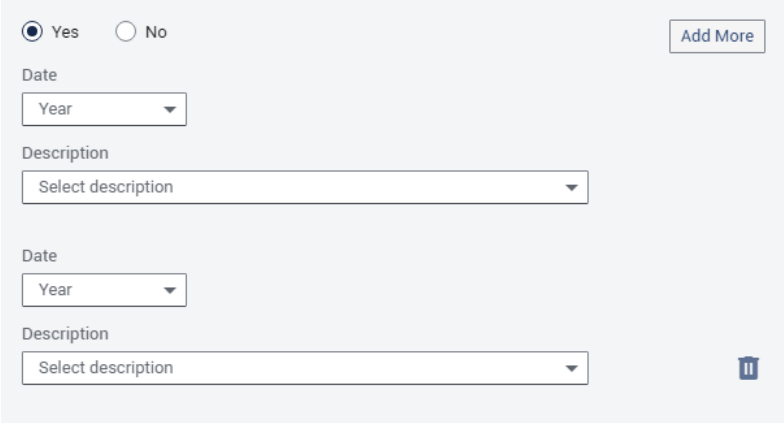


- **Irritable bowel syndrome, Crohn's disease, stomach ulcers, or gastric bypass?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



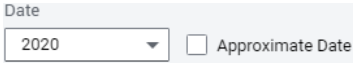
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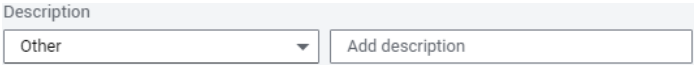
  Note: To delete an additional set of responses, click the corresponding **Delete** button.

  Optionally, select a year and/or description for each set of responses:

  - **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



- **Description** – Select one of the following descriptions:
  - **Irritable bowel syndrome**.
  - **Crohn's disease**.
  - **Stomach ulcers**.
  - **Gastric bypass**.
  - **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.

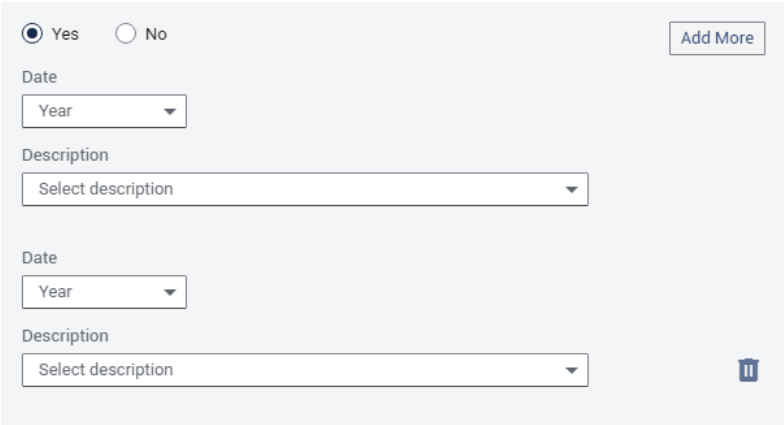


- **Cancer, tumors, chemotherapy, or radiation?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



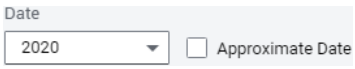
  For each additional set of responses you want to add, click **Add More**. You can add up to four additional sets of responses.



  Note: To delete an additional set of responses, click the corresponding **Delete** button.

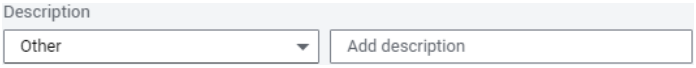
  Optionally, select a year and/or description for each set of responses:

  - **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



  - **Description** – Select one of the following descriptions:
    - **Cancer: Head and Neck**.
    - **Cancer: Brain**.
    - **Cancer: Breast**.
    - **Cancer: Skin**.

- **Cancer: Lung**.
- **Cancer: Prostate**.
- **Cancer: Colorectal**.
- **Cancer: Kidney**.
- **Cancer: Bladder**.
- **Cancer: Non-Hodgkin's Lymphoma**.
- **Cancer: Thyroid**.
- **Cancer: Endometrial**.
- **Tumors**.
- **Chemotherapy**.
- **Radiation**.
- **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.

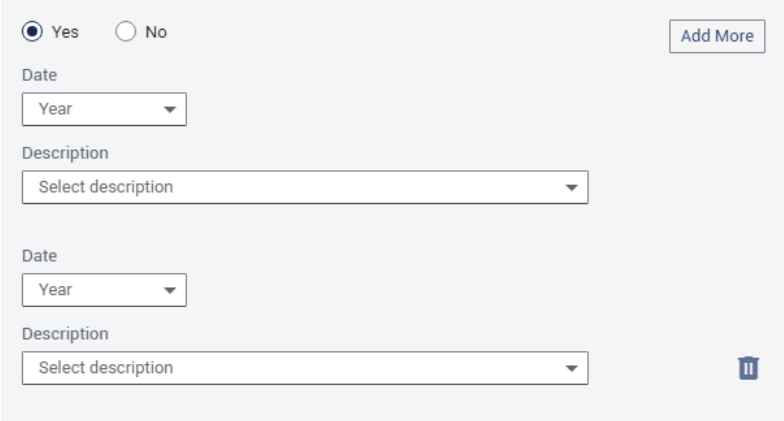


- **Do you take medications that suppress your immune system (e.g. Remicade)?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



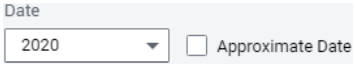
  For each additional set of responses you want to add, click **Add More**. You can add up to four additional sets of responses.



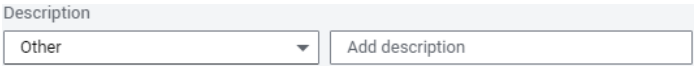
  Note: To delete an additional set of responses, click the corresponding **Delete** button .

Optionally, select a year and/or description for each set of responses:

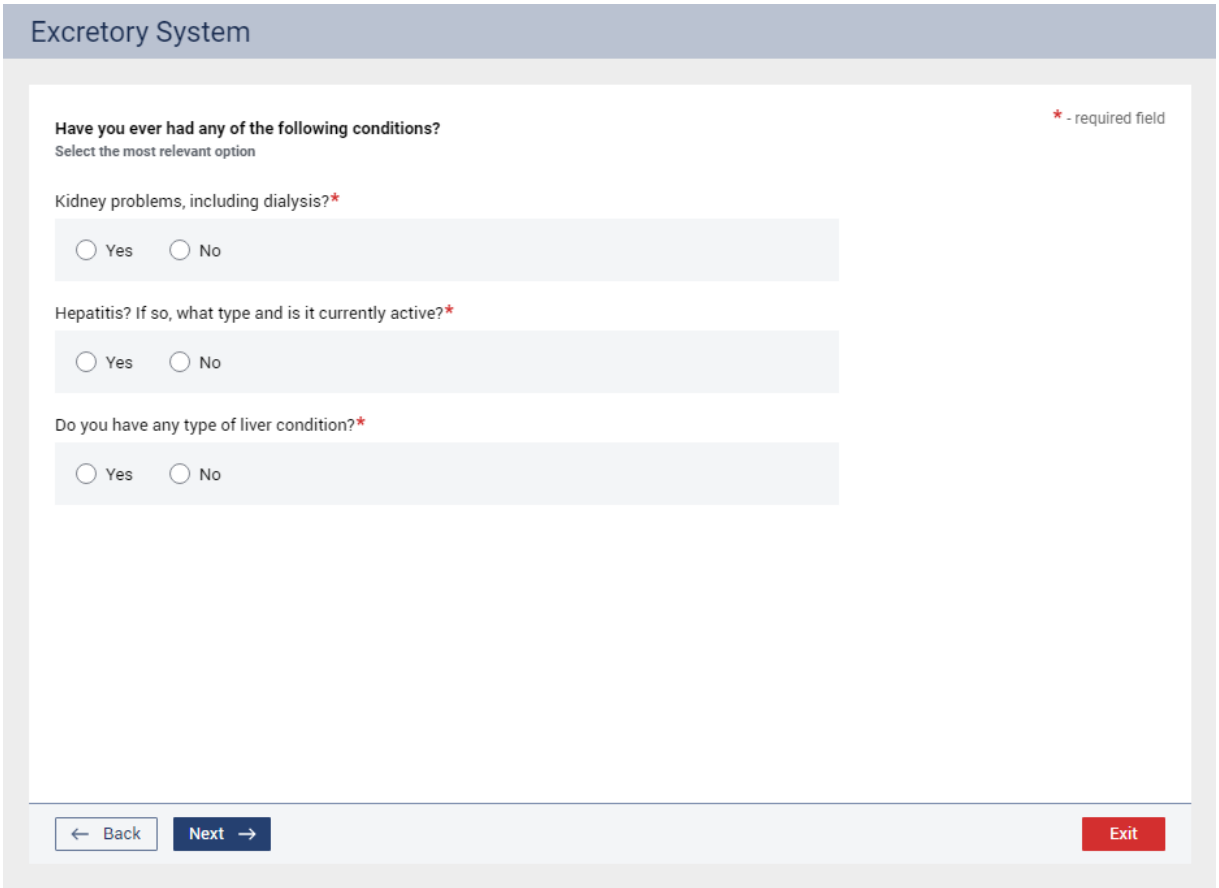
- **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



- **Description** – Select one of the following descriptions:
  - **Prednisone**.
  - **Tacrolimus**.
  - **Cyclosporine**.
  - **Mycophenolate**.
  - **Imuran**.
  - **Rapamune**.
  - **Remicade**.
  - **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.



Excretory System



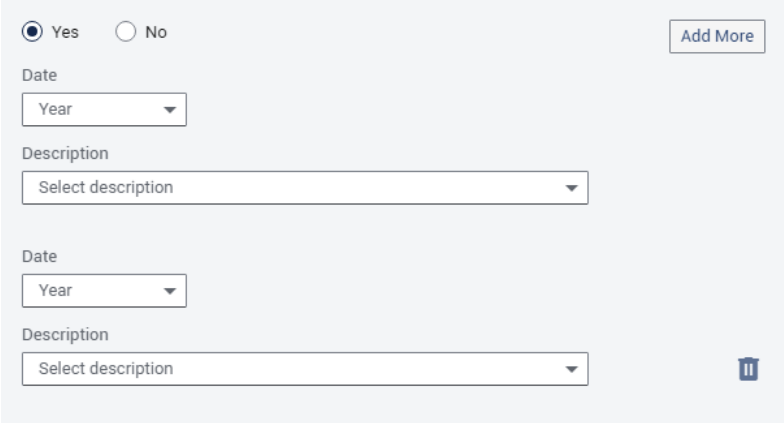
Specify if the patient has ever had any of the following conditions:

- **Kidney problems, including dialysis?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



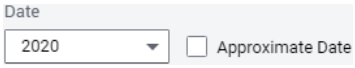
For each additional set of responses you want to add, click **Add More**. You can add up to four additional sets of responses.



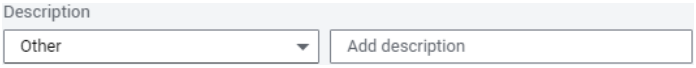
Note: To delete an additional set of responses, click the corresponding **Delete** button .

Optionally, select a year and/or description for each set of responses:

- **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



- **Description** – Select one of the following descriptions:
  - **Chronic Kidney Disease: Stage 1**.
  - **Chronic Kidney Disease: Stage 2**.
  - **Chronic Kidney Disease: Stage 3**.
  - **Chronic Kidney Disease: Stage 4**.
  - **Dialysis: Hemodialysis**.
  - **Dialysis: Periodontal Dialysis**.
  - **Kidney Transplant**.
  - **Polycystic Kidney Disease (PKD)**.
  - **Glomerulonephritis**.
  - **Kidney Cancer**.
  - **Fabry Disease**.
  - **Alport Syndrome**.
  - **Focal Segmental Glomerulosclerosis (FSGS)**.
  - **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.

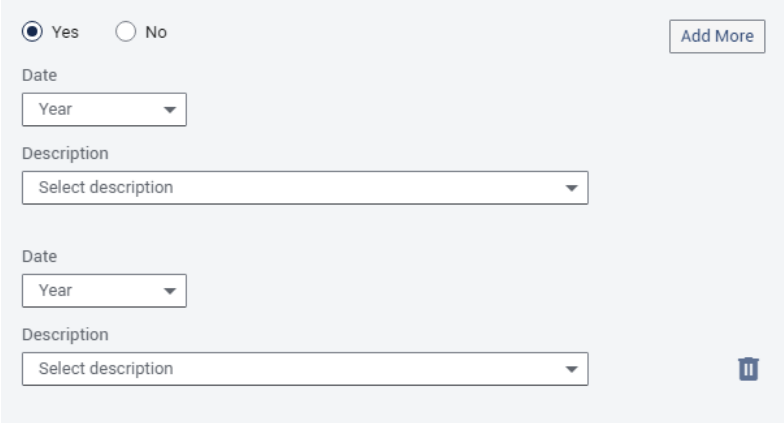


- **Hepatitis? If so, what type and is it currently active?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



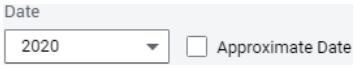
  For each additional set of responses you want to add, click **Add More**. You can add up to four additional sets of responses.



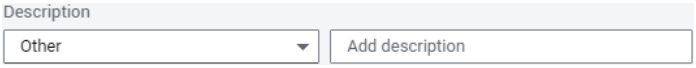
  Note: To delete an additional set of responses, click the corresponding **Delete** button .

  Optionally, select a year and/or description for each set of responses:

  - **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



  - **Description** – Select one of the following descriptions:
    - **Hepatitis: A**.
    - **Hepatitis: B**.
    - **Hepatitis: C**.
    - **Hepatitis: D**.
    - **Hepatitis: E**.
    - **Hepatitis: Autoimmune**.
    - **Active: Yes**.
    - **Active: No**.
    - **Active: In Treatment**.
    - **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.

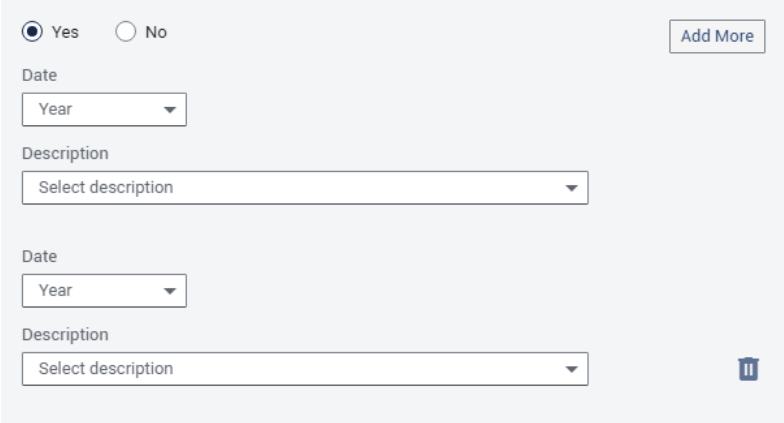


- **Do you have any type of liver condition?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



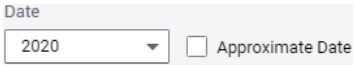
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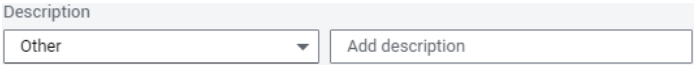
  Optionally, select a year and/or description for each set of responses:

  - **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.

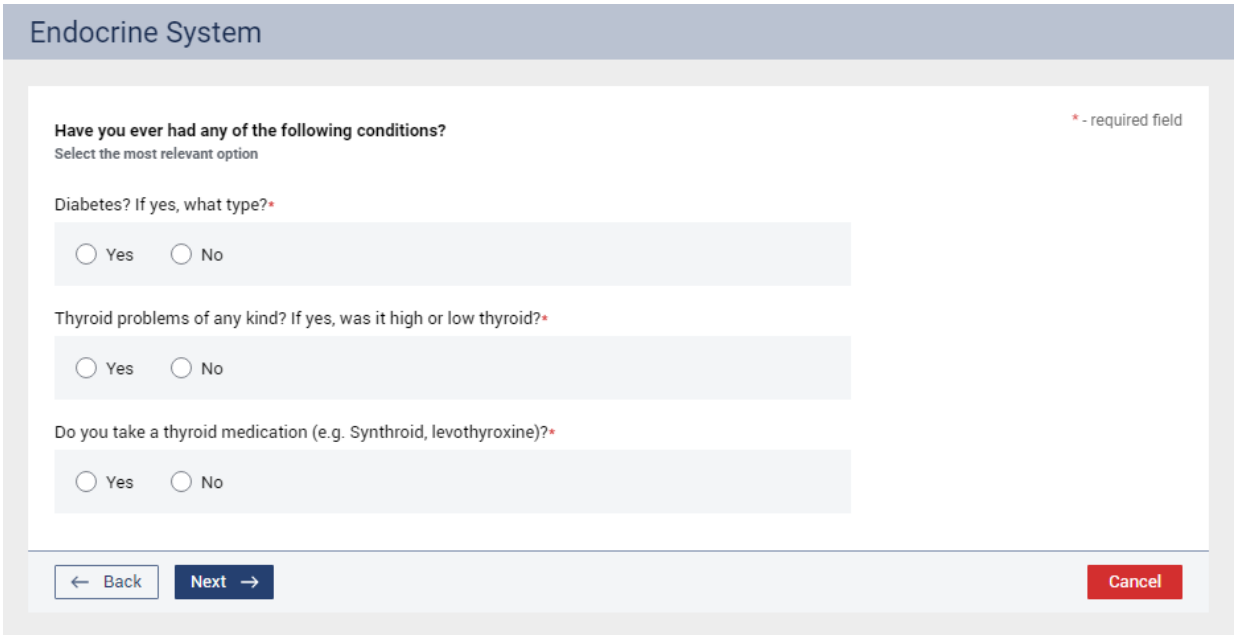


  - **Description** – Select one of the following descriptions:
    - **Fatty Liver Disease**.
    - **Fibrosis**.
    - **Cirrhosis**.
    - **Liver Cancer**.
    - **Hemochromatosis**.
    - **Alcohol Related Liver Disease**.
    - **Alpha-1 Antitrypsin Deficiency**.
    - **Budd-Chiari Syndrome**.
    - **Gilbert Syndrome**.
    - **Type 1 Glycogen Storage Disease (GSD 1)**.
    - **Hepatorenal Syndrome (HRS)**.
    - **Wilson Disease**.

- **Liver Transplant**.
- **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.



Endocrine System



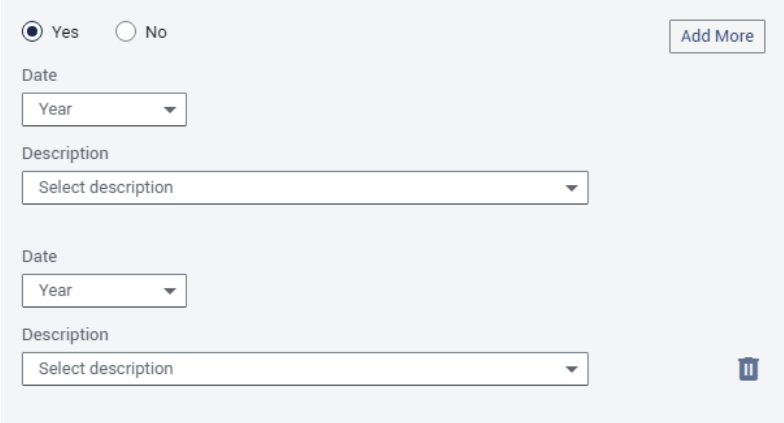
Specify if the patient has ever had any of the following conditions:

- **Diabetes? If yes, what type?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



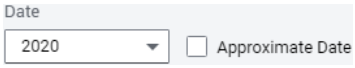
For each additional set of responses you want to add, click **Add More**. You can add up to four additional sets of responses.



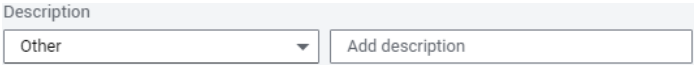
Note: To delete an additional set of responses, click the corresponding **Delete** button .

Optionally, select a year and/or description for each set of responses:

- **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.

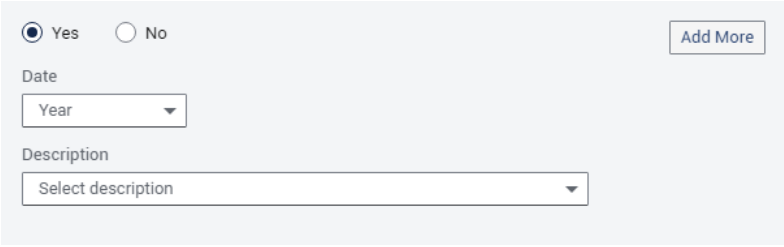
  

- **Description** – Select one of the following descriptions:
  - **Type 1**.
  - **Type 2**.
  - **Gestational**.
  - **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.

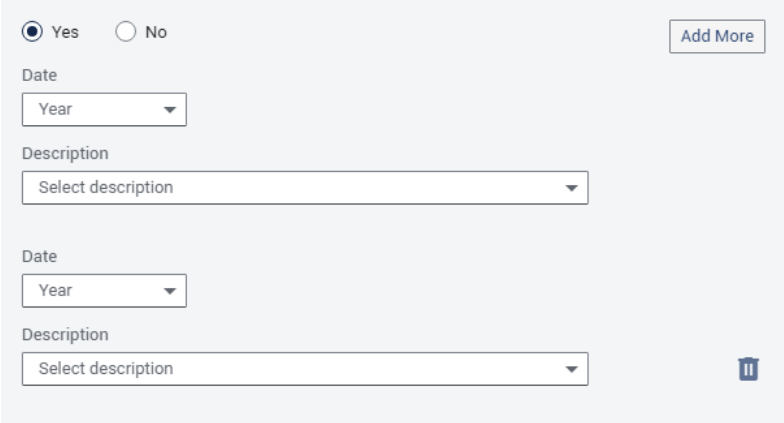
    

- **Thyroid problems of any kind? If yes, was it high or low thyroid?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



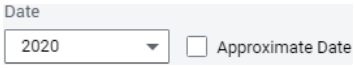
For each additional set of responses you want to add, click **Add More**. You can add up to four additional sets of responses.



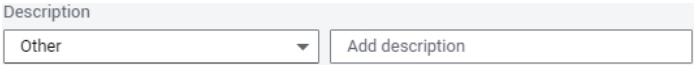
Note: To delete an additional set of responses, click the corresponding **Delete** button .

