SHIRE DENTAL SYSTEM

USER MANUAL

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CONTENTS

DENTAL SYSTEM LOGIN

1)Username: Type in your username

2) Password: Type in your password, if applicable. Passwords are case sensitive.

3) Click OK.

The default username of **ADMIN** with no password will be available for selection when your server is first installed to enable you to set up your own usernames (see below for username configuration).
This name then appears in the user box at the top of the desktop.

CHANGING USERS

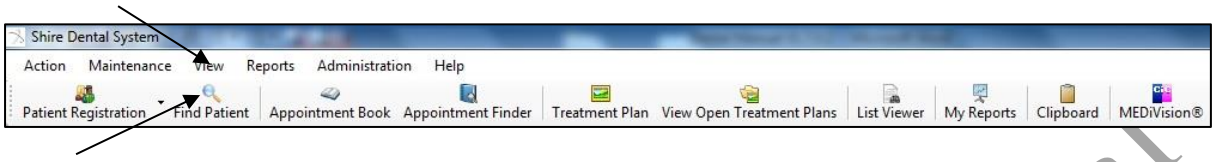
Once a user has logged onto the dental system at least once with their own username, they will have the ability to change users by clicking the down arrow alongside the current username and changing this to their own username.

Passwords

If the user has a password, this must be entered before they will be able to continue, otherwise all options will remain inactive. If the user has no password, then just changing the user in the drop-down box will suffice.

DATA ENTRY AND NAVIGATION

A menu contains a list of commands that you can choose to specify what you want to do. Each entry in a menu is called an option. Menus are displayed at the top of the dental system desktop on the **Menu Bar**.



A **Toolbar** contains buttons with images (icons) which link to common menu options. You can choose these options either from the menus or by clicking the icons. The toolbar can be edited by the user, ie you can remove from display any icons that you are not intending to use. The option to customize the toolbar can be found on the **Tools** menu.

- Toolbar options can be selected by a single click of the left mouse button.
- Menu options can be selected either by using a single click of the left mouse button or by using the keyboard. If one of the letters in a menu is underscored – this is called a hot key – you can hold down the **Alt** key and press the menu hot key to select (open) that menu. Use the arrow keys to highlight the required option and press the **Enter** key. Once a menu is open, you can use the left and right arrow keys to move between the different menus.

DENTAL SYSTEM DESKTOP

From the desktop you can:-

Create new patient(s)

Search for existing patients

Appointment Book - to manually book appointments

Appointment Finder - Access an appointment finder that will allow you to look for the first available appointment for a patient.

YOU CAN ALSO DIRECTLY ACCESS:

Charting - where you can chart historic/pending treatment.

View Open Treatment Plans – click this to display open courses of treatment.

The List Viewer – reminder or to do lists can be configured to suit your requirements and you are able to add relevant patients to these lists.

Clipboard – as you access patient records, those patients details are automatically stored in the clipboard. The clipboard can be viewed by clicking the Clipboard icon on the toolbar and you will be able to navigate from the clipboard to different parts of the system.

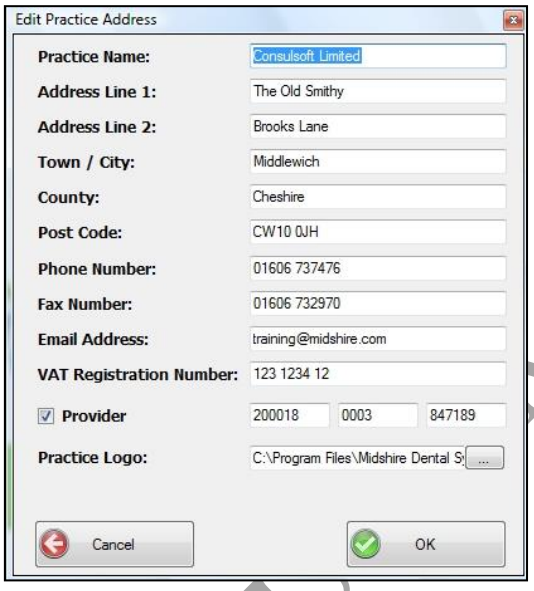
Medivision – This option is only applicable if Medivision has been installed on your server. If it has been installed, this is a link into the programme.