Optionally, select a year and/or description for each set of responses:

- **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.

- **Description** – Select one of the following descriptions:
  - **Hyperthyroidism (High)**.
  - **Hypothyroidism (Low)**.
  - **Goiter**.
  - **Thyroiditis**.
  - **Graves' disease**.
  - **Thyroid cancer**.
  - **Thyroid Storm (history of)**.
  - **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.

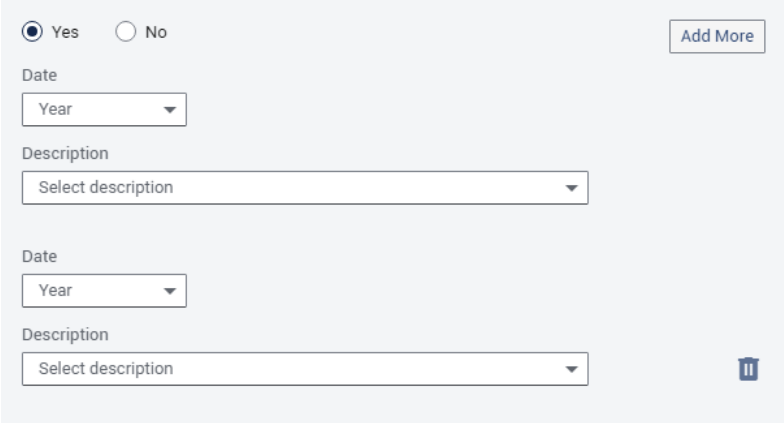
    

- **Do you take a thyroid medication (e.g. Synthroid, levothyroxine)?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



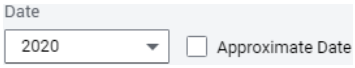
For each additional set of responses you want to add, click **Add More**. You can add up to four additional sets of responses.



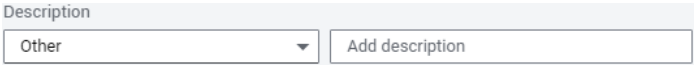
Note: To delete an additional set of responses, click the corresponding **Delete** button .

Optionally, select a year and/or description for each set of responses:

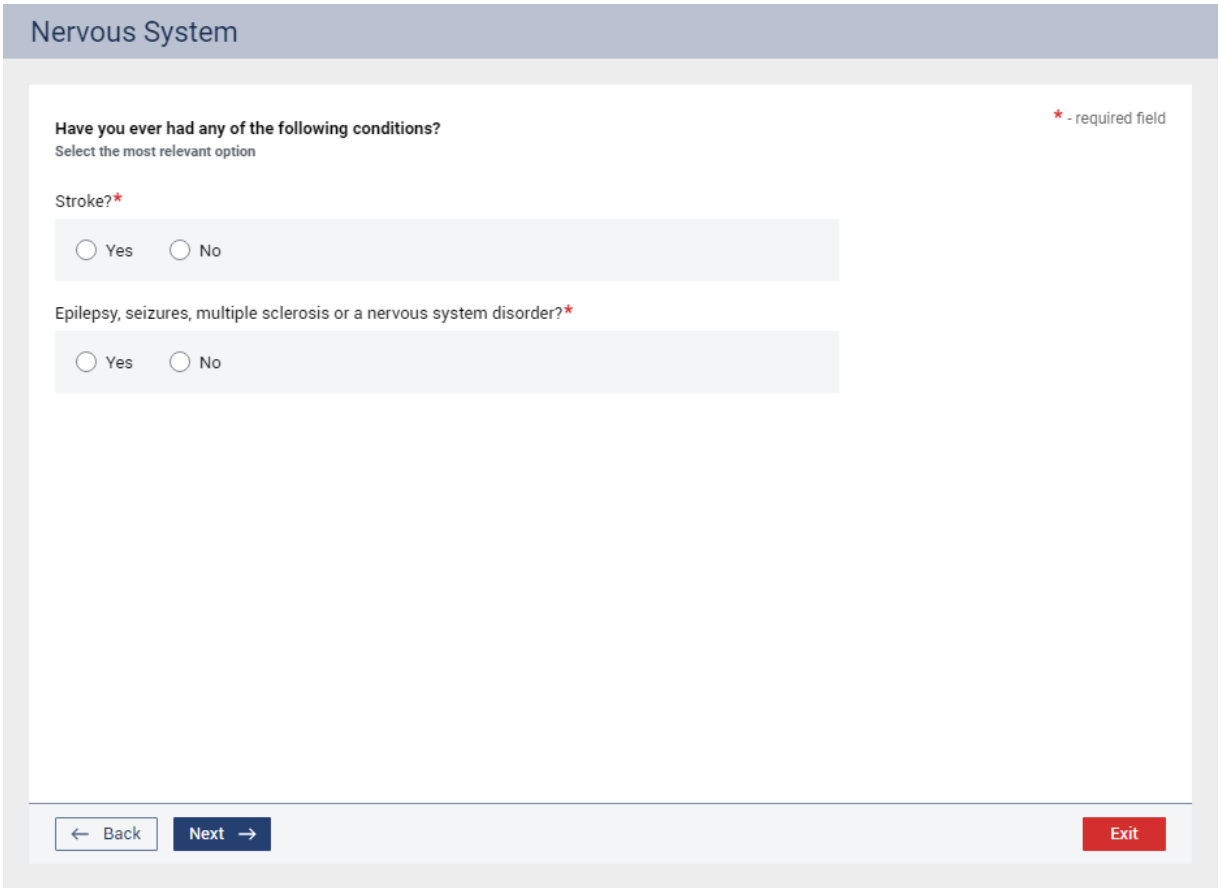
- **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



- **Description** – Select one of the following descriptions:
  - **Levothyroxine (Synthroid, Lexoxyl, Tirosint)**.
  - **Methimazole**.
  - **Armour thyroid**.
  - **Cytomel**.
  - **Iodine**.
  - **Potassium Iodide (Thyro Shield)**.
  - **Propylthiouracil**.
  - **Sodium Iodide (HiCon)**.
  - **Tapazole**.
  - **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.



Nervous System



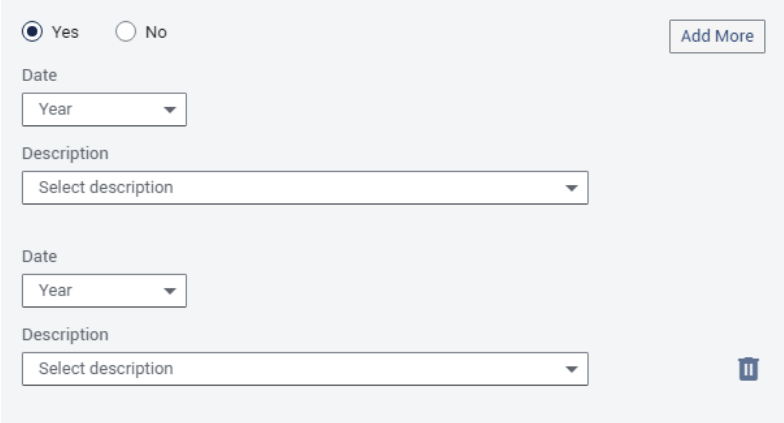
Specify if the patient has ever had any of the following conditions:

- **Stroke?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



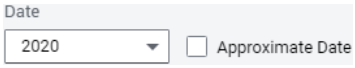
For each additional set of responses you want to add, click **Add More**. You can add up to four additional sets of responses.



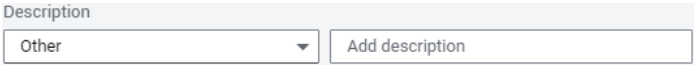
Note: To delete an additional set of responses, click the corresponding **Delete** button .

Optionally, select a year and/or description for each set of responses:

- **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.

- **Description** – Select one of the following descriptions:
  - **Stroke (Unknown type)**.
  - **Ischemic Stroke**.
  - **Hemorrhagic Stroke**.
  - **Cryptogenic Stroke**.
  - **Transient Ischemic Attack (TIA)**.
  - **Residual Deficits: Right Side**.
  - **Residual Deficits: Left Side**.
  - **Residual Deficits: Both Sides**.
  - **Residual Deficits: None**.
  - **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.

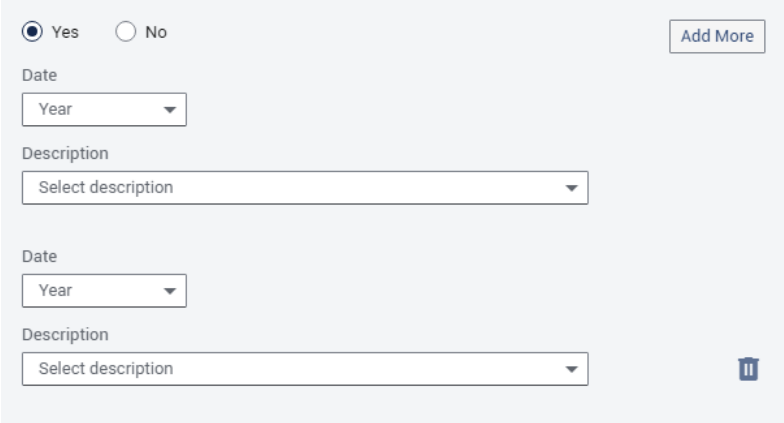
    

- **Epilepsy, seizures, multiple sclerosis or a nervous system disorder?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



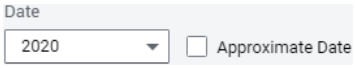
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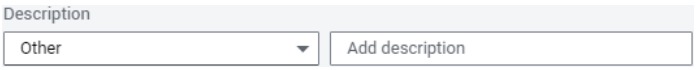
Note: To delete an additional set of responses, click the corresponding **Delete** button .

Optionally, select a year and/or description for each set of responses:

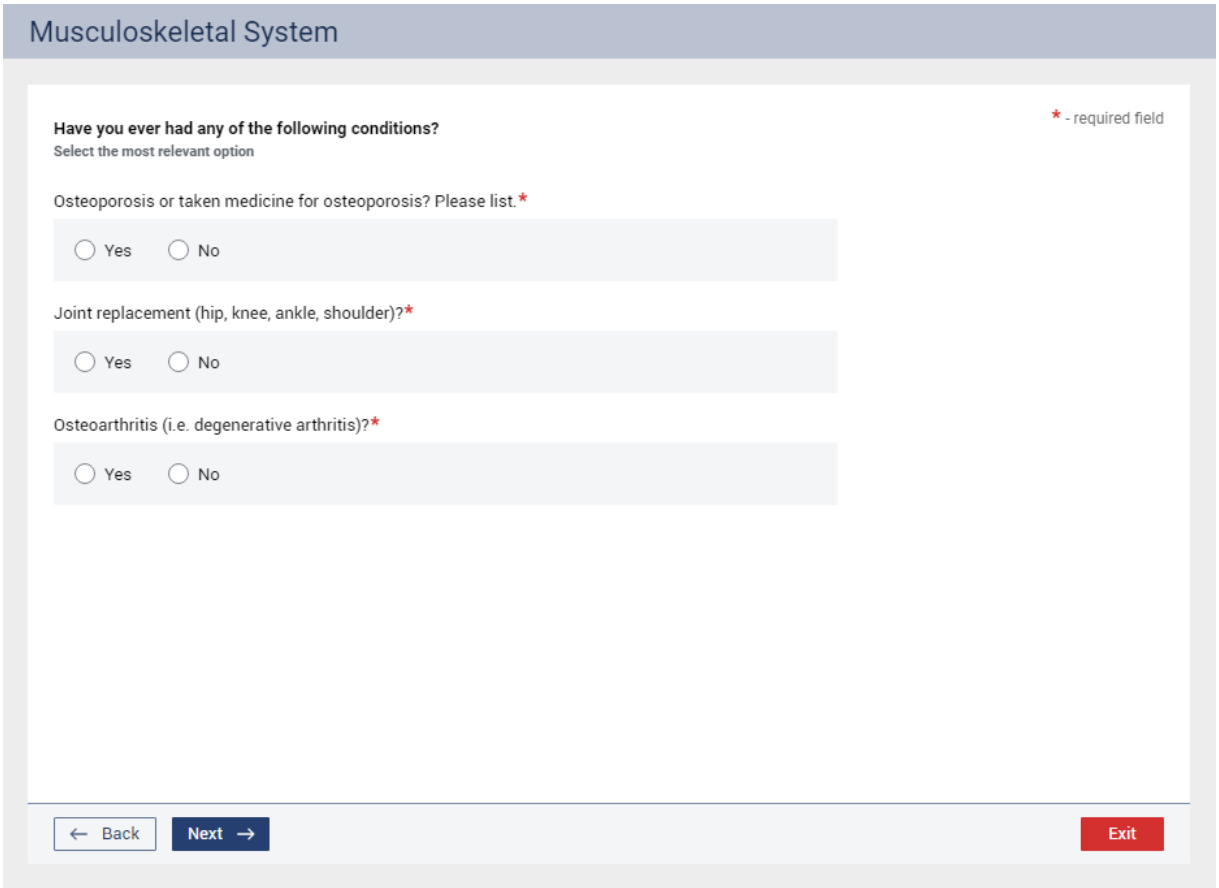
- **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



- **Description** – Select one of the following descriptions:
  - **Epilepsy**.
  - **Multiple Sclerosis**.
  - **Seizures**.
  - **Status Epilepticus (History of)**.
  - **Alzheimer's Disease**.
  - **Dementia**.
  - **Parkinson's Disease**.
  - **Paresthesia (Numbness)**.
  - **Bell's Palsy**.
  - **Migraine Headaches**.
  - **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.



Musculoskeletal System



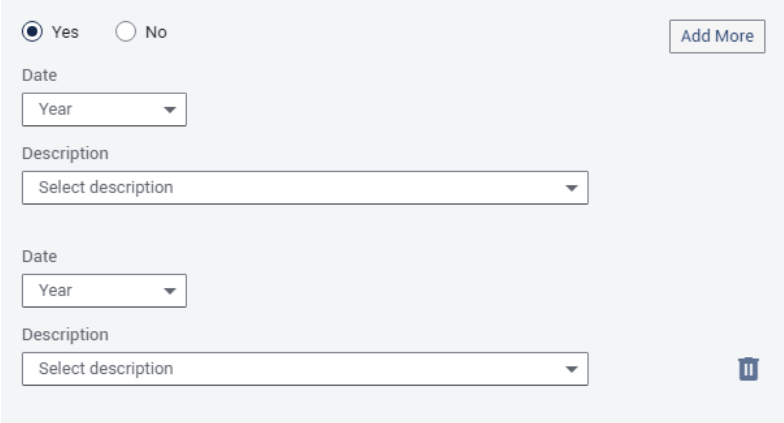
Specify if the patient has ever had any of the following conditions:

- **Osteoporosis or taken medicine for osteoporosis? Please list.** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



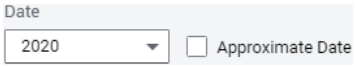
For each additional set of responses you want to add, click **Add More**. You can add up to four additional sets of responses.



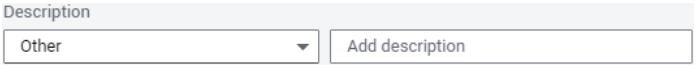
Note: To delete an additional set of responses, click the corresponding **Delete** button.

Optionally, select a year and/or description for each set of responses:

- **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



- **Description** – Select one of the following descriptions:
  - **Primary Osteoporosis (Most common-age related)**.
  - **Secondary Osteoporosis (From med condition)**.
  - **Paget's Disease**.
  - **Osteogenesis Imperfecta**.
  - **Idiopathic Juvenile Osteoporosis**.
  - **Current Osteoporosis Medications: None**.
  - **Current Osteoporosis Medications: Oral Bisphosphonate**.
  - **Current Osteoporosis Medications: Injection/IV Bisphosphonate**.
  - **Current Osteoporosis Medications: Alendronate (Fosamax)**.
  - **Current Osteoporosis Medications: Ibandronate (Bonivia)**.
  - **Current Osteoporosis Medications: Zoledronic Acid (Zometa)**.
  - **Current Osteoporosis Medications: Risendonate (Actonel)**.
  - **Current Osteoporosis Medications: Vitamin D**.
  - **Current Osteoporosis Medications: Calcium**.
  - **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.

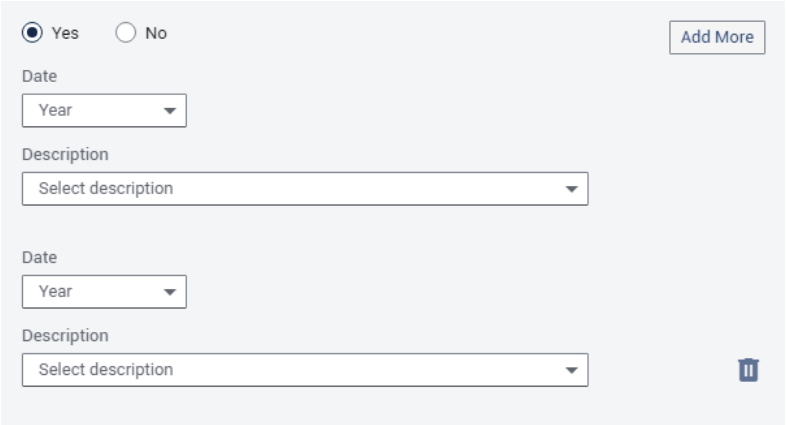


- **Joint replacement (hip, knee, ankle, shoulder)?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



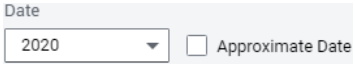
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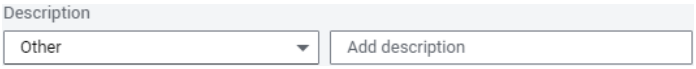
Note: To delete an additional set of responses, click the corresponding **Delete** button .

Optionally, select a year and/or description for each set of responses:

- **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



- **Description** – Select one of the following descriptions:
  - **Hip**.
  - **Knee**.
  - **Ankle**.
  - **Shoulder**.
  - **Finger**.
  - **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.

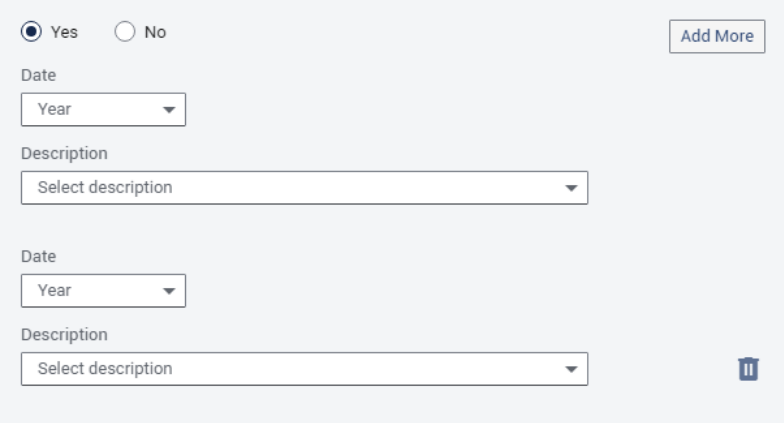


- **Osteoarthritis (i.e. degenerative arthritis)?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



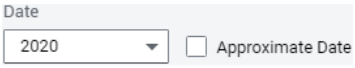
  For each additional set of responses you want to add, click **Add More**. You can add up to four additional sets of responses.



  Note: To delete an additional set of responses, click the corresponding **Delete** button .

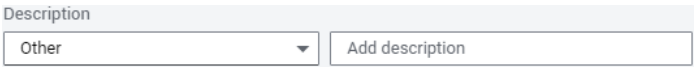
  Optionally, select a year and/or description for each set of responses:

  - **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.

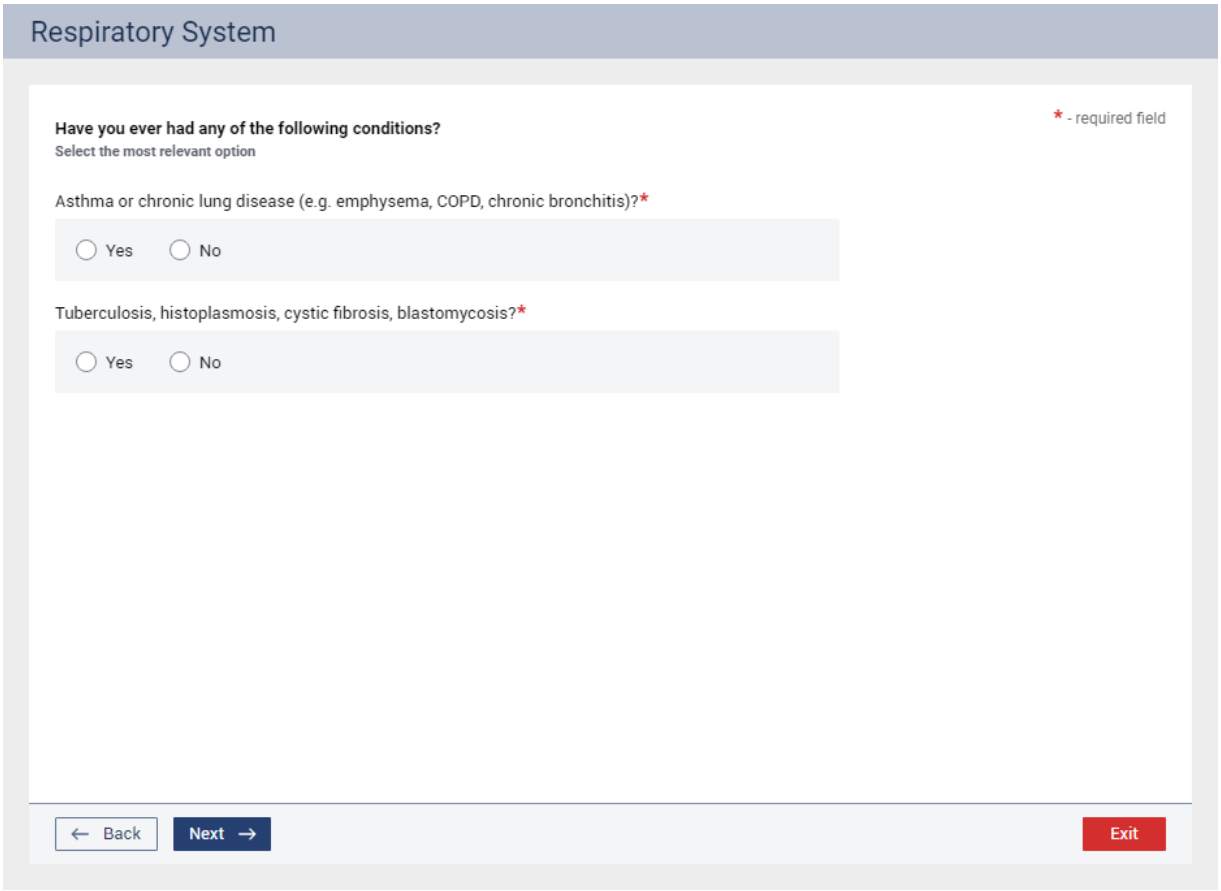


  - **Description** – Select one of the following descriptions:
    - **Osteoarthritis**.
    - **Rheumatoid Arthritis**.
    - **Juvenile Arthritis**.
    - **Ankylosing Spondylitis**.
    - **Systemic Lupus Erythematosus (Lupus)**.
    - **Gout**.
    - **Infectious and/or Reactive Arthritis**.
    - **Psoriatic Arthritis**.
    - **Fibromyalgia**.
    - **Scleroderma**.

- **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.

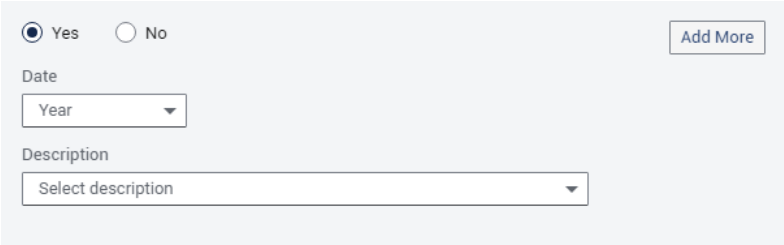


Respiratory System

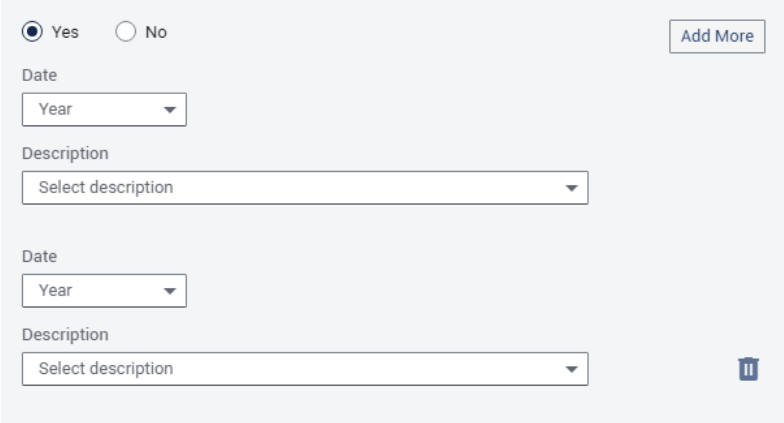


Specify if the patient has ever had any of the following conditions:

- **Asthma or chronic lung disease (e.g. emphysema, COPD, chronic bronchitis)?** – Select **Yes** or **No**. With **Yes** selected, a set of responses (**Date** and **Description**) is available.



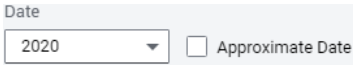
For each additional set of responses you want to add, click **Add More**. You can add up to four additional sets of responses.



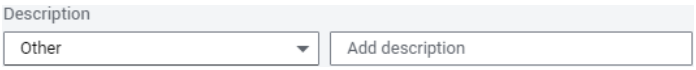
Note: To delete an additional set of responses, click the corresponding **Delete** button.

Optionally, select a year and/or description for each set of responses:

- **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



- **Description** – Select one of the following descriptions:
  - **Asthma**.
  - **Exercise Induced Asthma**.
  - **Allergy Induced Asthma**.
  - **Status Asthmaticus (History of)**.
  - **Emphysema**.
  - **COPD**.
  - **Chronic Bronchitis**.
  - **Lung Cancer**.
  - **Pulmonary Embolism**.
  - **Pulmonary Fibrosis**.
  - **Uses Supplemental Oxygen**.
  - **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.

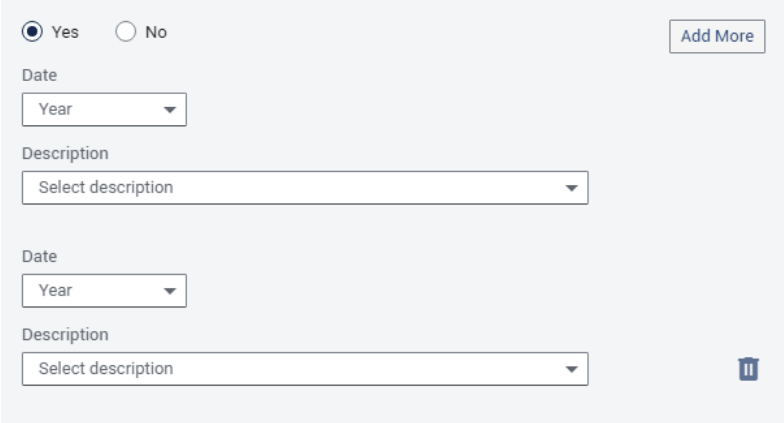


- **Tuberculosis, histoplasmosis, cystic fibrosis, blastomycosis?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



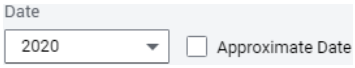
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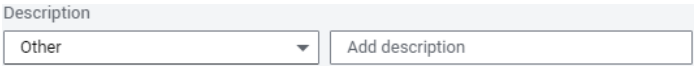
  Note: To delete an additional set of responses, click the corresponding **Delete** button .

  Optionally, select a year and/or description for each set of responses:

  - **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



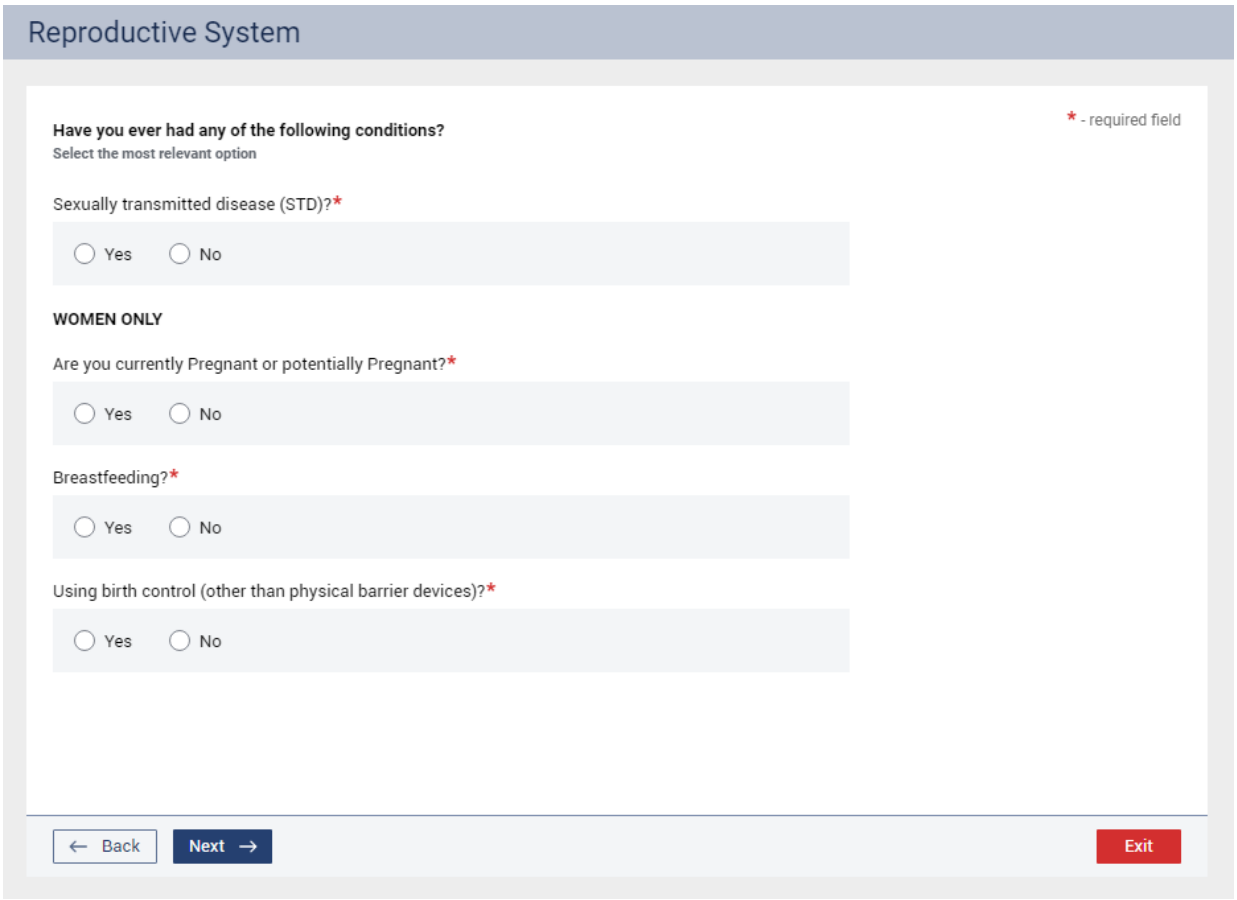
  - **Description** – Select one of the following descriptions:
    - **Tuberculosis**.
    - **Histoplasmosis**.
    - **Cystic Fibrosis**.
    - **Blastomycosis**.
    - **Coccidioidomycosis (Valley Fever)**.
    - **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.



Reproductive System



Male



Female

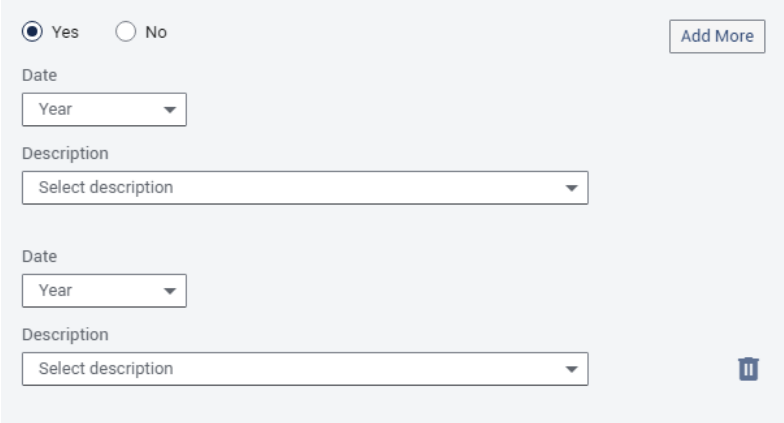
Answer the following questions:

- **Sexually transmitted disease (STD)?** – Select **Yes** or **No** to specify if the patient has ever had this condition.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



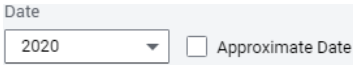
For each additional set of responses you want to add, click **Add More**. You can add up to four additional sets of responses.



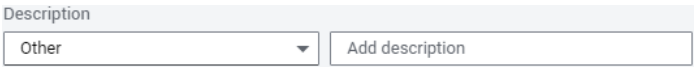
Note: To delete an additional set of responses, click the corresponding **Delete** button .

Optionally, select a year and/or description for each set of responses:

- **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.

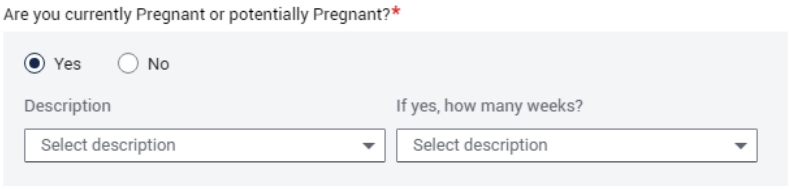


- **Description** – Select one of the following descriptions:
  - **Chlamydia**.
  - **Gonorrhea**.
  - **Syphilis**.
  - **Mycoplasma Genitalium (MG)**.
  - **Trichomoniasis**.
  - **Human Papilloma Virus (HPV)**.
  - **Herpes**.
  - **HIV/AIDS**.
  - **Hepatitis**.
  - **Bacterial Vaginosis (BV)**.
  - **Chancroid**.
  - **Lymphogranuloma Venereum (LGV)**.
  - **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.



- **WOMEN ONLY** – The following questions are available only if **Female** is selected as the patient's **Sex** (in Family File):
  - **Are you currently Pregnant or potentially Pregnant?** – Select **Yes** or **No** to specify the patient's pregnancy status.

    With **Yes** selected, a set of responses is available.



    For each additional set of responses you want to add, click **Add More**. You can add up to four additional sets of responses.

    Optionally, select a description and duration:

    - **Description** – Select one of the following descriptions:
      - **Pregnant**.
      - **Potentially Pregnant**.
      - **Trying to get Pregnant**.
      - **In Vitro Fertilization**.
      - **Other** – With this option selected, the Add description box is available. Optionally, enter up to 60 characters.



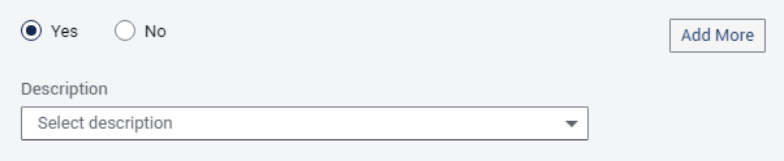
    - **If yes, how many weeks?** – Select one of the following options:
      - **Potential or week unknown**.
      - **1st Trimester (week 0-13)**.
      - **2nd Trimester (week 14-26)**.
      - **3rd Trimester (week 27-40)**.
      - **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.



    - **Breastfeeding?** – Select **Yes** or **No** to specify if the patient currently breast feeds.

- **Using birth control (other than physical barrier devices)?** – Select **Yes** or **No** to specify if the patient uses birth control.

  With **Yes** selected, the **Description** list is available as a response.



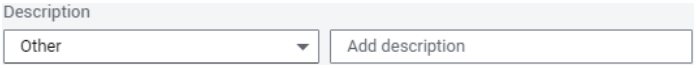
  For each additional response you want to add, click **Add More**. You can add up to four additional responses.



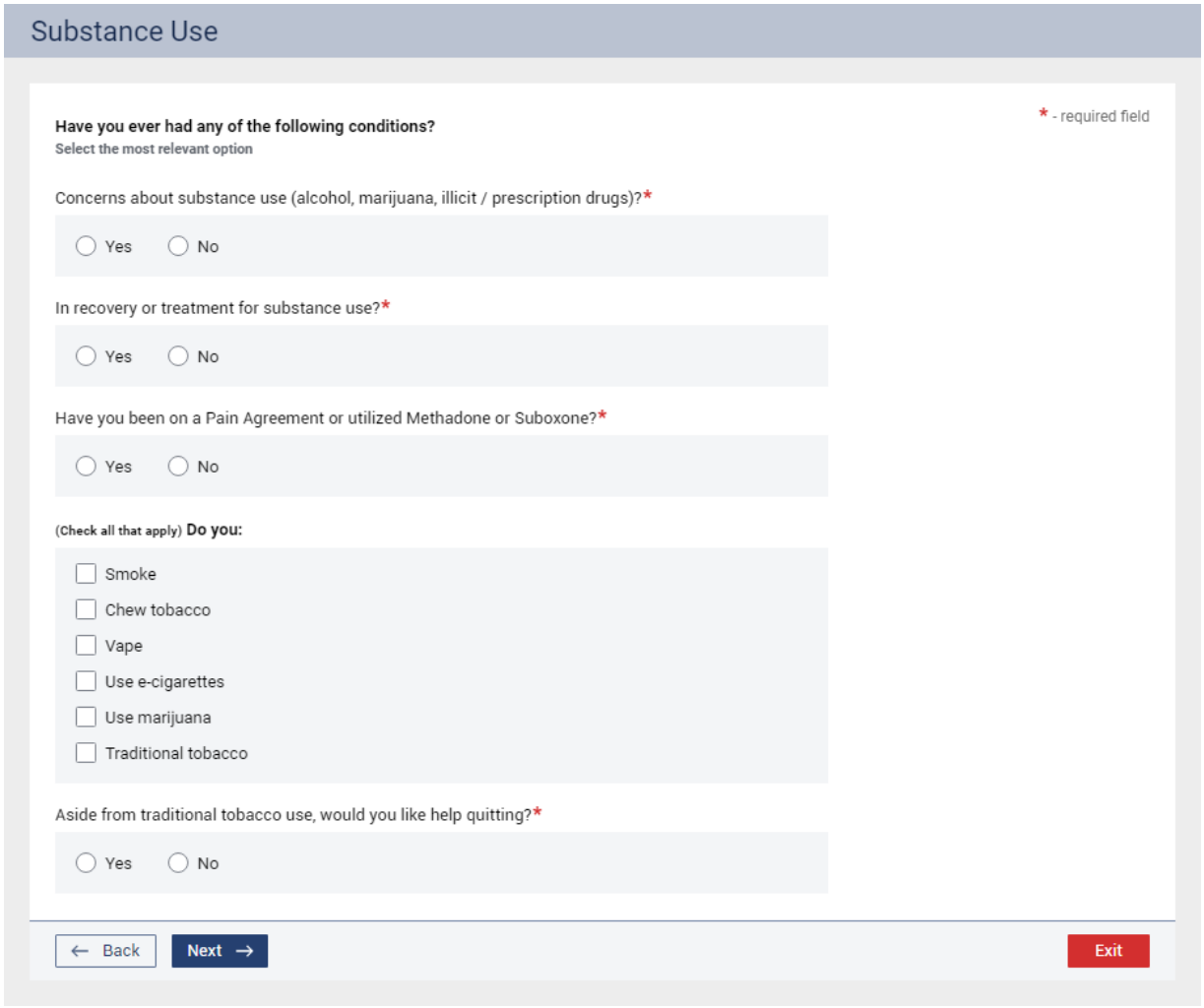
  Note: To delete an additional response, click the corresponding **Delete** button .

  Optionally, select a **Description** for each response:

  - **Hormonal Implant**.
  - **Hormonal Injection (Shot)**.
  - **Hormonal Patch**.
  - **Hormonal Ring**.
  - **Birth Control Pill**.
  - **Surgical (Tubes Tied, etc…)**.
  - **Other** – With this option selected, an **Add description** box is available. Optionally, enter up to 60 characters.



Substance Use



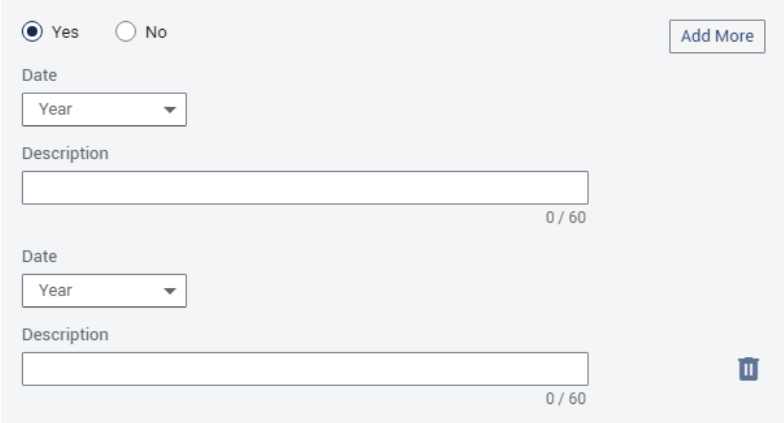
Answer the following questions:

- **Concerns about substance use (alcohol, marijuana, illicit / prescription drugs)?** – Select **Yes** or **No** to specify if the patient has ever had these concerns.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



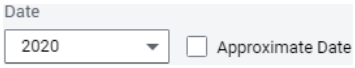
For each additional set of responses you want to add, click **Add More**. You can add up to four additional sets of responses.



Note: To delete an additional set of responses, click the corresponding **Delete** button.

Optionally, select a year and/or enter a description for each set of responses:

- **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



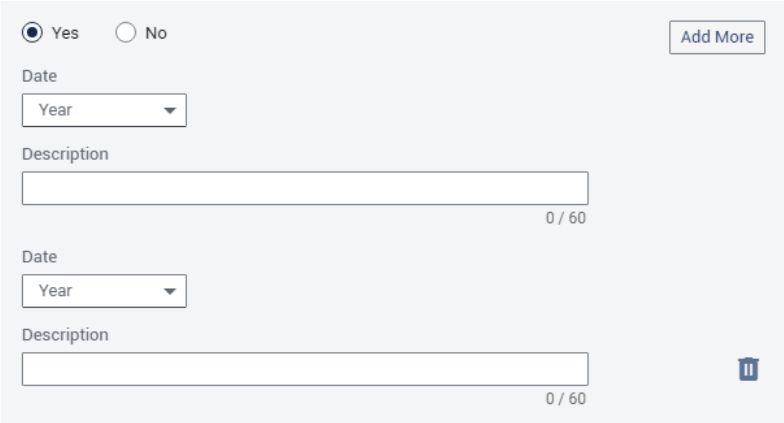
- **Description** – Optionally, enter up to 60 characters for the description.

- **In recovery or treatment for substance use?** – Select **Yes** or **No** to specify if the patient has ever been in recovery or treatment for substance abuse.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



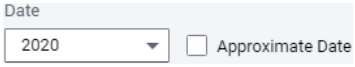
For each additional set of responses you want to add, click **Add More**. You can add up to four additional sets of responses.



Note: To delete an additional set of responses, click the corresponding **Delete** button.

Optionally, select a year and/or enter a description for each set of responses:

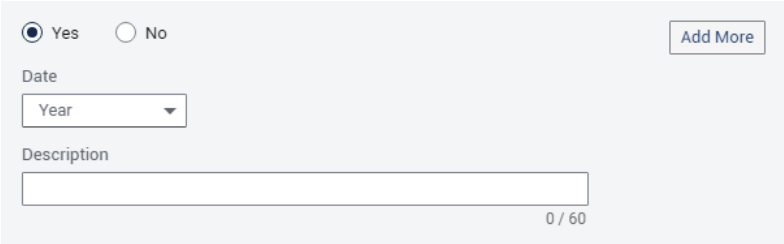
- **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



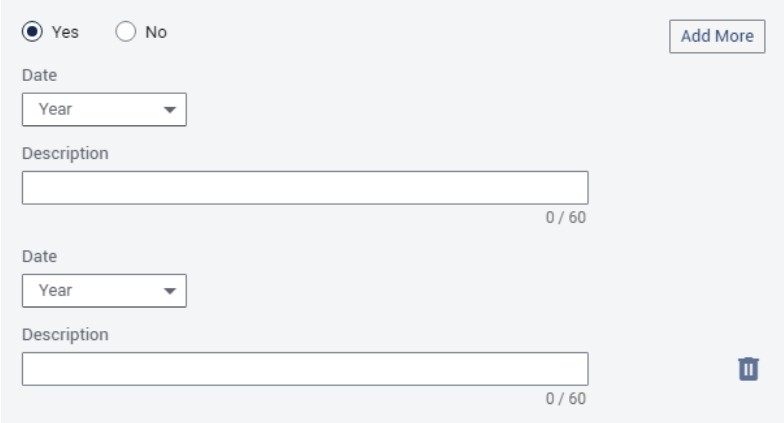
- **Description** – Optionally, enter up to 60 characters for the description.