These options can be accessed by single-clicking the relevant icon on the toolbar or selecting the option from the **Action** menu.

PRACTICE DETAILS

Your practice details should be entered as follows:-

1) Select **Practice Details** from the **Administration** menu and complete all relevant fields.



2) If your practice is a dental provider, click the **Provider** box and enter the practice contract number. Otherwise leave this box unticked.

3) When all relevant details have been entered, click **OK**.

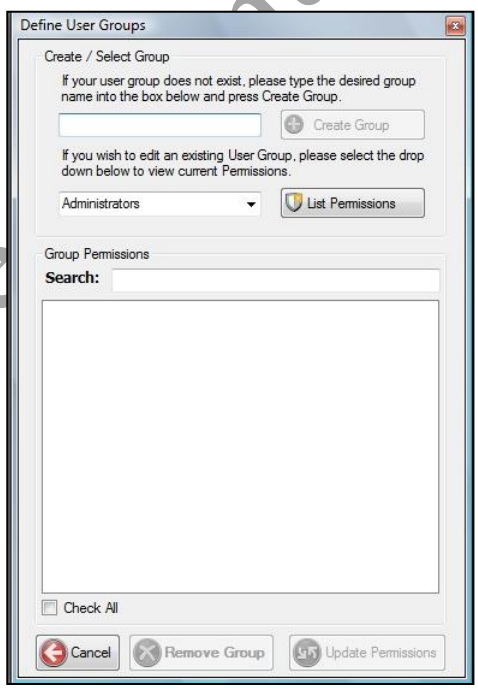
USERNAMES AND PERMISSIONS

Options in the Dental System have permissions associated with them. User Groups can be set up and an individual user is made a member of a group. Permissions can be selected or deselected for each group of users.

Each user of the system should have their own username – passwords are optional but each user must be a member of a group. In this way, you have control over which parts of the system each user is given access to. If a permission is changed for a user group, then it is changed for all members of that group.

USER GROUP PERMISSIONS

To create a new user group:-



1) Select the **Manage Groups/Users** option from the **Administration** menu.
2) Click **Groups,** type in the name of the group and click the **Create Group** button – you will be prompted that the user group has been successfully created.
3) Click **OK**.
4) This group will then be available for selection in the existing user group box. Select the group and click the **List Permissions** button and all permissions will be displayed.
5) Click once to place a tick in the box alongside a permission to activate (allow) that permission for this group. To deactivate a permission, leave it unticked (or if you have already activated it, click the box again and the tick will be removed).

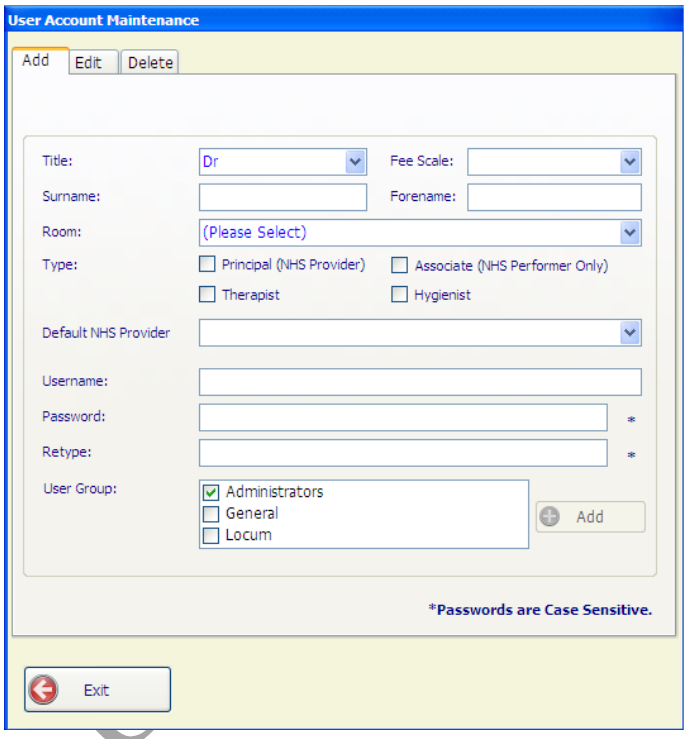
   You can also click on the first permission and press the space bar to add a tick and use the down arrow to move to the next permission.