- **Have you been on a Pain Agreement or utilized Methadone or Suboxone?** – Select **Yes** or **No** to specify if the patient has ever had an agreement or uses the medications mentioned.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



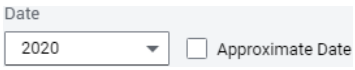
For each additional set of responses you want to add, click **Add More**. You can add up to four additional sets of responses.



Note: To delete an additional set of responses, click the corresponding **Delete** button.

Optionally, select a year and/or enter a description for each set of responses:

- **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



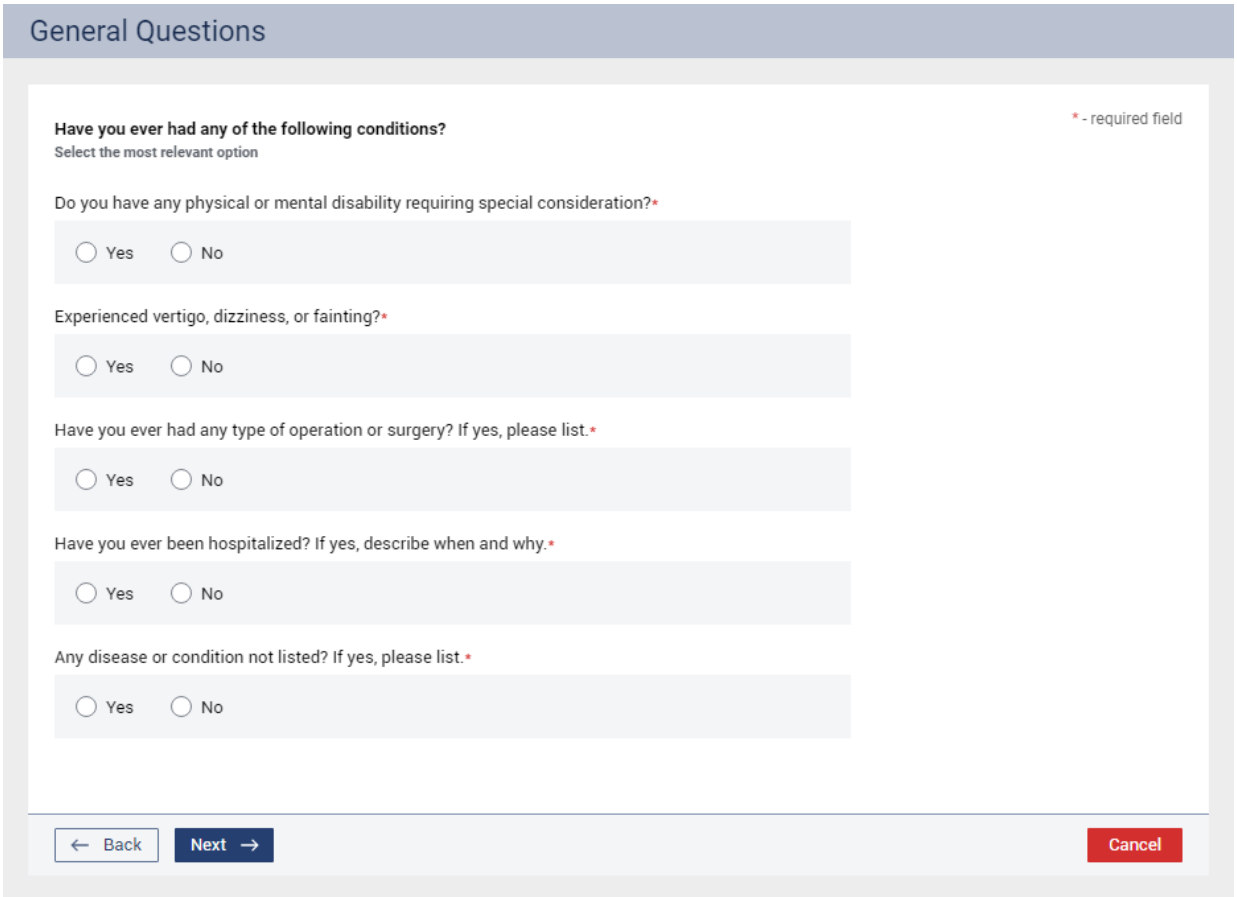
- **Description** – Optionally, enter up to 60 characters for the description.

- **(Check all that apply) Do you** – Select the check boxes that correspond to the patient's current habits:
  - **Smoke**.
  - **Chew tobacco**.
  - **Vape**.

- **Use e-cigarettes**.
- **Use marijuana**.
- **Traditional tobacco**.

- **Aside from traditional tobacco use, would you like help quitting?** – Select **Yes** or **No** to specify if the patient is interested in getting help.

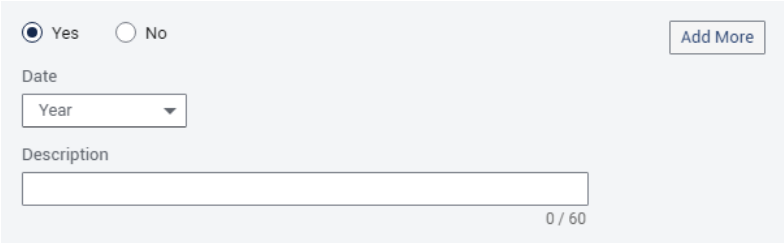
General Questions



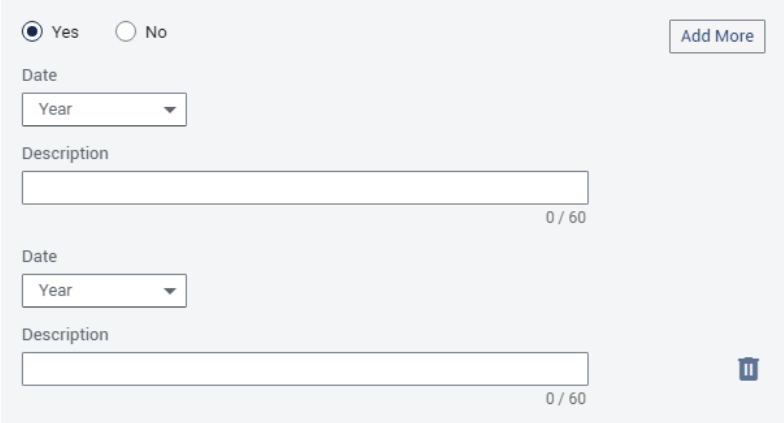
Specify if the patient has ever had any of the following conditions:

- **Do you have any physical or mental disability requiring special consideration?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



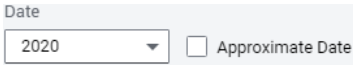
For each additional set of responses you want to add, click **Add More**. You can add up to four additional sets of responses.



Note: To delete an additional set of responses, click the corresponding **Delete** button.

Optionally, select a year and/or enter a description for each set of responses:

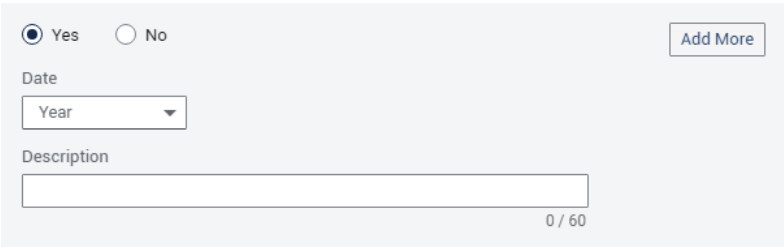
- **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



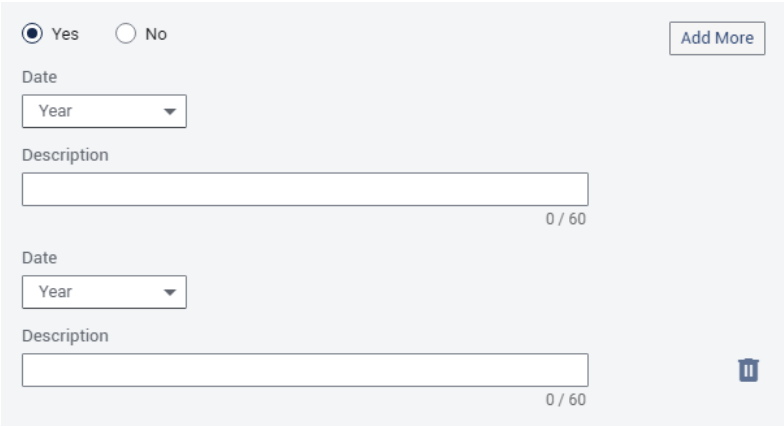
- **Description** – Optionally, enter up to 60 characters for the description.

- **Experienced vertigo, dizziness, or fainting?** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



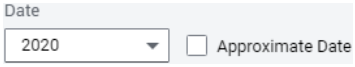
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Optionally, select a year and/or enter a description for each set of responses:

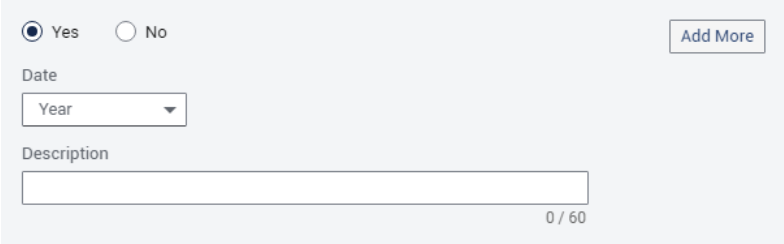
- **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



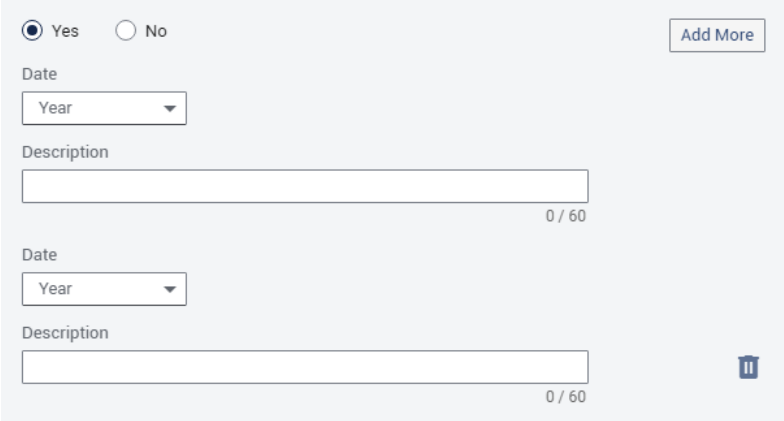
- **Description** – Optionally, enter up to 60 characters for the description.

- **Have you ever had any type of operation or surgery? If yes, please list.** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



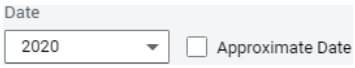
  For each additional set of responses you want to add, click **Add More**. You can add up to four additional sets of responses.



  Note: To delete an additional set of responses, click the corresponding **Delete** button .

  Optionally, select a year and/or enter a description for each set of responses:

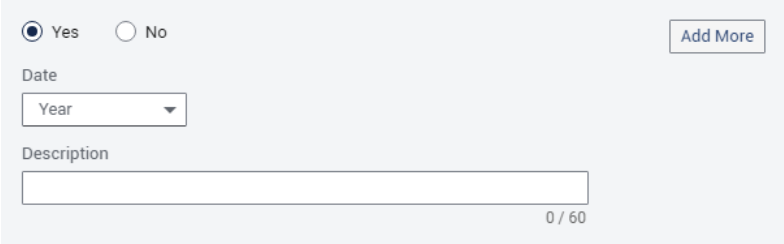
  - **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



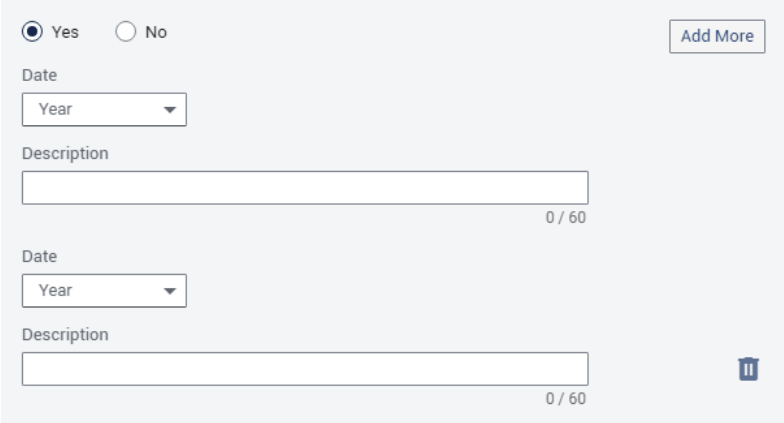
  - **Description** – Optionally, enter up to 60 characters for the description.

- **Have you ever been hospitalized? If yes, describe when and why.** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



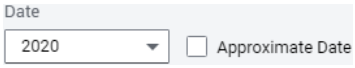
  For each additional set of responses you want to add, click **Add More**. You can add up to four additional sets of responses.



  Note: To delete an additional set of responses, click the corresponding **Delete** button.

  Optionally, select a year and/or enter a description for each set of responses:

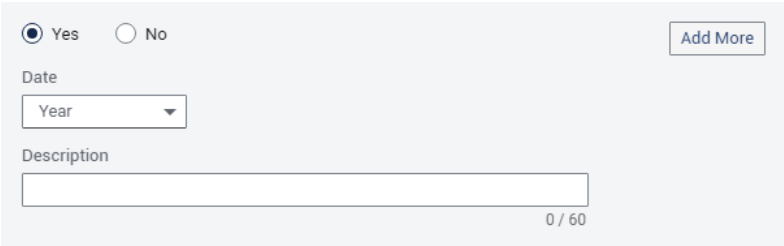
  - **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



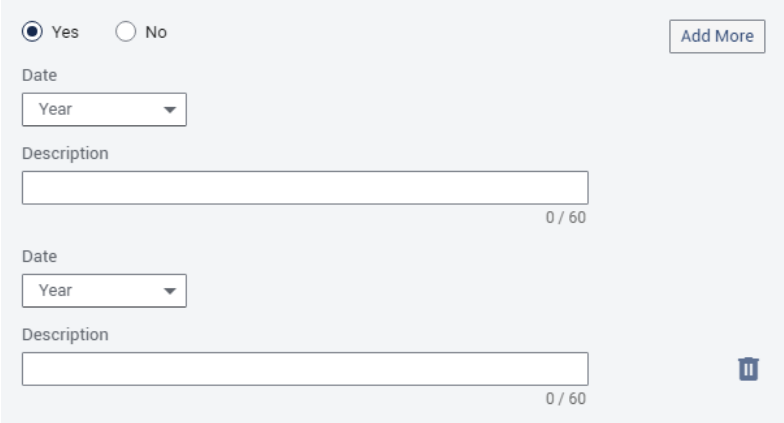
  - **Description** – Optionally, enter up to 60 characters for the description.

- **Any disease or condition not listed? If yes, please list.** – Select **Yes** or **No**.

  With **Yes** selected, a set of responses (**Date** and **Description**) is available.



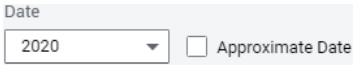
For each additional set of responses you want to add, click **Add More**. You can add up to four additional sets of responses.



Note: To delete an additional set of responses, click the corresponding **Delete** button .

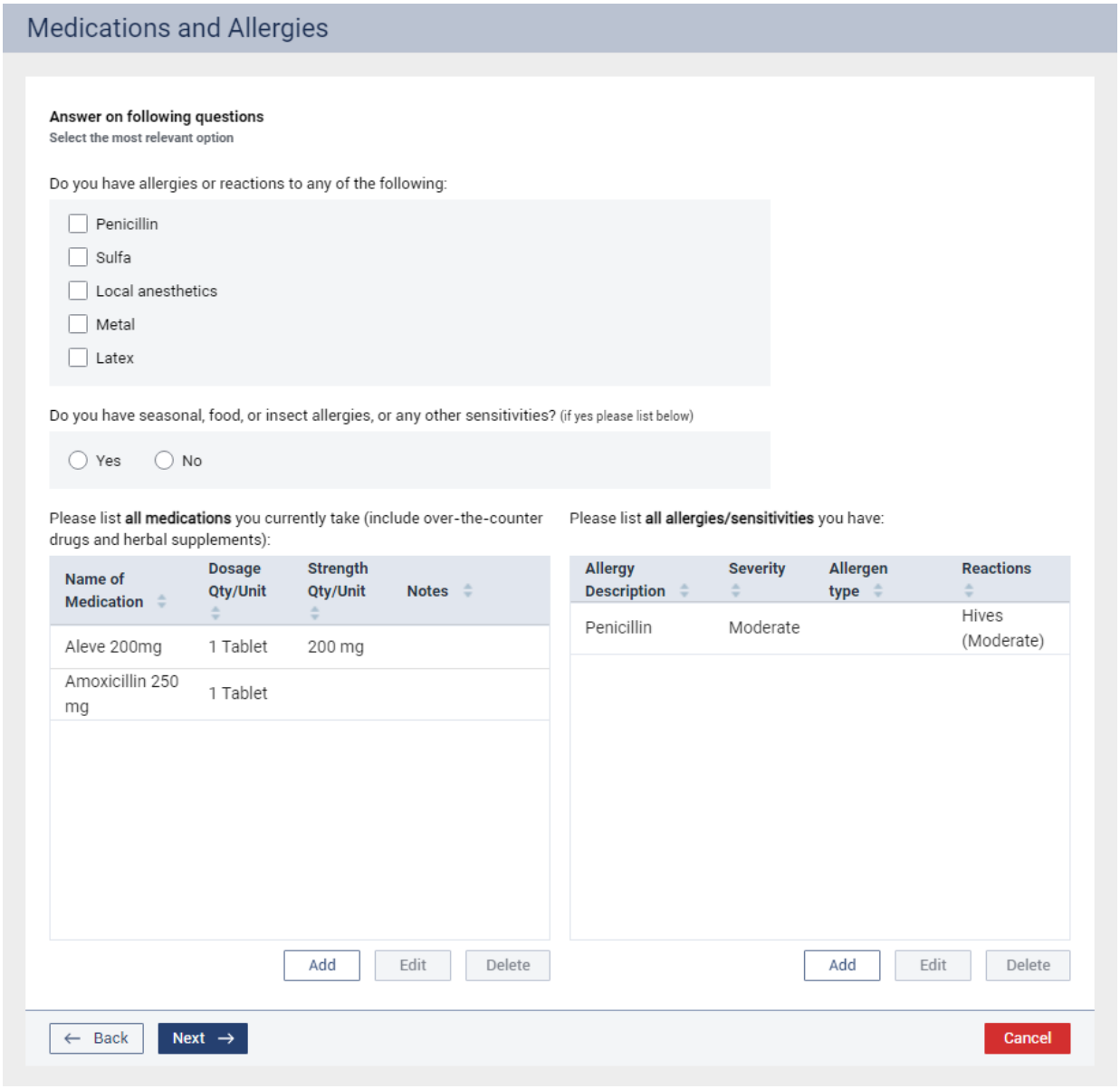
Optionally, select a year and/or enter a description for each set of responses:

- **Date** – Select a year or **Unknown**. If a year is selected, to specify that the year is approximate, select the **Approximate Date** checkbox.



- **Description** – Optionally, enter up to 60 characters for the description.

Medications / Allergies



Optionally, answer the following questions:

- **Do you have allergies or reactions to any of the following** – Select the check boxes that correspond to the items that affect the patient:
  - **Penicillin**.
  - **Sulfa**.
  - **Local anesthetics**.
  - **Metal**.
  - **Latex**.
- **Do you have seasonal, food, or insect allergies, or any other sensitivities? (if yes please list below)** – Select **Yes** or **No** to specify if the patient has any other sensitivities.

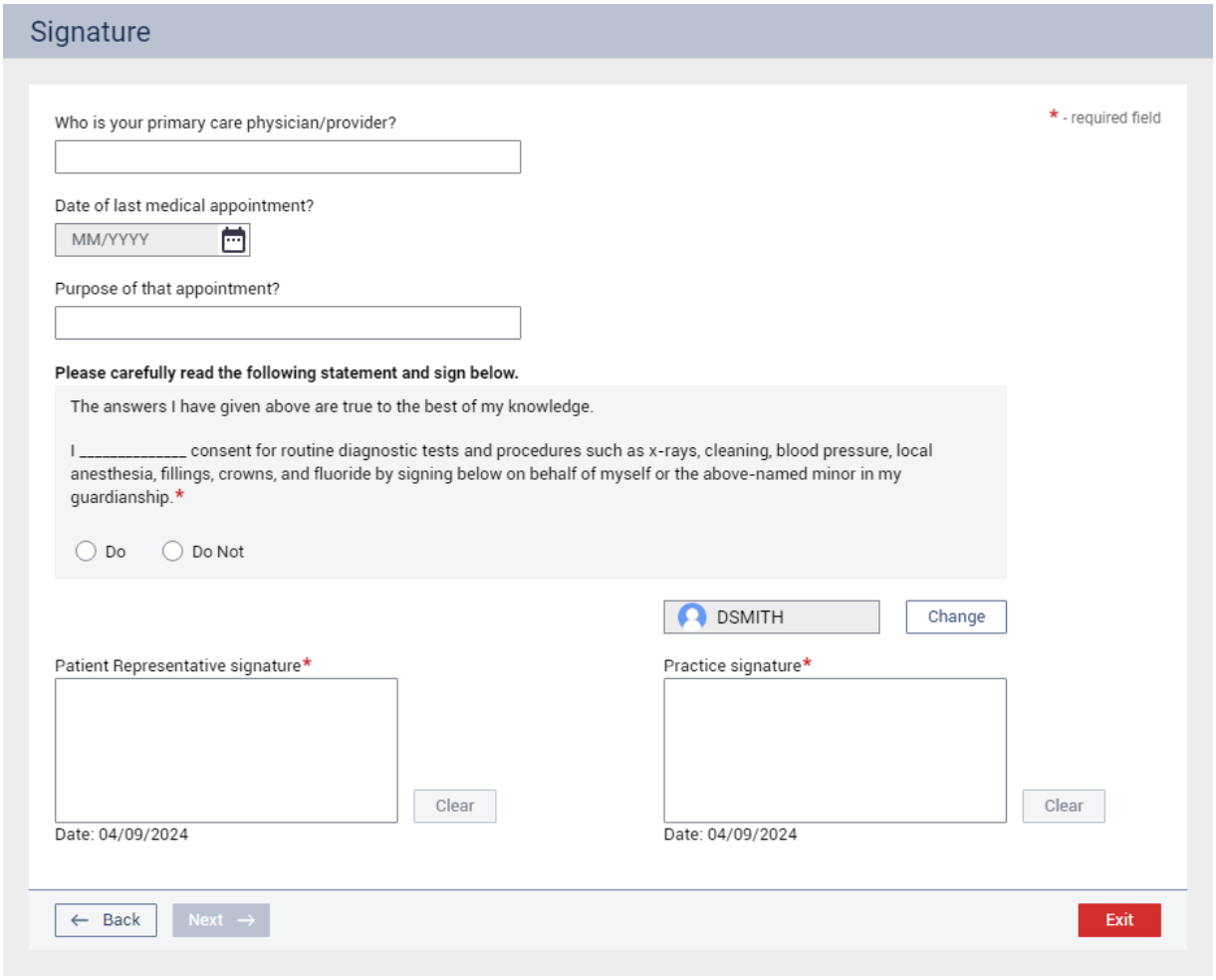
- **Please list all medications you currently take (include over-the-counter drugs and herbal supplements)** – Do any of the following:
  - To add a medication, click **Add**, select a medication, set up the applicable options, and then click **OK**.
  - To edit a medication, select it, click **Edit**, make the necessary changes, and then click **OK**.
  - To delete a medication, select it, click **Delete**, and then click **Ok** to confirm the deletion.

  Note: Prescriptions entered in the **Patient Prescription** window are listed, but you cannot edit or delete them from the assessment. From the assessment, you can add, edit, and delete only the medications that you can add, edit, and delete in the **Medical Alerts** window.

- **Please list all allergies/sensitivities you have** – Do any of the following:
  - To add an allergy, click **Add**, select an allergy, set up the applicable options, and then click **OK**.
  - To edit an allergy, select it, click **Edit**, make the necessary changes, and then click **OK**.
  - To delete an allergy, select it, click **Delete**, and then click **Ok** to confirm the deletion.

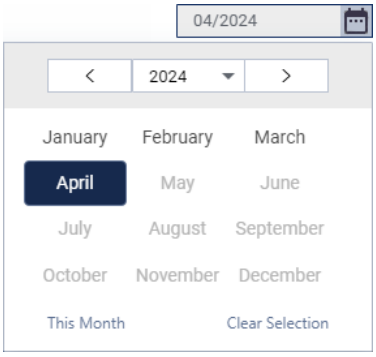
  Note: Allergies from the **Medical Alerts** window are listed. Making changes from the assessment affects the **Medical Alerts** window.

Signature



Complete the following steps:

1. Optionally, answer the following questions:
   - **Who is your primary care physician/provider?** – Enter a name.
   - **Date of last medical appointment?** – Click the calendar icon to select a date.



   - **Purpose of that appointment?** – Enter the reason.

2. Under **Please carefully read the following statement and sign below**, select the **Do** or **Do Not** option to acknowledge the statement and provide consent.

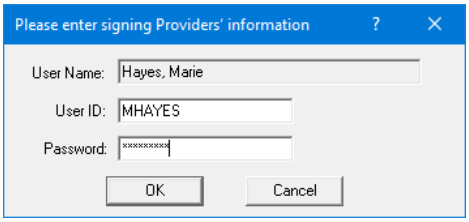
   Note: This question is available only if the **Require patient signature** check box (in the **Visit Information** section) is selected.

3. In the **Patient Representative signature** box, the patient or guardian signs using a mouse.

   Notes:

   - This signature box is available only if the **Require patient signature** check box (in the **Visit Information** section) is selected.
   - You can click **Clear** to remove the signature and re-sign.

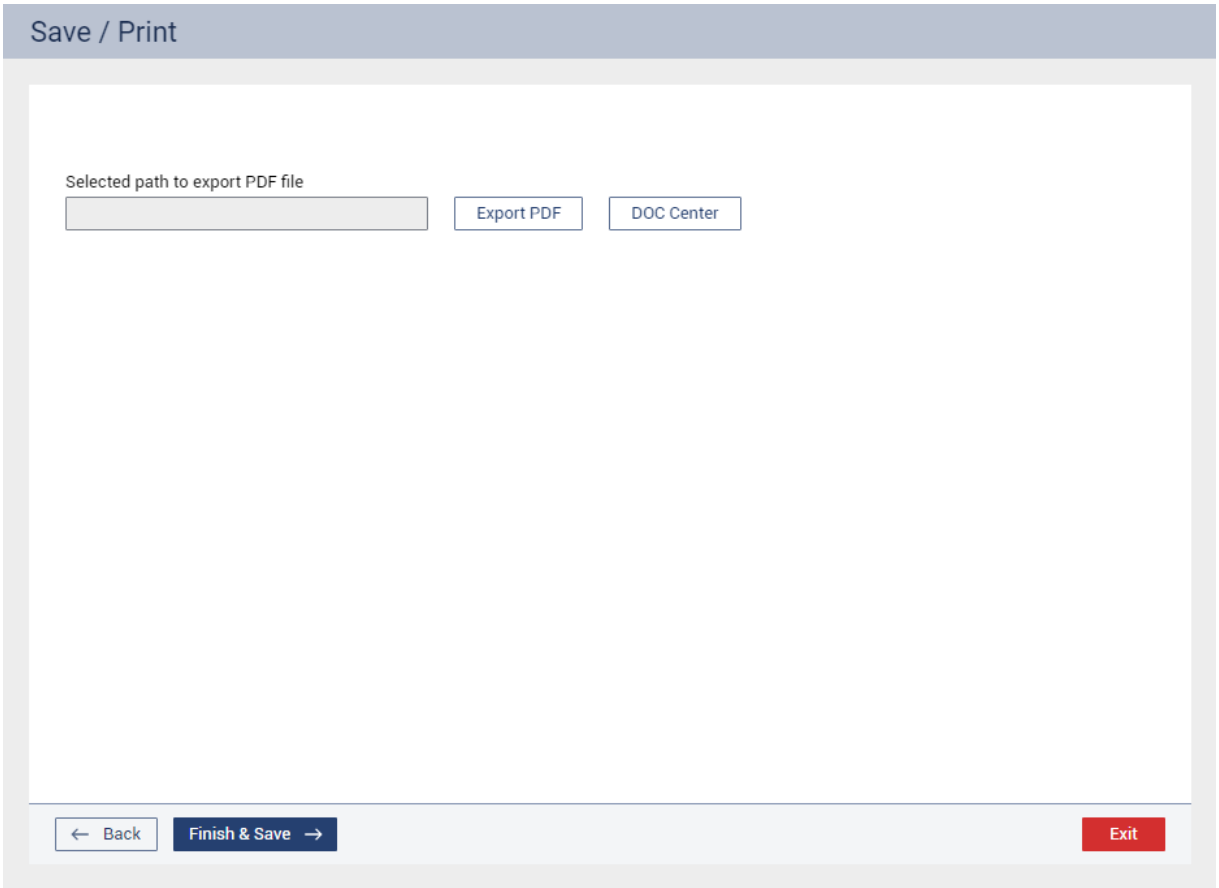
4. If you are not logged in as the provider for the visit, optionally, click the **Change** to have that provider enter his or her credentials.



5. In the **Practice signature** box, a provider or staff member signs using a mouse.

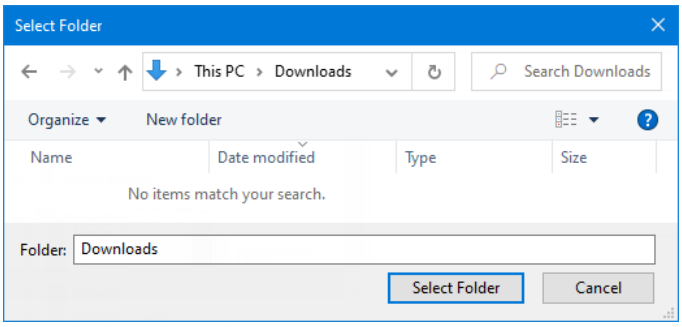
   Note: You can click **Clear** to remove the signature and re-sign.

Save / Print



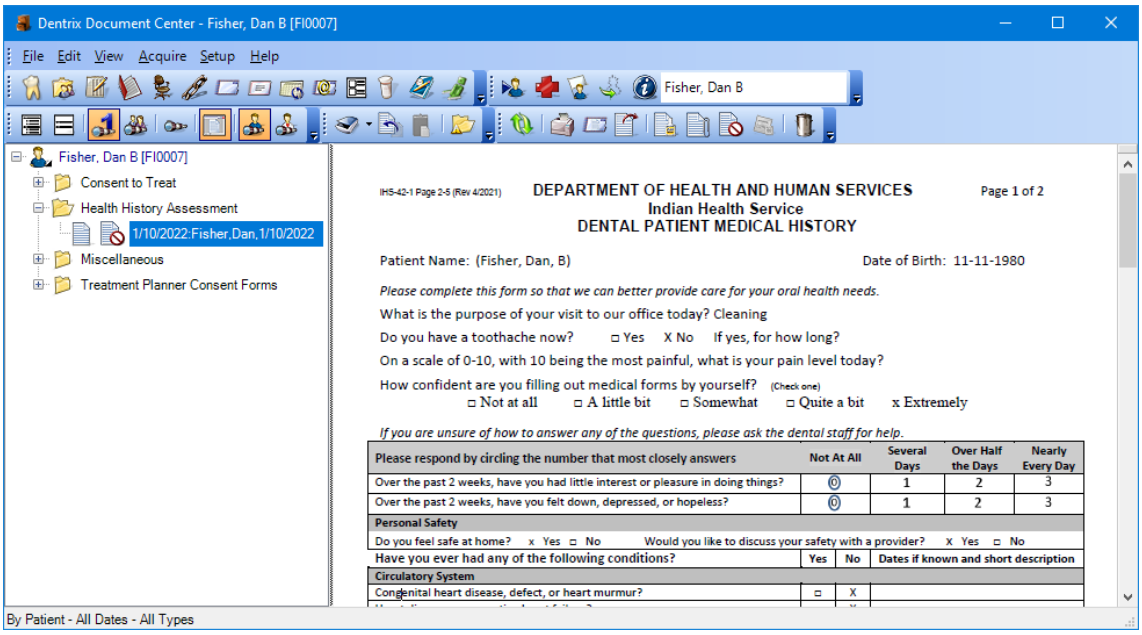
Complete the following steps:

1. Do any of the following:
   - To save a copy of the assessment as a .pdf file, click **Export PDF**, and then select the folder where you want to save it.



Note: The name of the file consists of the patient's last name, the patient's first name, and the date of the assessment (in a YYYY/MM/DD format).

- To attach a copy of the assessment as a .pdf file to the patient's Document Center record, click **Doc Center**.



Notes:

- The **Document Type Template** that is used for importing the document is the **Patient Health History**.
- The document's default **Document Type** is **Health History Assessment**.
- The document's default **Description** consists of the patient's last name, the patient's first name, and the date of the assessment (in a MM/DD/YYYY format).

2. Click **Finish & Save**.

Sending Email Messages

If you have email access, you can create and send email messages to patients quickly.

To send an email message to a patient

Do one of the following:

- In the Family File, with a patient selected, from the **File** menu, click **Send Message**.
- In the Appointment Book, with a patient's appointment selected, from the **File** menu, click **Send Message**.
- In the Document Center, with a patient selected, from the **File** menu, click **Send Document(s)**.
- In the Treatment Planner, with a patient selected, point to **Switch To**, and then click **Send Message**.

Your email program opens so that you can compose and send a message.

Note: The patient's email address, if one has been entered in the Family File, appears in the **To** box. However, if no email address has been added for the patient, you can enter an address in the **To** box.

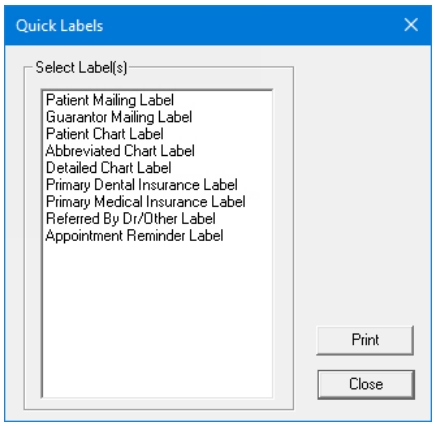
Quick Labels

With Quick Labels, you can take advantage of the integration of Dentrix Enterprise with Microsoft Word to quickly create a label for a single patient.

To print a quick label

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

   The **Quick Labels** dialog box appears.



2. Select the label you want to print:
   - **Patient Mailing Label** – A mailing label for the selected patient.
   - **Guarantor Mailing Label** – A mailing label for the selected patient's head-of-house.
   - **Patient Chart Label** – A chart label for the selected patient, including his or her name, chart number, home phone, work phone, and address.
   - **Abbreviated Chart Label** – A chart label for the selected patient, including his or her name (in large, bold letters), SS#, date of birth, first visit date, chart number, home phone, and work phone in a condensed format.
   - **Detailed Chart Label** – A chart label for the selected patient, including his or her name (in large, bold letters), SS#, date of birth, primary provider, chart number, first visit date, marital status, gender, address, home phone, work phone, employer, primary insurance, and secondary insurance.
   - **Primary Dental Insurance Label** – A mailing label addressed to the patient's primary dental insurance plan (if set up in the Family File).
   - **Secondary Dental Insurance Label** – A mailing label addressed to the patient's secondary dental insurance plan (if set up in the Family File).
   - **Primary Medical Insurance Label** – A mailing label addressed to the patient's primary medical insurance plan (if set up in the Family File).
   - **Secondary Medical Insurance Label** – A mailing label addressed to the patient's secondary medical insurance plan (if set up in the Family File).
   - **Referring Patient Label** – A mailing label addressed to the patient who referred the patient to the practice (if set up in the Family File).
   - **Referred By Dr/Other Label** – A mailing label addressed to the doctor who referred the patient to the practice (if set up in the Family File).
   - **Referred To Doctor Label** – A mailing label addressed to the doctor that the patient has been referred to (if set up in the Family File).

- **Appointment Reminder Label** – A reminder label listing the patient's next appointment date and time.

3. Click **Print** to print the selected label. For information about setting up a label printer for labels, see "Setting Up Default Printers" in Chapter 1: Introduction and Initial Setup.

Quick Letters

With Quick Letters, you can take advantage of the integration of Dentrix Enterprise with Microsoft Word to quickly create a letter for a single patient.

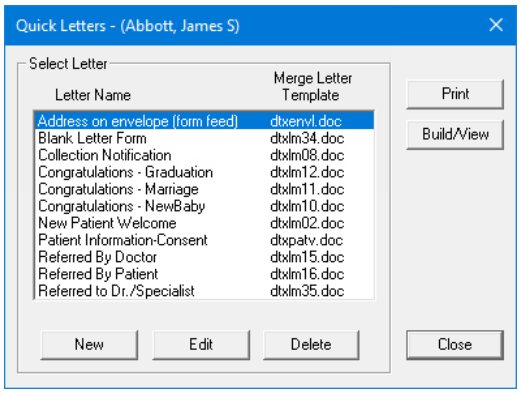
To merge a quick letter

1. Open and minimize Microsoft Word.



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

   The **Quick Letters** dialog box appears.



3. Select the letter you want to merge:
   - **Address On Envelope (Form Feed)** – An envelope for the selected patient.
   - **Blank Letter Form** –A blank letter for the selected patient with his or her name, address and greeting.
   - **Collection Notification** – A 90 Day Past Due letter for the selected patient.
   - **Congratulations – Graduation** – A congratulations letter for a new graduate.
   - **Congratulations – Marriage** – A congratulations letter for a newly married patient.
   - **Congratulations – New Baby** – A congratulations letter for a new parent.
   - **New Patient Welcome** – A welcome letter for a new patient.
   - **Patient Information – Consent** – A patient information form with some patient information pre-entered.
   - **Referred by Doctor** – A thank you letter for a doctor who referred the patient.
   - **Referred by Patient** – A thank you letter for a patient who referred the selected patient.
   - **Referred to Doctor** – A referral information letter for the doctor to whom the selected patient has been referred.

4. 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**.

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

Continuing Care

The Continuing Care module in Dentrix Enterprise is an up-to-date, flexible, and powerful means for monitoring your patients' pending dental care (recall or recare). The following is a short list of the advantages the continuing care system can bring to your office:

- **Multiple Recall Types** – You can create as many continuing care types as needed.
- **Continuing Care Cards** – You can efficiently create continuing care reminder cards for patients with and without appointments to maintain communication with your patients.
- **Individualized Continuing Care** – Each patient can have specific continuing care defaults, such as intervals and providers.
- **Simplicity of Scheduling** – Dentrix Enterprise helps you schedule continuing care for patients. By attaching the appropriate continuing care type to an appointment, the appointment automatically has the correct provider and amount of time needed.
- **Increased Tracking Ability** – You can use continuing care to track not only exams and cleanings but patient statuses or activities, such as treatment plans. For example, you enter a treatment plan and assign it a continuing care type, which has a call back date. If the patient has not completed the treatment plan when the call back interval has lapsed, he or she appears on the continuing care list so that you can follow up with that patient to get an appointment scheduled.

The continuing care system is quite powerful, but there are two keys to using it effectively:

- **Knowledge** – Because the continuing care system is so flexible, it will require you to learn how it works to make it work for you.
- **Time** – It will take time to set up the continuing care system. Take the time now to get the system in place, and the benefits down the road will be well worth the effort.

This section covers the following topics about the Continuing Care module:

- Getting Started with Continuing Care
- Opening Continuing Care
- Using the Continuing Care List
- Printing from Continuing Care

Getting Started with Continuing Care

Before you start using the Dentrix Enterprise continuing care system, you must do some setup to get your continuing care program up and running.

To get started with continuing care

1. Set up the continuing care type defaults.

   Take some time to sit down as an office and define what is to be tracked. Then, add or modify existing continuing care types to meet the needs of your practice. For details about continuing care types, see "Setting Up Continuing Care Types" in Chapter 1: Introduction and Initial Setup.

2. Assign continuing care types to procedures.

   Dentrix Enterprise can automatically assign continuing care types to patients when they have certain procedures completed. Additionally, Dentrix Enterprise will automatically update continuing care due dates when those procedures are completed. You will need to assign continuing care types to the procedures you want to use in this manner. For details about procedure codes, see "Editing Procedure Codes" in Chapter 1: Introduction and Initial Setup.

3. Customize your Continuing Care view.

   Your practice will have a specific way to organize or sort your list of continuing care patients. You can set up Continuing Care views to create many different ways of looking at the continuing care information. For details about Continuing Care views, see the "Managing Continuing Care views" topic in the Dentrix Enterprise Help.

4. Customize patient continuing care defaults.

   For the next few months, when a patient schedules a continuing care appointment, take a minute to set up his or her continuing care defaults in the Family File. Theoretically, within six months, you will have set the continuing care defaults for every active patient in your continuing care program. For details about assigning continuing care to patients, see "Assigning Continuing Care" in Chapter 2: Family File, and see the "Overriding continuing care defaults" topic in the Dentrix Enterprise Help.

5. Attach continuing care to appointments.

   From this point forward, when a patient schedules a continuing care appointment, make sure you attach the appropriate continuing care type to the appointment. For details about continuing care appointments, see "Scheduling Appointments" in Chapter 3: Appointment Book.

Opening Continuing Care

You can open the Continuing Care module from any main module.

Tip: To view the continuing care for all clinics, you must access the Continuing Care module from the Appointment Book.

To access Continuing Care

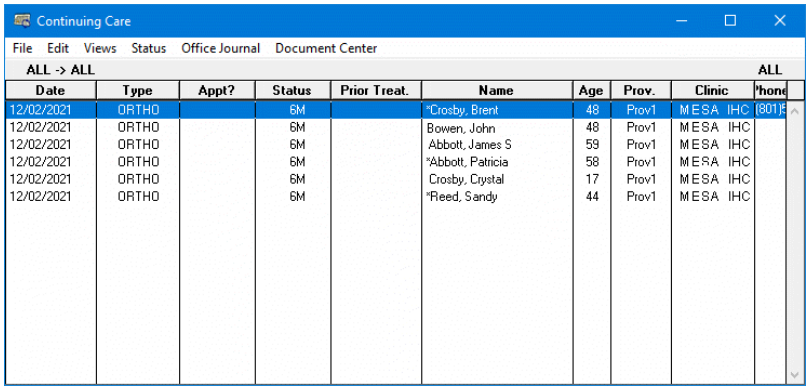
In any module, from the **File** menu, click the **Continuing Care** button  .

The **Continuing Care** window appears.

If you open Continuing Care from the Patient Chart, Ledger, or Family File, the list shows continuing care information for the selected patient and his or her family members. If Continuing Care is opened from the Appointment Book or Office Manager, the list shows continuing care information for the entire patient database.

Using the Continuing Care List

As you go down the Continuing Care list, using the phone numbers shown, you can call each patient to schedule an appointment or change the status of the patient's continuing care. For information about scheduling a continuing care appointment, see "Scheduling Appointments" in Chapter 3: Appointment Book.



Date	Type	Appt?	Status	Prior Treat.	Name	Age	Prov.	Clinic	Phone
12/02/2021	ORTHO		6M		*Crosby, Brent	48	Prov1	MESA IHC	(801)5
12/02/2021	ORTHO		6M		Bowen, John	48	Prov1	MESA IHC	
12/02/2021	ORTHO		6M		Abbott, James S	59	Prov1	MESA IHC	
12/02/2021	ORTHO		6M		*Abbott, Patricia	58	Prov1	MESA IHC	
12/02/2021	ORTHO		6M		Crosby, Crystal	17	Prov1	MESA IHC	
12/02/2021	ORTHO		6M		*Reed, Sandy	44	Prov1	MESA IHC	

Printing from Continuing Care

From Continuing Care, you can print the following:

- **Continuing Care List** – To print the Continuing Care list for the entire practice, from the **File** menu, click **Print**.
- **Continuing Care Labels** – To quickly print mailing labels, from the **File** menu, point to **Print Mailing Labels**, and then click the option that corresponds to the number of columns on your sheet of labels.