   Alternatively, you can click the **Check All** box to place a tick alongside each permission, and then remove the ticks from the permissions that you wish to deactivate.
6) When all of the relevant permissions have been selected, click **Update Group Permissions**.
7) Repeat steps 2-6 until all required groups have been created.
8) Click **Close** to exit the option.

Note: to remove a User Group, select the group and click the **Remove Group** button but make sure that no users are members of that group before you delete it.

NEW USERS

Each user of the system should be allocated a username and each username must be made a member of a group.



1) Select the **Manage Groups/Users** option from the **Administration** menu and click **Users**. The screen will default to the **Add** tab.

2) **Title** – select a title from the drop down menu. New titles can be created by selecting **Patient Registration Options/Titles** from the **Edit** menu.

3) **Fee Scale** – if the user is a dentist and uses an individual fee scale by default, this fee scale can be selected from the drop down list. If you specify a fee scale for a user, then this fee scale becomes the default scale offered when entering treatment. If your fee scales have not yet been configured, this can be specified at a later date. This field can be left blank where appropriate.

4) **Surname/Forename** – type in the name of the user.

5) **Room** – a dentist can be associated with an appointment room so that any appointments made in that room will then default to that dentist's name. The system will also warn you if you attempt to book an appointment for another dentist into that room. Linking a room to a dentist is optional. If you do not have your appointment book set up at this stage, the username can be linked to a room at a later date.

6) **User Type** – select a user type. For NHS purposes, any user marked as Principal will be assumed to be a Provider and any user marked as an Associate will be assumed to be a Performer. If the user is not one of the types listed, then leave all of the boxes unticked.

7) **Default NHS Provider** – For NHS practices, choose the default Provider from the drop-down box. This will be used to default the correct Provider/Performer labels on printed claim forms/EDI transmissions. Leave this field blank if you are not an NHS practice.

8) **Username** – enter a username for this user. This is the name that will be used to logon to the system, eg the initials of the user.

9) **Password** – passwords are optional. They can be a combination of letters, numbers and symbols – but not spaces. Passwords are case sensitive so if they are added in

upper case, then they should be typed in upper case when logging on, otherwise access will be denied.

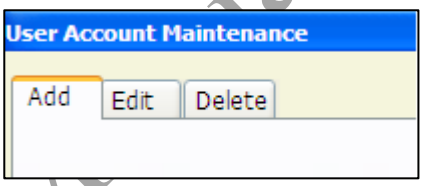
10) **User Groups** – click the user group from the list displayed.

11) Click **Add**.

12) You will be prompted that the user has been successfully created. Click **OK**.

13) Repeat these steps for each user.

EDITING USERS



1) Select the **Manage Groups/Users** option from the **Administration** menu and click **Users**. The screen will default to the **Add** tab.

2) Click the **Edit** tab.

To Edit Personal Details

Make the required changes and click **Update**.

To Reset a Password

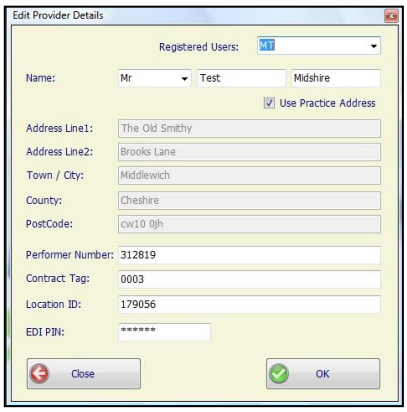
Click the **Change Password** box. Enter and confirm the new password and click **Update**.

DELETING USERS

Click the **Remove** box**.** Select the user from the drop down box and click **Remove**.

PROVIDER DETAILS (NHS ONLY)

Provider details are required for each user who is also a performer. To add provider details for a registered user:



1) Select the **Provider Details** option from the **Administration** menu and choose the user from the drop down list of registered users.

2) Complete the name, address details (tick the **Use Practice Address** box if you wish to use the address stored on the Practice Details Screen) together with the relevant performer number, contract tag and location number.

3) Click **OK**.

Note: If the practice is the provider, then make sure that the Provider box is ticked on the Practice Details Screen (Administration menu) and the relevant contract number recorded.

MATERIALS AND COLOURS ON CHARTS

Base Charts

Materials can be assigned to base chart entries and colours linked to materials so that base charting options are displayed in that colour to easily distinguish different types of fillings, crowns, etc. If more than one material has been assigned to a work code, then you will be prompted for the material when you chart using that work code and the colour assigned to that material will be applied to the relevant tooth.

Subsequent Courses of Treatment

Materials and colours are assigned to items charted on subsequent courses of treatment by linking a material/colour to a specific fee code. When you chart items of treatment using that fee code, then the material/colour assigned to that fee code will be applied to the relevant tooth.

Once the materials table has been configured for base charts, then these materials and colours will be available for selection when creating or editing fee codes.

If you are using the charting module, therefore, and intend to implement different materials and colours for various items of treatment, then the materials and colours need to be configured before adding/editing your fee codes.

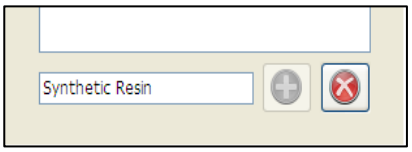
SETTING UP MATERIALS/COLOURS

Select the **Pricing/Treatment Observations** option from the **Maintenance** menu and click the **Materials** tab. Default materials are listed in the **Materials** box on the left-hand side of the screen.

Add/Delete New Materials

To add a material, click on the **Add New Material** entry box at the bottom of the Materials box, type in the material to be added and click the **Add** button.

To delete an existing material, click on the material and click the **Delete** button.



Link a Material to a Colour

Select a material, click on the colour bar in the middle of the screen. Select a colour from the colour pallet for that material and click **OK**.

Link a Material to a Work Code

Select a material and click on all relevant work codes for that material in the work code box on the right hand side of the screen. Then each time that the work code is used on the base chart, that material will be offered for selection and, once the material has been chosen, the relevant colour will be displayed on the chart. Only those materials that you have linked to the relevant work code will be available for selection when charting.

FEE SCALES

You can create as many different fee scales as you wish with the relevant fee scale being confirmed at the start of each course of treatment. Each time that you create a patient record, you are able to choose the relevant fee scale for that patient. Once you have set up all of your fee scales, you can specify which of those fee scales you wish to classify as your default fee scale. This is the fee scale that will default on a new patient record, then each time that you start a new course of treatment for that patient, that fee scale will be the default one offered. At the point that you start a new course of treatment, however, you will be able to change to a different fee scale if applicable.

You are also able to price up mixed courses of treatment, ie include fees in the one course of treatment from more than one fee scale.

- On each patient screen, you can specify the normal fee scale for that patient.
- On each user screen, you can specify the normal fee scale for that user.

(Both of these fields can be left blank, if preferred.)

- You can specify your practice default fee scale on the **Administration** menu - **System Maintenance/Application Preferences/Treatment Plan** tab.

When you open a new course of treatment, the fee scale for that patient for that course of treatment will default as follows:-

i) patient default - if there is an entry on the patient screen; if not

ii) user default – if there is an entry on the user screen; otherwise

iii) your default fee scale will be offered.

These default fee scales can be overwritten, however, when adding a course of treatment.

FEE SCALE STRUCTURE

Fee scales comprise of **WORK CODES** that are linked to **FEE CODES**. Work codes are used to filter your fee codes. When you are charting pending treatment on a tooth, (or adding pending treatment manually to a treatment plan) you enter a work code, eg C for crown, and all of the fee codes that are relevant for that work code will be available for selection so that you can specify the type of crown that you wish to fit and the price that you wish to charge for it.