Tips:

- For instructions on how to create continuing care cards for patients who have already scheduled their continuing care visit, see "Creating Appointment Reminder Cards" in Chapter 8: Office Manager.
- For instructions on how to create continuing care cards for patients who have not yet scheduled their continuing care visit, see "Creating Cards for Patients Without Appointments" in Chapter 8: Office Manager.

Patient Questionnaire

Patient Questionnaire is designed to replace the new patient forms, health history update, and other forms used in your office to collect information from patients. With Patient Questionnaire, you can create a custom set of questions that can be printed for your patients to answer. Once the patient completes the questionnaire, the answers can be input into Dentrix Enterprise so that you have an electronic copy of the information.

For those offices moving toward the "paperless office," Patient Questionnaire is a way to computerize information that otherwise would be stored in a paper chart. Best of all, when the information needs to be reviewed for accuracy, a new copy with the previous answers can be generated; the patient only has to modify those items that have changed since the last visit.

This section covers the following topics about questionnaires:

- Setting Up Questionnaires
- Printing Questionnaires
- Entering Questionnaire Responses

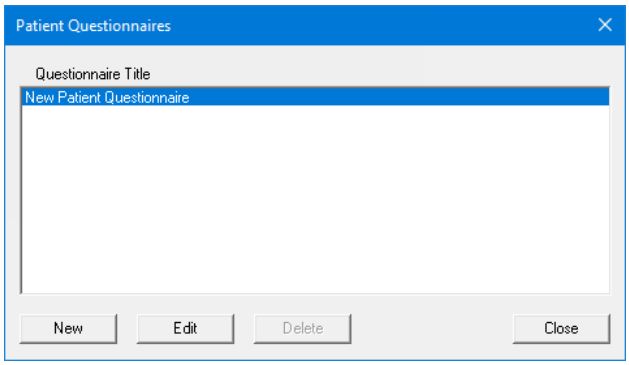
Setting Up Questionnaires

You can create and edit patient questionnaires to collect information from patients. Questions ask a patient to provide information. Statements provide a patient with information, such as instructions for completing a form.

To create or edit a questionnaire

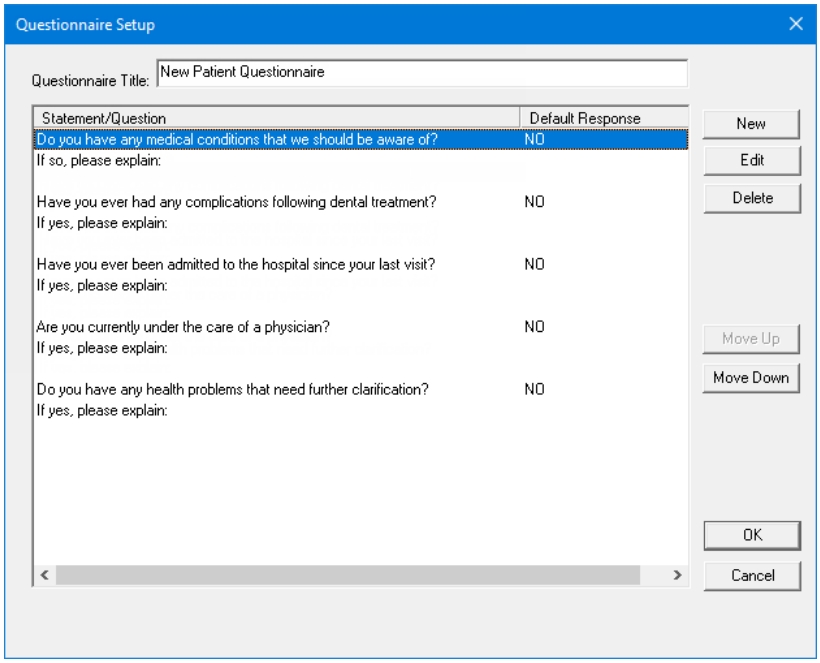
1. In Office Manager, from the **Maintenance** menu, point to **Practice Setup**, and then click **Patient Questionnaire Setup**.

   The **Patient Questionnaires** dialog box appears.



2. Click **New** to create a new questionnaire; or select an existing questionnaire, and then click **Edit** to edit that questionnaire.

   The **Questionnaire Setup** dialog box appears.



3. Enter or change the **Questionnaire Title**.
4. Do any of the following:
   - **Add** – To add a statement or question, Click **New**. In the **Statement/Question for Questionnaire** dialog box that appears, enter the text for a statement or question as you want it to appear on the patient questionnaire form, select the appropriate text type, and then click **OK**.
   - **Edit** – To edit a statement or question, select that statement or question, and then click **Edit**.

- **Delete** – To delete a statement or question, select that statement or question, and then click **Delete**. On the confirmation message that appears, click **Yes**.

  Warning: If you delete a statement/question on a questionnaire assigned to a patient, Dentrix Enterprise also deletes the patient's responses.

  Tips:

  - To change the type of statement or question (for example, from a "Note/Explanation" to a "Date"), delete the statement/question, and then re-enter it.
  - To arrange the order of statements and questions for your questionnaire, select an item, and then click **Move Up** or **Move Down** until the desired position is reached.

5. Click **OK** to save the questionnaire and return to the **Patient Questionnaires** dialog box.
6. Click **Close**.

Printing Questionnaires

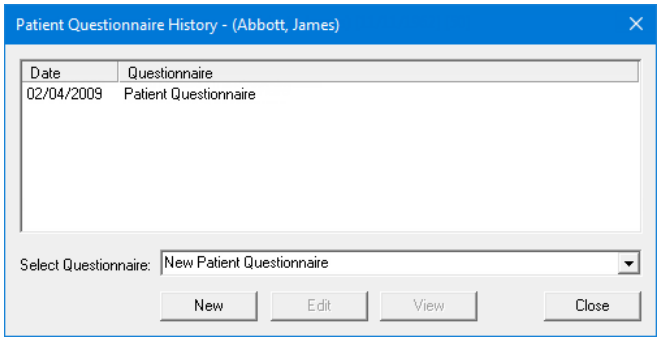
You can print a questionnaire when a patient arrives for an appointment. The printed questionnaire lists information that has been previously entered, including patient information, referral information, spouse or guarantor information, employment information, insurance information, and any answers that have been entered in the Patient Questionnaire module for a patient. The patient can then correct those entries that are inaccurate and add any information not currently known.

You can print a questionnaire from any module except the Office Manager. For a new patient with an appointment who does not yet have a Family File record, you must create a Family File record before you can print a questionnaire for him or her.

To print a questionnaire

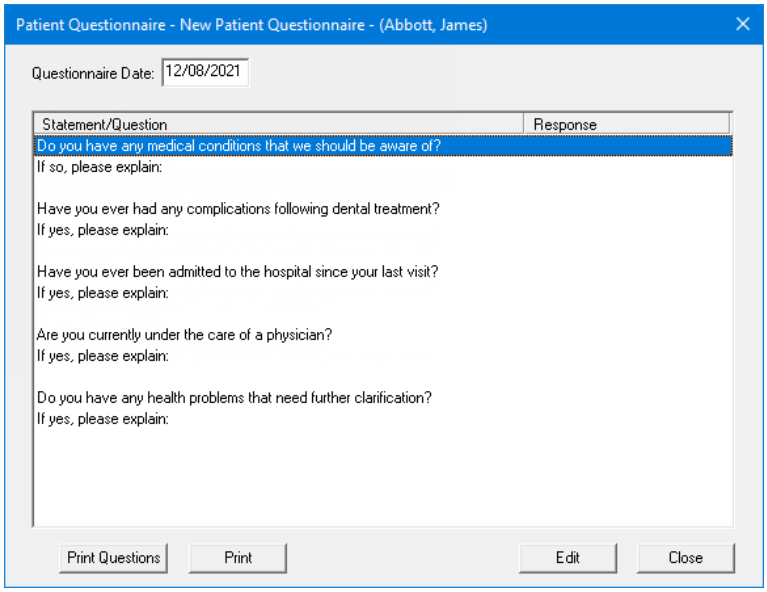
1. In Family File, Ledger, or Chart, with a patient selected (in Appointment Book, with a patient's appointment selected), click the **Patient Questionnaire** button  .

   The **Patient Questionnaire History** dialog box appears.



2. From the **Select Questionnaire** list, select the questionnaire you want to print for the patient.
3. Click **New**.

   The selected questionnaire opens.



4. Click a print button:
   - **Print** – To print the questionnaire. The questionnaire has two pages: the first page contains basic patient information, such as name, address, employer, insurance information, and referral sources; the second page contains your customized questions. Any information previously entered into Dentrix Enterprise prints on the form. The patient will fill in the blanks and make corrections as needed.
   - **Print Questions** – To print a summary of patient information and your customized questions.

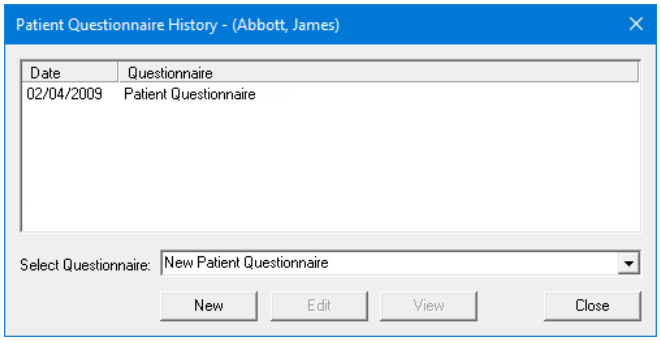
Entering Questionnaire Responses

Once a patient has completed a questionnaire, you can store the responses in Dentrix Enterprise.

To input questionnaire responses from a patient

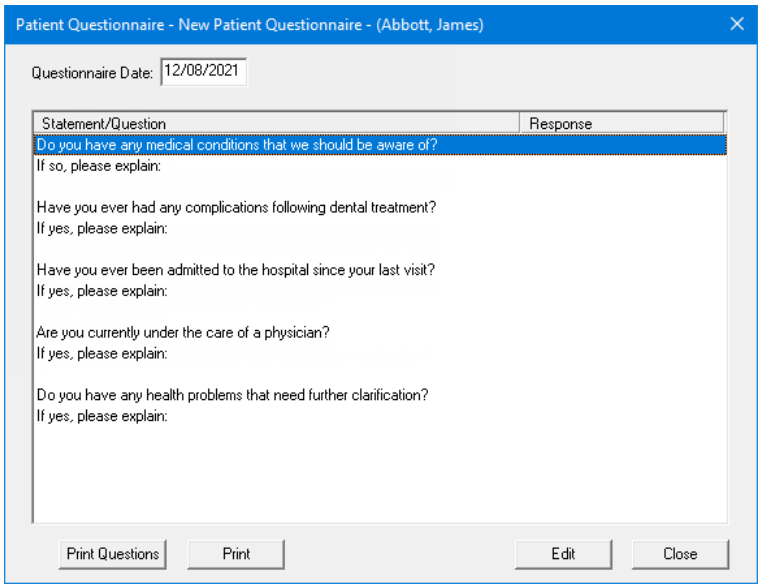
1. In Family File, Ledger, or Chart, with a patient selected (in Appointment Book, with a patient's appointment selected), click the **Patient Questionnaire** button  .

   The **Patient Questionnaire History** dialog box appears.



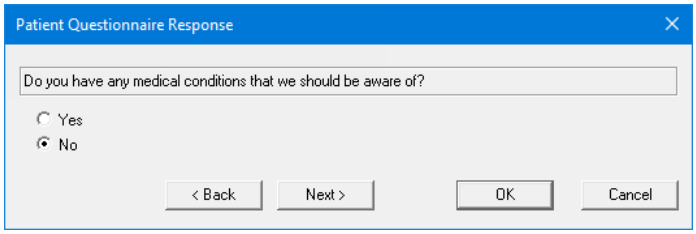
2. Do one of the following:
   - From the S**elect Questionnaire** list, select the questionnaire you want the patient to fill out, and then click **New** to add the questionnaire.
   - Select an existing questionnaire for the patient, and then click **Edit** to edit that questionnaire.

   The **Patient Questionnaire** dialog box appears.



3. Double-click the first question listed.

   The **Patient Questionnaire Response** dialog box appears.



4. Select or enter the appropriate patient response, and then click **Next** to advance to the next question. Repeat this until all questions are answered.
5. Click **OK** to save the patient responses and return to the **Patient Questionnaire** dialog box.
6. Click **Close** to close the **Patient Questionnaire** dialog box.
7. Click **Close** to close the **Patient Questionnaire History** dialog box.

Prescriptions

The Prescriptions module can help you quickly create and accurately track medicines prescribed to your patients. This section covers the following topics about using the Prescriptions module:

- Setting Up Prescription Types
- Setting Up Prescription Printer Defaults
- Entering Prescriptions
- Re-printing Prescriptions

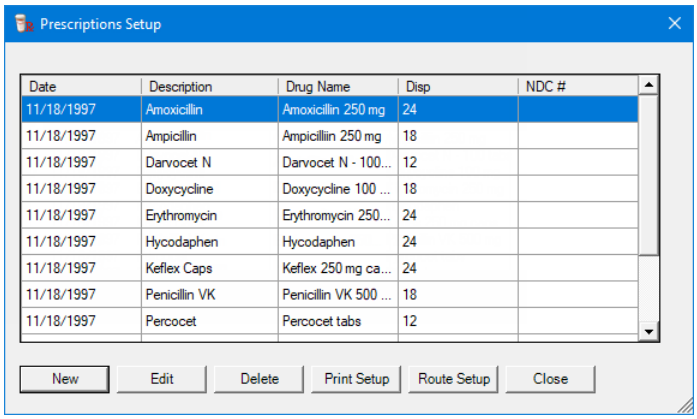
Setting Up Prescription Types

Prescription types are the default prescription settings. The act as templates to help you quickly enter prescriptions into Dentrix Enterprise. You can add and edit these defaults at any time.

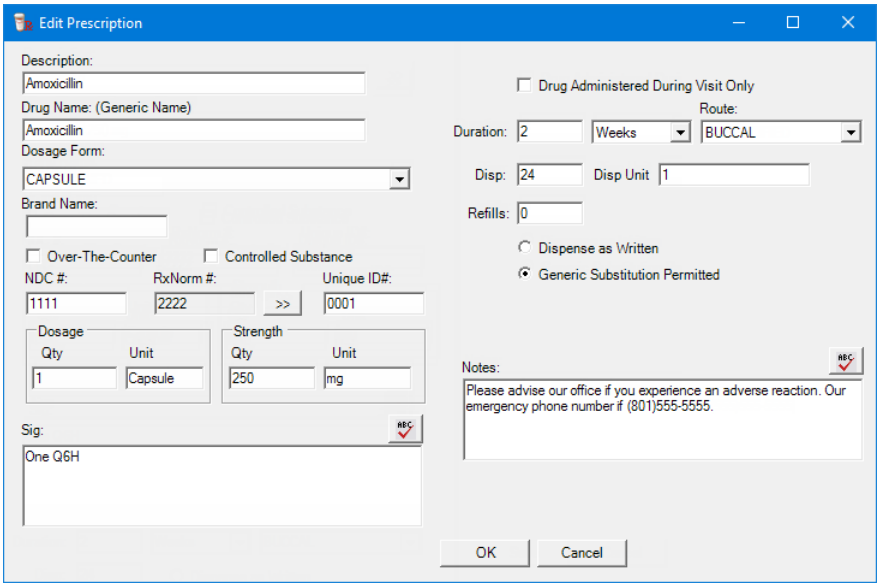
To add or edit a prescription type

1. In Office Manager, from the **Maintenance** menu, point to **Practice Setup**, and then click **Prescriptions Setup**.

   The **Prescriptions Setup** dialog box appears.



2. Do one of the following:
   - Click **New** to add a prescription. The **New Standard Prescription** dialog box appears.
   - Select an existing prescription, and then click **Edit** to edit that prescription. The **Edit Standard Prescription** dialog box appears.



3. Set up the following options:
   - **Description** – Enter a description for the prescription. This does not appear on the prescription.
   - **Drug Name** – Enter the drug information.
   - **Sig** – Enter the dosage interval and any instructions that you want to have print on the prescription.
   - **Disp** – Enter the number or amount of the medication to dispense.
   - **Refills** – If the prescription may be refilled, enter the number of refills allowed.
   - **Drug substitution**
     - **Dispense as Written** – Select this option if the pharmacy may only use the drug named on the prescription.
     - **Generic Substitution Permitted** – Select this option if the pharmacy may fill the prescription with a generic drug.
   - **Notes** – Enter any instructions regarding the prescribed medication for the patient. The notes will print below the prescription.
4. Click **OK**.

For a comprehensive explanation of all the available options for prescription types, see the "Adding and editing prescription types" topic in the Dentrix Enterprise Help.

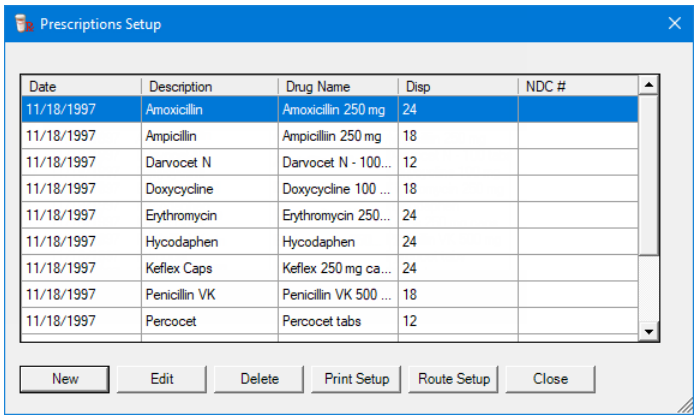
Setting Up Prescription Printer Defaults

You can customize the printer defaults for prescriptions printed from the Prescriptions module.

To set up a prescription printer

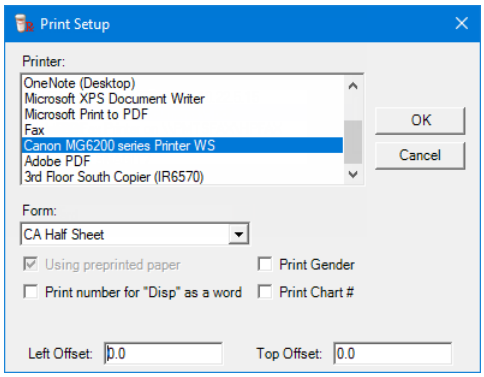
1. In Office Manager, from the **Maintenance** menu, point to **Practice Setup**, and then click **Prescription Setup**.

   The **Prescription Setup** dialog box appears.



2. Click **Print Setup**.

   The **Print Setup** dialog box appears.



3. Set up the following printer options:
   - **Printer** – Select the printer you want to use to print prescriptions.
   - **Form** – If your state requires a specific format for prescriptions, select the correct form.
   - **Using preprinted paper** – If you will be using preprinted paper when creating prescriptions, select this option.
   - **Print number for "Disp" as a word** – To list the number or amount of the medication to dispense as a word (for example, "four" instead of "4"), select this option.
   - **Print Gender** – To print a patient's gender, select this option.
   - **Print Chart #** – To print a patient's chart number, select this option.
   - **Disable Printing** – If you will be using the Prescriptions module to record prescription information but will not be printing prescriptions, select this option.
4. Click **OK** to save the changes and return to the **Prescriptions Setup** dialog box.

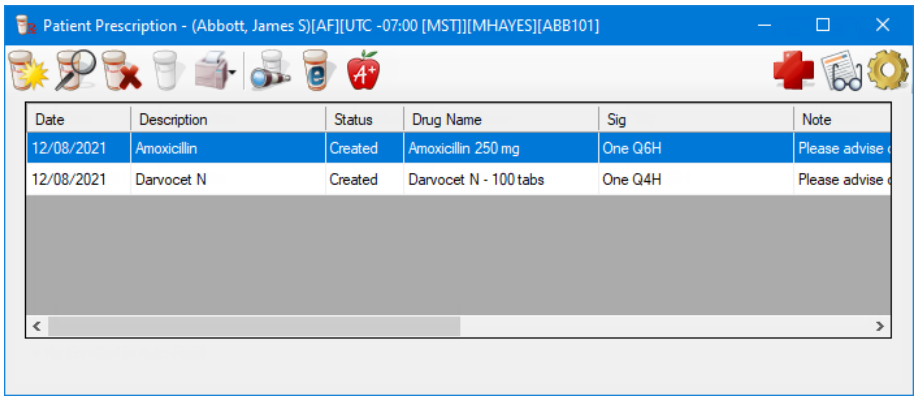
Entering Prescriptions

In Dentrix Enterprise, you can add a prescription you are prescribing to a patient.

To add a prescription

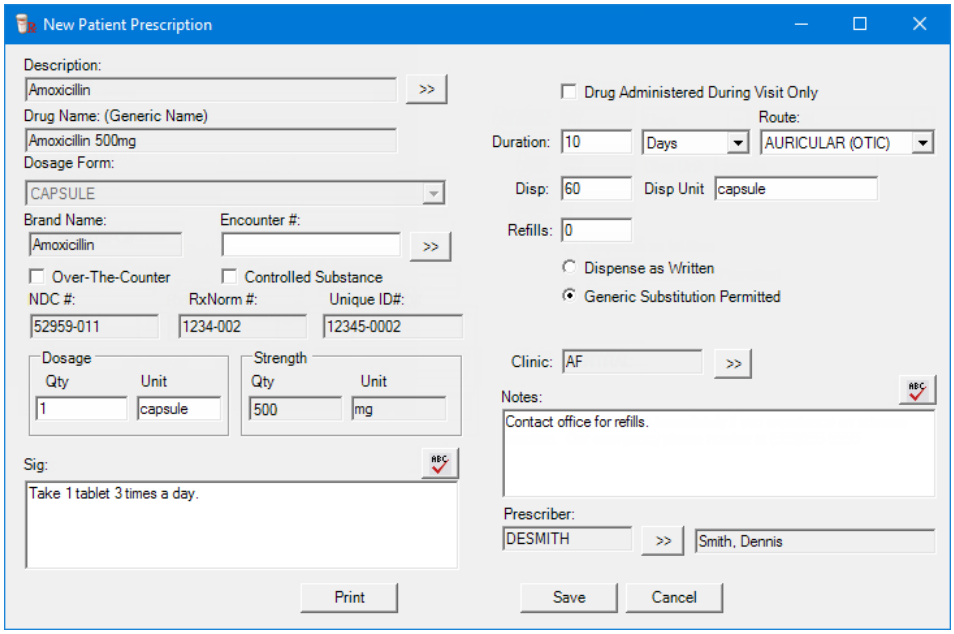
1. In Family File, Ledger, or Chart, with a patient selected (in Appointment Book, with a patient's appointment selected), from the **File** menu, click the **Prescriptions** button .