The estimate/treatment plan can either:-

1) default automatically to the correct fee code if only one fee code is relevant for that work code; or

2) offer a list of relevant fee codes if more than one code is relevant.

Some work codes have been programmed into the dental system software and those work codes (primarily those used on the charting screen but also some that relate directly to the NHS rules) cannot be deleted by yourselves. There is also a reserved work code for an exam that cannot be deleted (.xm).

Standard work codes used for chargeable treatment are listed below with the reserved ones in a separate column:-

RESERVED			UNRESERVED	
WORK CODE	**DESCRIPTION**		**WORK CODE**	**DESCRIPTION**
.XM	**Exam**		**DOM**	**Domiciliary Services**
A	**Artificial Tooth**		**OB**	**Obturators**
B	**Bridge Retainer**		**OHI**	**Oral Hygiene Instruction**
C	**Crown**		**OT**	**Other Treatment**
F	**Filling**		**RAD**	**Radiographs**
I	**Implant**		**SED**	**Sedation Services**
NHS	**NHS Charge Bands**		**SP**	**Scale and Polish**
OS	**Other Services**		**STK**	**Stock Sales**
P	**Bridge Pontic**		**OB**	**Obturators**
RT	**Root Treatment**			
S	**Fissure Sealant**			
V	**Veneer**			
W	**Watch**			
X	**Extraction**			

- Each fee must be linked to a work code.
- Each work code that is used for charting must have at least one fee code linked to it, otherwise it will cause an error when charting.
- New work codes for work that isn't charted can be added for additional items of treatment that you may wish to include in your fee scale (see page 22).
- Once a work code has been created, it will be included in all fee scales. Similarly, if a work code is deleted, it will be removed from all fee scales.

PRIVATE FEE SCALES

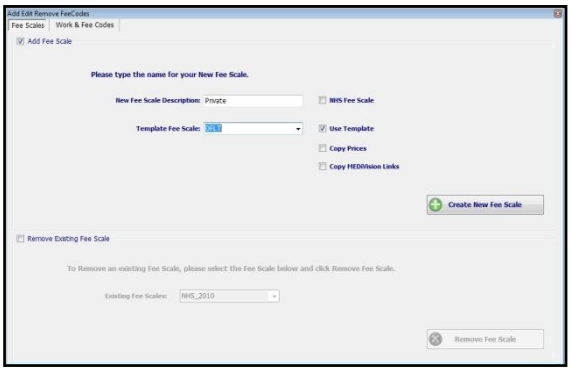
If you are a purely private practice, a default fee scale (called DFLT) but with no fees added, will already exist on your server, ready for you to add your own fees to it. If you only require one fee scale, then this is the scale to develop. One of your fee scales must be specified as the default fee scale on the system but it doesn't have to be called DFLT – a new fee scale can be created and allocated as your default fee scale.

You will, of course, be able to choose the relevant fee scale for the patient on the first visit of each course. You can also add private treatment to a primarily NHS course.

SETTING UP YOUR DEFAULT PRIVATE FEE SCALE

If you only have one private fee scale and you are happy to leave this named as DFLT, then you can go straight to page 12 for instructions on how to add the fee codes. If you wish to rename your default fee scale, follow the instructions below.

1) Select **Pricing/Treatment/Observations** from the **Maintenance** menu and the following screen will be displayed.



2) There are two tabs at the top of the screen – **Fee Scales** and **Work and Fee Codes**. (Unless you wish to rename your default fee scale, click the **Work & Fee Codes** tab and go directly to **Adding the Fees** section below.)

3) If you do wish to rename your default fee scale, stay on the **Fee Scales** tab and leave the tick in the **Add Fee Scale** section.

4) Type the name for the fee scale in the **New Fee Scale Description** box - you can name it what you wish.

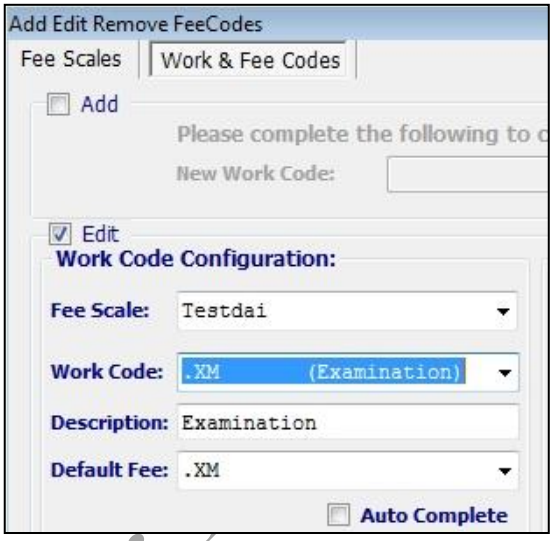
5) Click the **Create New Fee Scale** button.

6) Select this new fee scale as your default fee scale in the **Administration** menu/**System Maintenance**/ **Application Preferences**/**Treatment Plan** tab.

7) You can then delete the **DFLT** fee scale if you wish.

ADDING THE FEES

If you intend using the facility to store materials and colours when charting, then see page 9 for configuration notes prior to adding any fees.



1) Select **Pricing/Treatment/Observations** from the **Maintenance** menu and click the **Work & Fee Codes** tab. At least one fee for each work code that generates a charge must be created in each fee scale for you to be able to chart using that work code.

2) Leave the tick in the **Edit Work Code** box option and select your default fee scale from the drop down **Scale** box.

3) **IN THE WORK CODE SECTION,** select the first work code from the drop down **Code** box**.**

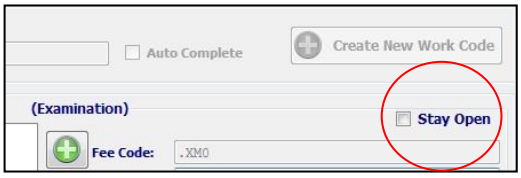
4) Leave the **Default Fee** box blank for the time being.

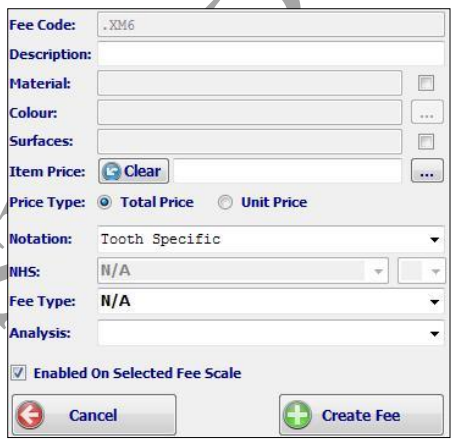
5) Click the **Auto Complete** box if you wish to automatically mark as completed all fees for this work code – useful for examination fees – otherwise leave this box unticked.

6) **IN THE FEES SECTION**, click the **Hide Inactive Fees** box.

7) Click the plus sign to the right of the **Fees** display box. This will open up the fee entry screen display.

8) Click the **Stay Open** box. This will ensure that you do not need to click the plus sign each time that you wish to add another fee code.





9) A new fee code will be generated automatically. This will comprise of the letters of the work code plus a sequential number that is generated by the system. This fee code cannot be edited.

10) Type the description for the fee into the **Description** box (maximum 60 characters). This is the description by which you will search for the fee when charging work and which will be printed onto any invoices generated.

The Material, Colour and Surfaces fields are optional and should only be activated where appropriate by ticking the box alongside the field. See notes on Materials and Colours for Base Charts on page 9 before activating the Materials field.

11) **Material –** Any material added to this field will be recorded on the tooth history when this fee is selected, eg composite or amalgam for fillings. Activate the **Material** field

and select the relevant material from the drop-down list. The colour associated with that material will then be applied to the relevant tooth when adding this fee.