   The **Patient Prescription** dialog box appears.



2. Click the **New Prescription** button .

   The **New Patient Prescription** dialog box appears.



3. Click the **Description** search button >> to select a prescription type.
4. Customize the prescription information for the patient as needed:
   - **Dosage** – The amount of the drug that can be taken at one time (for example, 1 Capsule).
   - **Sig** – The dosage interval and instructions.
   - **Drug Administered During Visit Only** – The drug was administered to the patient during his or her visit.

- **Duration** – The number of days, weeks, or months from the issued date that this prescription is valid.
- **Disp and Disp Unit** – The amount of the drug to dispense and the unit it is dispensed as.
- **Refills** – The refill amount.
- **Drug substitution** – Must be dispensed as written, or a generic drug substitution is allowed.
- **Notes** – Instructions for the patient.

5. If necessary, click the **Prescriber** search button ›› to select the provider who is prescribing the drug.
6. Click **Print** to print the prescription.
7. Click **OK** to save the prescription.

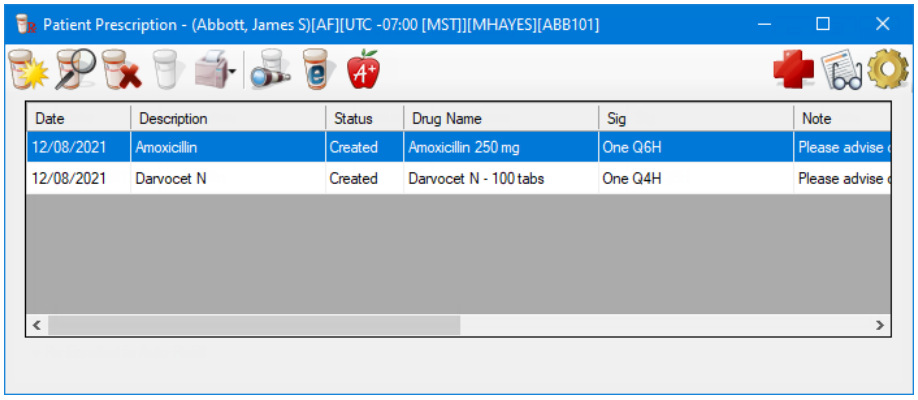
Re-printing Prescriptions

You can re-print any prescription that has been added to a patient's record.

To re-print a prescription

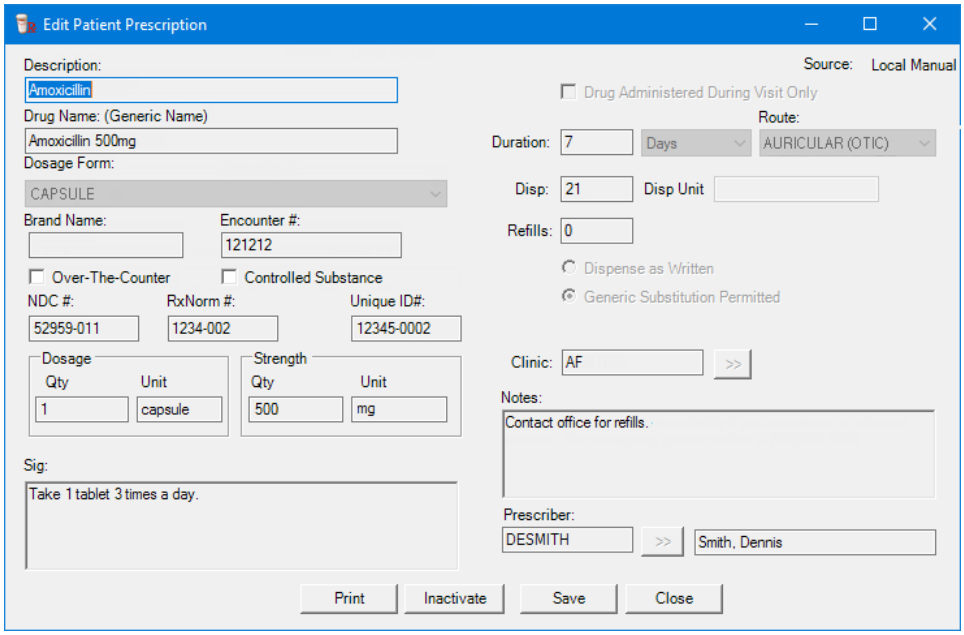
1. In Family File, Ledger, or Chart, with a patient selected (in Appointment Book, with a patient's appointment selected), from the **File** menu, click the **Prescriptions** button .

   The **Patient Prescription** dialog box appears.



2. Select the prescription that you want to re-print.
3. Click the **View Prescription** button .

   The **Edit Patient Prescription** dialog box appears.



4. Click **Print**.
5. Click **Close** to return to the **Patient Prescription** dialog box.

Patient Alerts

Patient alerts are customizable alerts that you can attach to patients (and families) when you want a message to appear for certain conditions. A patient alert appears for a patient when someone accesses the specified areas of Dentrix Enterprise. A patient alert attached to a family (a family alert) appears for a patient and any of that patient's family members (as set up in the Family File) when someone accesses the specified areas of Dentrix Enterprise.

If a patient alert has been set up to have a flag symbol appear on appointments, the symbol appears on appointments for that patient. For a family alert, the symbol appears on appointments for all family members. There is also the option to include a patient's aged balance in an alert for easy reference.

Patient alerts are also essential in respecting patient's requests for privacy and disclosure of information. You can manage patient alerts from any patient-specific module, including Family File, Chart, Ledger, and Appointment Book. This section covers the following topics about patient alerts:

- Creating Patient Alerts
- Suspending Patient Alerts
- Suspending Patient Alerts Temporarily

Creating Patient Alerts

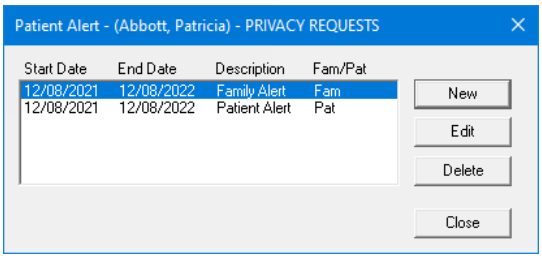
You can create up to 10 alerts for any patient.

To create a patient alert

1. In any patient-specific module (for example, the Family File), with a patient selected, click the **Patient Alerts** button  .

   One of the following occurs:

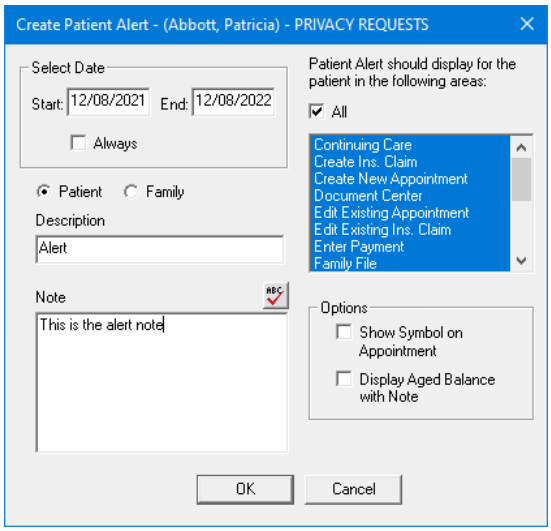
   - If any patient alerts exist for the patient, the **Patient Alert** dialog box appears. Proceed to step 2.



   - If the patient does not have any patient alerts, the **Create Patient Alerts** dialog box appears; skip to step 3.

2. Click **New**.

   The **Create Patient Alert** dialog box appears.



3. Set up the following options:
   - **Select Date** – In the **Start** and **End** boxes, enter the date range for which you want the patient alert to appear in the specified areas, or select **Always** to always display the patient alert when information about the patient is accessed and/or to always display an icon on the patient's appointments.
   - **Patient or Family** – **Patient** is selected by default. To make this alert appear for all family members, select **Family**.
   - **Description** – Enter a description for the patient alert (for example "Collections" or "Pre-Medicate").
   - **Patient Alert should display for the patient in the following areas** – In the list box, select all areas of Dentrix Enterprise in which you want the patient alert to appear, or select **All** to have the patient alert appear in all areas.
   - **Show Symbol on Appointment** – To have a flag symbol show in the upper-right corner of appointments for the patient, select this option.
   - **Display Aged Balance with Note** – To have the patient's account balance information show with the alert, select this option.
   - **Note** – Enter a detailed description of the alert.
4. Click **OK**.

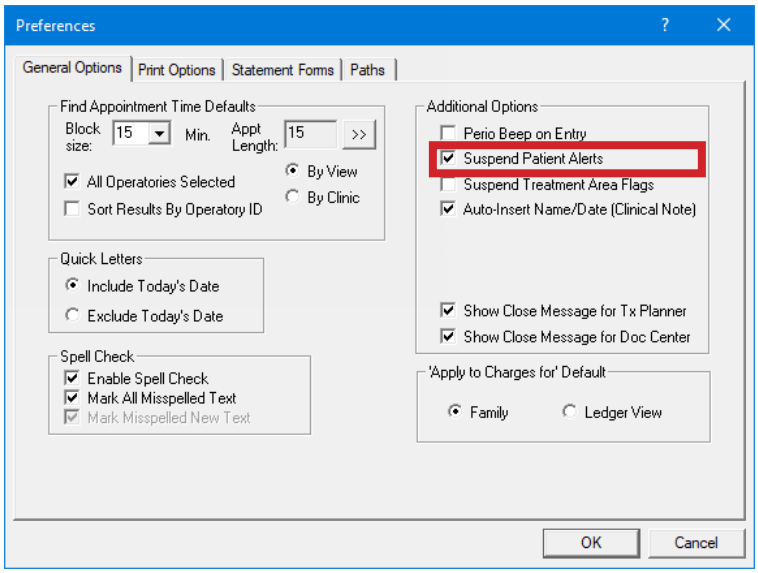
Suspending Patient Alerts

You can suspend all patient alerts on a specific computer. When this option is enabled, the workstation will ignore all patient alerts for all patients.

To suspend patient alerts on a computer

1. In Office Manager, from the **Maintenance** menu, point to **Practice Setup**, and then click **Preferences**.

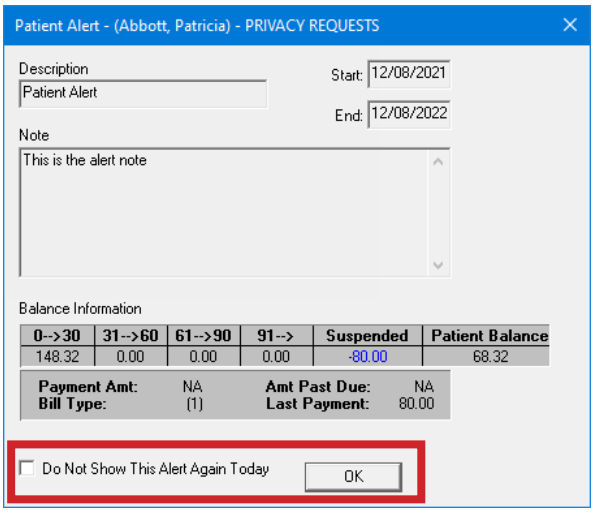
   The **Preferences** dialog box appears.



2. Under **Additional Options**, select **Suspend Patient Alerts** to disable patient alerts on this computer.
3. Click **OK**.

Suspending Patient Alerts Temporarily

When a patient alert appears for a patient, you can select the **Do Not Show This Alert Again Today** check box, and then click **OK**. That alert for that patient will not appear on any of the computers in the office for that day.



Office Journal

Like a journal of your daily activities, Office Journal has two main functions: to keep a record of past events and to remind you of events in the future. Office Journal helps you keep a comprehensive record of contact made between your office and your patients.

Also, Dentrix Enterprise automatically adds entries for appointments, billing statements, letters, payment agreement notes, payments, and privacy requests:

- **Appointments** – Office Journal will record the following appointments:
  - **Scheduled appointments** – The date, time, appointment provider, and appointment reason.
  - **Purged appointments** – The original date, time, reason, and provider for the purged appointment.
  - **Broken appointments** – The original appointment date, time, reason, and provider.
- **Billing statements** – Office Journal will record the date, "Please Pay" amount, and account balance of billing statements generated.
- **HIPAA privacy** – Office Journal will record when any privacy requests are made through Family File.
- **Letters** – Office Journal will record the date, provider, and the name of any letters generated for patients, using either Quick Letters or Letters from Office Manager.
- **Payment agreement notes** – Office Journal will record the date, provider, and notes of any payment agreements entered.
- **Payments** – Office Journal will record the date, provider, and amount of any insurance and patient payments. You can view guarantor transactions when viewing a guarantor or an entire family in Office Journal.

This section covers the following topics about using Office Journal:

- Opening Office Journal
- The Office Journal Window
- Adding Manual Journal Entries

Opening Office Journal

You can open Office Journal from any module, the ASAP List, the Unscheduled List, Continuing Care, and Collections Manager.

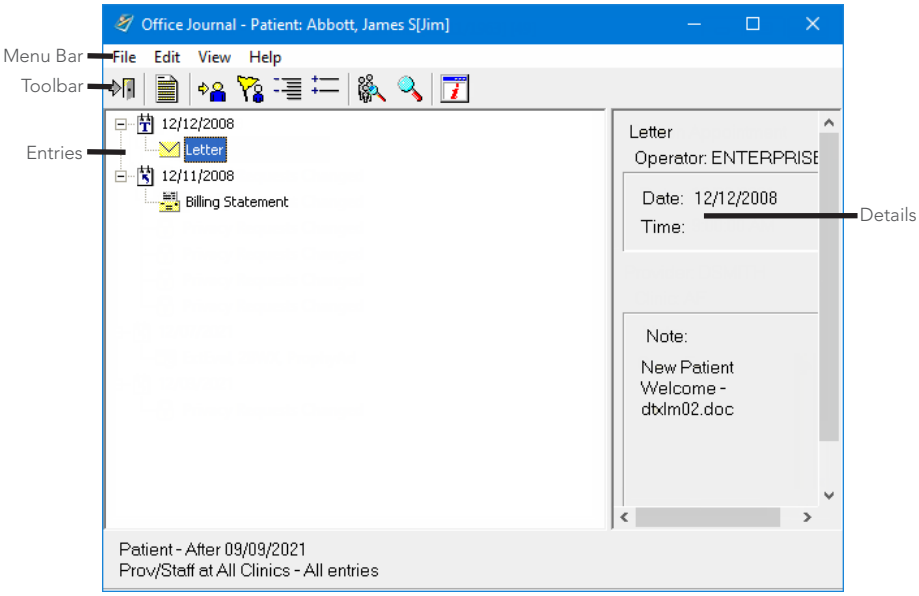
To open a patient's Office Journal

In any patient-specific module (for example, Ledger), with a patient selected, click the **Office Journal** button  .

Tip: From Office Manager, you cannot select a patient, but you can still open Office Journal. Click the **Office Journal** button  ; 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.

The Office Journal Window

The **Office Journal** window consists of a menu bar, toolbar, list of entries, and details pane.



This section covers the following topics to help you understand how to use the **Office Journal** window:

- The Office Journal Toolbar
- Changing the Office Journal View

The Office Journal Toolbar

Office Journal includes a toolbar with buttons to access features of this module.



Each button on the toolbar is explained in the following table.

	Click the **Close Office Journal** button to close the Office Journal module.
	Click the **Add Journal Entry** button to add an entry for the selected patient.
	Click the **Select** button to select a patient, provider, staff member, or referral.
	Click the **Patient Alerts** button to view and manage the selected patient's alerts or add new alerts.
	Click the **Expand** button to expand the list of entry dates to see more information.
	Click the **Collapse** button to collapse the list of entries to see only the entry dates.
	Click the **Journal** button to switch between viewing entries by patient and family.
	Click the **Info** button to show or hide the additional details for the selected entry.

Changing the Office Journal View

You can specify whether you want to view journal entries by patient or family, provider or staff, and by referral. You can also filter the list of entries that appear in Office Journal according to criteria you specify.

To change the view

- **Patient or Family** – If you are not viewing Office Journal by a patient name, to view entries for a certain patient, from the **View** menu, click **By Patient**, and then select a patient. To view entries for an entire account, while viewing a patient's entries, from the **View** menu, click **Family**.

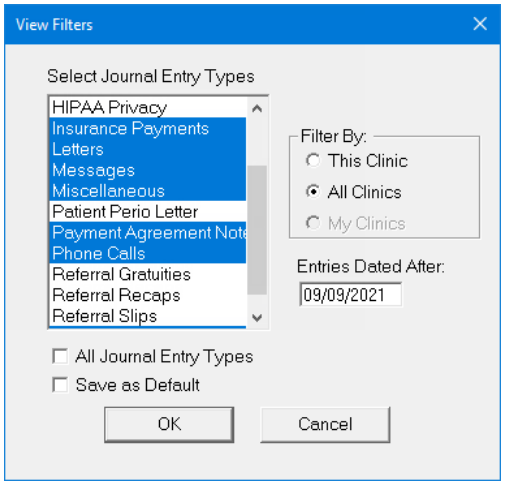
  Note: When viewing a family member who is not the guarantor, Office Journal does not display entries for billing statements and guarantor payments. These items appear only when viewing the family's guarantor.

- **Provider/Staff** – If you are not viewing Office Journal by a provider or staff member, to view entries for a certain provider or staff member, from the **View** menu, click **By Provider/Staff**, and then select a provider or staff member.
- **Referred BY or Referred TO** – If you are not viewing Office Journal by a referral, from the **View** menu, to view entries for a certain referral, click **By Referral By** or **By Referred To**, and then select a referral.

To customize the view

1. In Office Journal, from the **View** menu, click **Filters**.

   A dialog box of filters appears (the name depends on the current view).



2. Set up the filter options for the current view:
   - **Patient or Family**
     - **Select Journal Entry Types** – Select the entry types you want to view, or select **All Journal Entry Types** to include all types.
     - **Filter By** – Select **This Clinic** to view entries from the current clinic or **All Clinics** to include all clinics.
     - **Entries Dated After** – To view only items after a certain date, enter a cut-off date.
   - **Provider/Staff**
     - **Select Journal Entry Types** – Select the entry types you want to view. For Phone Calls, Reminders, Miscellaneous, and HIPAA Privacy, select the accompanying **Include Patient Entries** check box to include all patient entries for any of the selected types too.
     - **Entries Dated After** – To view only items after a certain date, enter a cut-off date.

- **Referral BY or Referred TO**
  - **Select Journal Entry Types** – Select the entry types you want to view, or select **All Journal Entry Types** to include all types.
  - **Select Provider/Staff** – Select the providers and/or staff you want to view, or select **For All Prov/Staff** to include all providers and staff.
  - **Entries Dated After** – To view only items after a certain date, enter a cut-off date.

3. Select **Save as Default** to save the current settings for the next time you open Office Journal.
4. Click **OK** to return to Office Journal with the selected view settings.

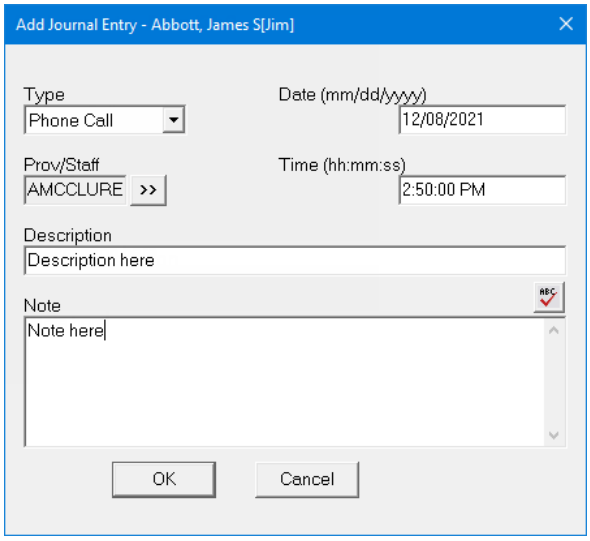
Adding Manual Journal Entries

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 Office Journal, click the **Add Journal Entry** button  .

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



2. Set up the following options:
   - **Type** – Select a type:
     - **Phone Call** – Use when making a phone call to a patient. Record information regarding the conversation.
     - **Reminder** – Use with a future date as a reminder about a contact with a patient.
     - **Miscellaneous** – Use for any other contact with the patient for which you want to keep a record.
     - **HIPAA Privacy** – Use to track patient information disclosure history and other privacy related notes for patients, providers, staff, and referrals.
   - **Prov/Staff** – Click the search button  to select a provider or staff member to assign to the journal entry.
   - **Description** – Enter a short description for the journal entry.
   - **Note** – Enter a longer description of the journal entry.

- **Date** – If needed, change the date of the journal entry.
- **Time** – If needed, change the time of the journal entry.

3. Click **OK** to save the entry.

Notes:

- Automatic entries (for appointments, billing statements, and so forth) cannot be edited, but you can edit manual journal entries.
- Payment, appointment, and payment agreement note entries cannot be deleted from Office Journal, but you can delete manual journal entries.

Collections Manager

With the Collections Manager module you can increase your practice's revenue by decreasing your account receivables. The Collections Manager displays a list of overdue accounts that need to be contacted, based on aged balances, payment dates, and other information you select. From this list, you have access to all the relevant information for an account to make decisions about collections.

Also, with Collections Manager, you can merge a letter, dial a phone number, and send an email message. Once the patient is contacted, you can make notes regarding the contact, set up a payment agreement, or change a billing type. Pulling all of this information and functionality into one window can make the collections process smoother, more efficient, and more productive.

This section covers the following topics about using Collections Manager:

- Opening Collections Manager
- Setting Up a View
- The Collections Manager Window
- Contacting Patients
- Removing Accounts from the List
- Adding Office Journal Entries
- Adding Guarantor Notes
- Setting Up Payment Plans
- Printing from Collections Manager

Opening Collections Manager

You can open Collections Manager from the Office Manager.

To open Collections Manager

In Office Manager, click the **Collections Manager** button  .

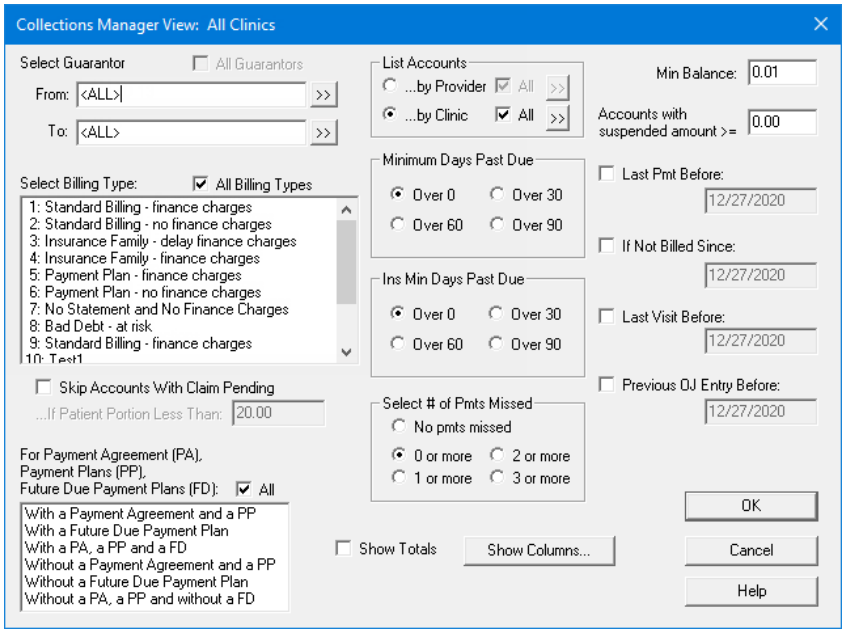
If a view has never been set up for Collections Manager, the **Collections Manager View** dialog box appears so that you can set up a view for Collections Manager before you can use the module; otherwise, the **Collections Manager** window appears and loads the view according to the filters set up previously.

Setting Up a View

The first time you try to use Collections Manager, you must first set up a view. Setting up a view allows you to filter out certain accounts so that only the accounts you want to contact appear. Once you have selected your view options, you can choose what account information you want to have appear in the list.

To set up a view

1. Do one of the following:
   - In Office Manager, click the **Collections Manager** button  . If a view has never been set up for Collections Manager, the **Collections Manager View** dialog box appears.
   - In Collections Manager, click **View Setup** on the menu bar. The **Collections Manager View** dialog box appears.



2. Set up the following filters:
   - **Select Guarantor** – Click the **From** and **To** search buttons >> to select a range of guarantors to include, or select **All Guarantors** to view all guarantors that meet the search criteria.

     Tip: If you have a very large patient base and want to limit the length of the list for ease of use, you can use A–J names one week, K–S names the next week, and so on.

   - **Select Billing Type** – Select up to 10 billing types for accounts you want to include (to select multiple items, while pressing the Ctrl key on your keyboard, click each item), or select **All Billing Types** to include accounts with any billing type.

     Tip: If you want the view to include more than 10 billing types, view the list by all billing types or in groups of 10.

   - **Skip Accounts With Claim Pending** – If your office waits for insurance to pay before collecting from an account, select this option. Dentrix Enterprise will exclude accounts that have insurance claims outstanding as long as the guarantor portion of the balance is less than the specified amount in the **If Patient Portion Less Than** box.

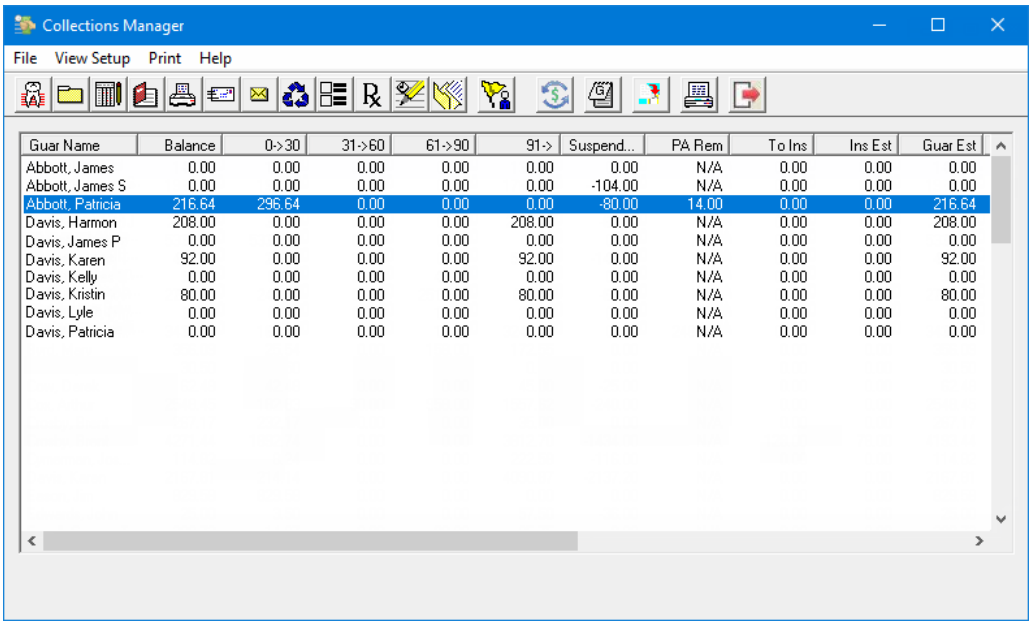
- **For Payment Agreement (PA) & Future Due Payment Plans (FD)** – Select **All** to include all accounts regardless of whether or not a payment agreement or future due payment plan has been set up for an account, or select one of the options in the list box to limit the view to only certain types of accounts. An account will be included if it matches at least one of the selected criteria.
- **List Accounts**
  - **By Provider** – Click the search button ›› to select the primary providers of the guarantors you want to include, or select **All** to include all providers.
  - **By Clinic** – Click the search button ›› to select the clinics of the accounts you want to include, or select **All** to include all clinics.
- **Minimum Days Past Due** – Select a minimum number of days past due to include only accounts with the specified minimum aged balance or older.
- **Ins Min Days Past Due** – Select a minimum number of days past due to include only accounts with outstanding insurance claims that have the specified minimum aged balance or older.
- **# of Pmts Missed** – Select a number of payments missed to include accounts that have missed a certain number of payments toward a payment agreement.

  Tip: If you do not want to use this filter, select **0 or more**.
- **Show Totals** – To display the total amounts for all the guarantors included, select this check box.
- **Min Balance** – Enter an amount to exclude accounts with a balance less than that amount, or enter 0.00 to include accounts with any balance.
- **Accounts with Suspended Amount** – Enter an amount to include accounts with a suspended amount equal to or greater than that amount, or enter 0.00 to include accounts with any suspended amount.
- **Last Pmt Before** –To exclude guarantors who are making regular payments toward their account balances, select this check box, and then enter the latest date a payment must have been posted. For example, if you allow guarantors 30 days to make a payment, enter a date that is one month prior to today's date.
- **If Not Billed Since** – To exclude accounts that have recently received a billing statement, select this check box, and then enter the latest date an account a billing statement must have been sent. For example, if you want to include accounts that have received a billing statement over two weeks ago, enter a date that is two weeks prior to today's date.
- **Last Visit Before** – To exclude accounts with patients who have been seen recently, select this check box, and then enter the latest date a family member must have been seen.
- **Previous Office Journal Entry Before** – To exclude accounts based on the last manual entry in the Office Journal, select this check box, and then enter the latest date a guarantor must have had a manual Office Journal entry entered.
- **Show Columns** – To specify what information you want to display, click **Show Columns**. There will be a column for each item you choose to show.

3. Click **OK** to open Collections Manager with the selected view options.

The Collections Manager Window

The **Collections Manager** window consists of a menu bar, a toolbar, and the list of guarantors that meet the view criteria you specify.



This section covers the following topics to help you understand how to use the **Collections Manager** window:

- The Collections Manager Toolbar
- Adjusting Column Widths
- Sorting the List

The Collections Manager Toolbar

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



The function of the buttons specific to Collections Manager are explained in the following table.

	Click the **Send Message** button to compose and send an email to the selected patient.
	Click the **Office Journal** button to record any communications with the selected guarantor.
	Click the **Document Center** button to attach a document, picture, or letters to the selected guarantor's record.
	Click the **Patient Alerts** button to enter an alert for the selected guarantor.
	Click the **Patient Finances** button to add payment plans or change the selected account's billing type.
	Click the **Guarantor Notes** button to enter notes for the selected account.
	Click the **Print** button to print the list of accounts being viewed. You have the option to include account notes on the printed list.

Adjusting Column Widths

To make viewing and editing the Collections Manager list easier, you can adjust the width of each individual column.

To adjust the size of a column

Click the right column border of the column header you want to resize, and then drag it to the left to decrease the size of the column or to the right to increase the size of the column.



Sorting the List

To sort the list by any of the columns being displayed, click the desired column header.

Contacting Patients

Once you have generated a list of accounts that need to be contacted, Collections Manager provides ways for you to quickly contact each patient. This section covers the following topics about contacting patients:

- Sending Collection Letters
- Sending Collection Email Messages

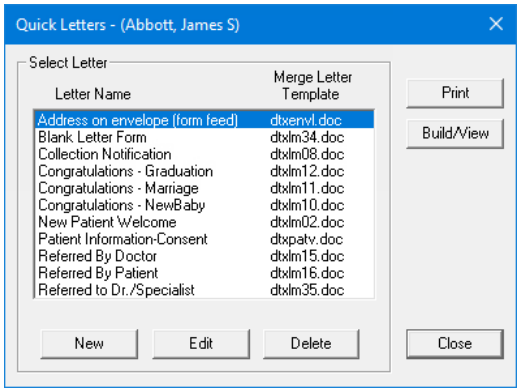
Sending Collection Letters

From Collections Manager, you can quickly create a collection letter using any of your pre-written letter templates.

To create a collection letter for a guarantor

1. With a guarantor selected in Collections Manager, click the **Quick Letters** button  .

   The **Quick Letters** dialog box appears.



2. Select the letter you want to merge.
3. Click **Build/View** to merge the letter in Microsoft Word. For more information about Quick Letters, see "Quick Letters" in this chapter.

Sending Collection Email Messages

From Collections Manager, you can quickly contact your patients through email.

To send an email message

With a guarantor selected in Collections Manager, from the **File** menu, click **Send Message** to compose an send an email message. For more information about this email feature, see "Sending Email Messages" in this chapter

Removing Accounts from the List

You can temporarily remove an account from the Collections Manager list. If no information has changed when the list is generated again, the account will reappear on the list.

To remove a guarantor from the list

With a guarantor selected in Collections Manager, right-click that guarantor, and then click **Hide Account**. The selected account is removed from the list for the current viewing session.

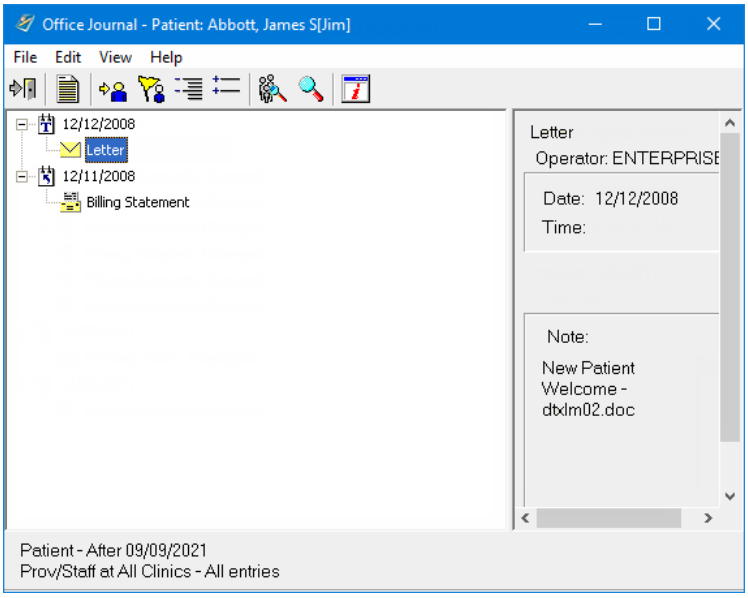
Adding Office Journal Entries

After you have attempted to contact or have successfully contacted a patient, you can enter notes regarding the attempted or successful contact as an Office Journal entry.

To add an Office Journal entry

1. With a guarantor selected in Collections Manager, click the **Office Journal** button  .

   The Office Journal opens.



2. Add a journal entry as explained in "Adding Manual Journal Entries" in this chapter.
3. Close Office Journal to return to Collections Manager.

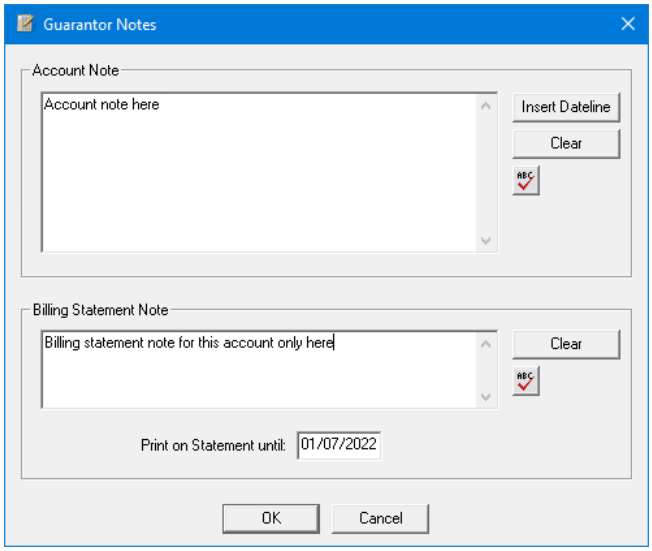
Adding Guarantor Notes

After you have contacted a guarantor, you can add notes regarding the account from the Collections Manager.

To add an account and/or billing statement note

1. With a guarantor selected in Collections Manager, click the **Guarantor Note** button  .

   The **Guarantor Notes** dialog box appears.



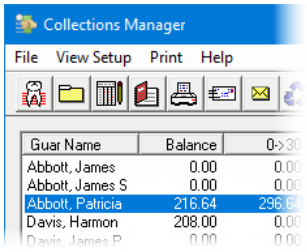
2. Enter an account note and/or billing statement note. For information about guarantor notes, see "Working with Notes in the Ledger" in Chapter 7: Ledger.
3. Click **OK**.

Setting Up Payment Plans

From the Collections Manager, you can set up a payment plan for a patient you have contacted.

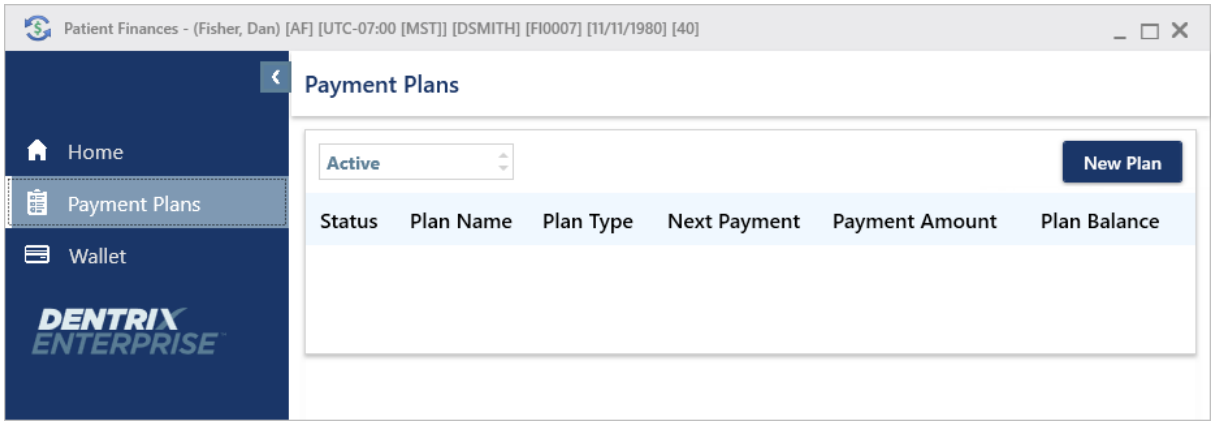
To set up a payment plan

1. In Collections Manager, double-click a guarantor.



2. If a payment plan does not already exists for the individual or family, on the message that appears and asks if you want to create a payment plan, click **Yes**.

   The **Patient Finances** window opens.



3. Select the **Payment Plans** tab.
4. To create a payment plan, click **New Plan**. For information about payment plans, see "Creating Payment Plans" in Chapter 7: Ledger.

Printing from Collections Manager

From Collections Manager, you can print the following:

- Collections Manager List
- Mailing Labels

For instructions on how to export the Collections Manager list to a spreadsheet program, such as Microsoft Excel, see the "Analyzing collections information" topic in the Dentrix Enterprise Help.

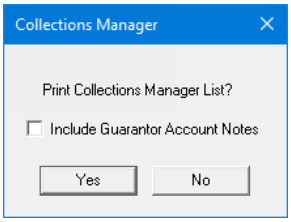
Collections Manager List

You can print all the accounts and the information for each, including guarantor notes, being viewed in Collections Manager.

To print the Collections Manager List

1. In Collection Manager, click the **Print** button  .

   A dialog box appears.



2. If you want to include Guarantor Notes for each account on the list, select **Include Guarantor Account Notes**.
3. Click **Yes**. The list prints from the default printer for Office Manager.

Mailing Labels

You can print mailing labels for all guarantors being viewed in the Collections Manager.

To print mailing labels

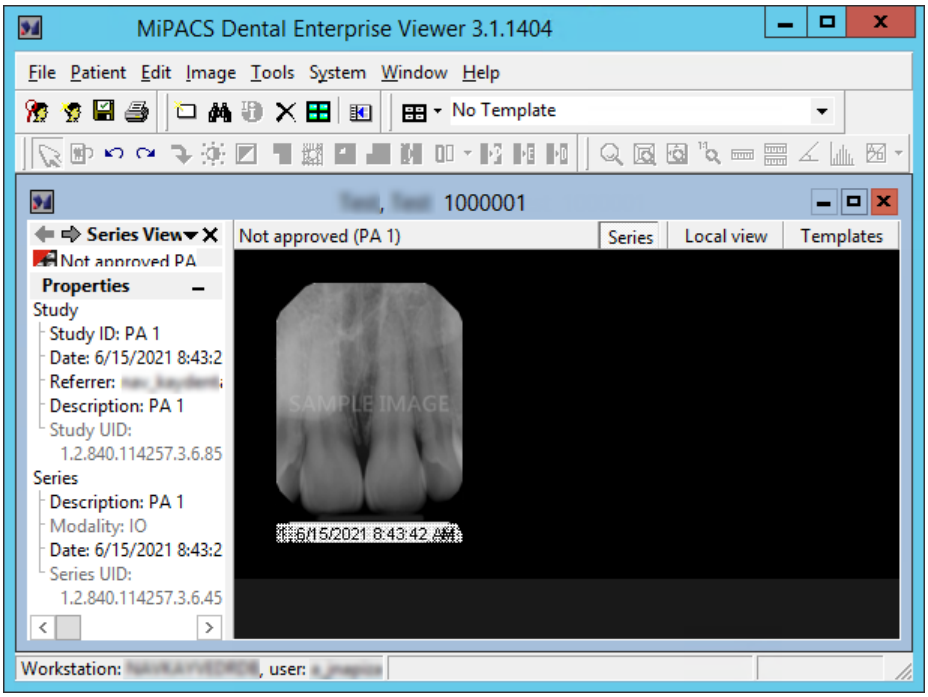
In Collections Manager, from the **Print** menu, point to **Mailing Labels**, and then click the option that corresponds to the correct number of columns to print on the sheet of labels you are using. On the confirmation message that appears, click **Yes**. The labels print from the default printer for Office Manager.

Exporting Images from MiPACS

To attach digital X-ray images that were acquired using MiPACS to insurance claims, you must first export those images from MiPACS and then import them into the Document Center.

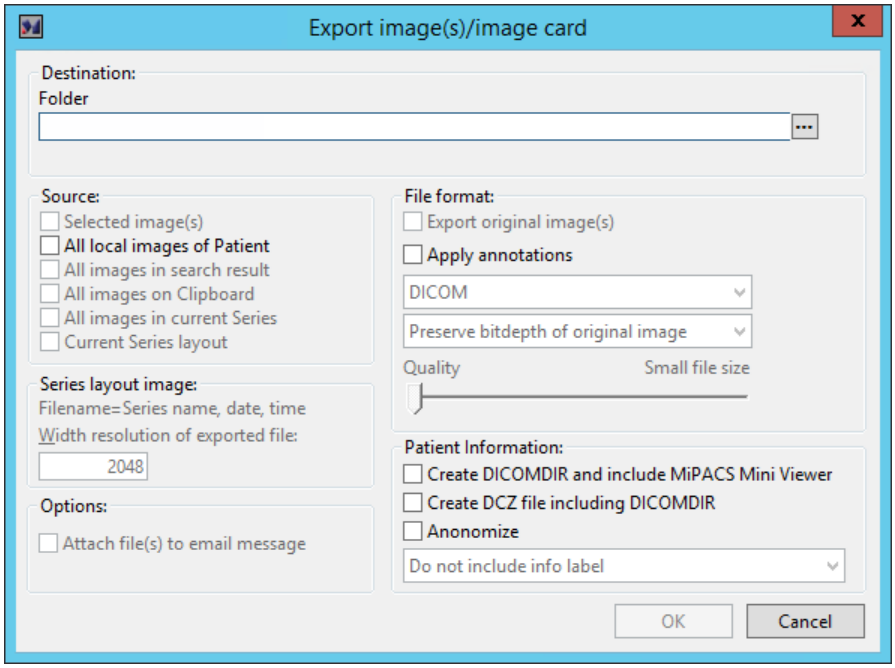
To export an image from MiPACS

1. In the **MiPACS Dental Enterprise Viewer** window, locate and select an image.



2. With the image selected, from the **Image** menu, click **Export Image**.

   The **Export Image(s)/image card** dialog box appears.



3. In the **Folder** box, enter the destination folder on the correct EDR server where you want to save a copy of the image: **\\[EDR server name]\Doc_Center\MiPACS Export\[patient Name_ description_date]**.

   Note: Replace **[EDR server name]** with a server name. Replace **[patient Name_ description_date]** with a folder name, such as JohnDoe_PA8_080821.

4. Set up the other options as needed, and then click **OK**.
5. Now, you can import the exported image into the patient's Document Center. For information on how to do this, see "Importing MiPACS Images" on page 693 in the Document Center chapter.

Note: After you import the image into the patient's Document Center, you will delete the image that you exported from MiPACS.

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