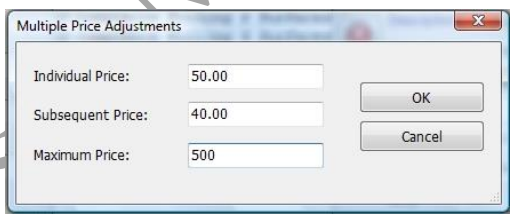
12) **Colour –** The colour assigned to that material will then be displayed in the Colour field.

13) **Surfaces** - for fillings, click the box alongside this field to activate the field and type in the number of surfaces for that filling. If the number of surfaces is not relevant for the fee, do not click the box and leave this field blank. This would filter the search when selecting a fee from the charting screen.

14) Type in the price for the item of treatment.

Note: The price can be either a total price per fee or it can be have a variable unit price depending on how many times this particular fee is charged for this course of treatment. To vary the charge, click the browse button alongside the **Price** field

This will launch the **Multiple Price Adjustments** screen.



- The system will then charge the **Individual Price** the first time that the fee is charged per course
- The **Subsequent Price** will be charged for the second and subsequent time/s that the fee is added.
- If the **Maximum Price** is set to zero, no maximum charge will apply. If it is set to anything other than zero, then this is the maximum price that will be charged for that fee, per course, irrespective of how many times it is used.

15) **Price Type –** leave as **Total Price** for fees where the quantity will always be 1 and change to **Unit Price** where the quantity may be more than one. You will then be prompted for the quantity when adding work.

16) **Tooth Notation** – select the relevant tooth notation from the drop down list. Whatever you select from this box is the choice that you will be offered when entering the tooth notation when this fee is charged.

17) **NHS** – this applies only to an NHS Fee Scale and will remain inactive for private fee scales.

18) **Fee Type** – this is an analysis category of specific fee types. It is not utilised in the current version of the programme but has been added for planned future development – we may decide to chart these fee types in a different way. For the time being, you should chart inlays and onlays as fillings with inlay or onlay as the **Fee Type Category**. The same applies to ¾ crowns. We may add to these types as the need arises.

19) **Analysis** – You are able to specify an analysis code for each fee that will give you the ability to analyse sales by analysis code. Analysis codes must be set up before they can be selected on fees – **Edit** menu**Pricing****Analysis Code Maintenance**.

20) **Enabled on Selected Fee Scale** – this will be ticked by default but the tick can be removed on any scale where that fee no longer applies. This can be used when copying the fee codes from an existing fee scale to a new fee scale, ie if one of the fees is not applicable in the new scale you can either remove the tick in this field or delete the fee code. If a fee is not enabled on a fee scale, then it won't be offered for treatment but can be re-enabled at any time.

21) Click the **Update Fee** button.

22) Repeat steps 6-19 until all fees have been added for the selected work code.

23) Although you cannot edit the fee codes themselves, you can change the order in which they appear in the fee scale. Click the fee code to be moved and click the **Up** or **Down Arrow** button accordingly.

24) Set the default fee for the selected work code before choosing your next work code.

- Whatever fee you select, will become the default fee code whenever that work code is used.
- If there is more than one fee code that relates to the work code, and you want to be offered a choice of fees when you use that work code, enter as much of the fee codes as is unique to all the relevant codes (the work code without a number). This will filter for all relevant fees whenever the work code is used.

25) Click the **Update Work Code** button.

26) **Auto Complete** box – With the full charting module, once you have added work to the estimate screen, you will be able to mark it as complete when the work has been carried out. If you tick this box, then the work will be automatically completed as it is added. This is useful for an examination or for those practices that are not using the full charting module and are only adding the work once it has been completed.

27) Repeat steps 1-24 until all fees have been added for each work code that relates to chargeable treatment.

CREATING ADDITIONAL PRIVATE FEE SCALES

Once your default fee scale has been set up correctly, you can create additional fee scales as required. All fees in your default fee scale can be copied into the new fee scale or you can start with an empty fee scale. The fee code prices in your default fee scale can either automatically be transferred to the new fee scale or the fees can be copied to the new scale with a zero price. This price can, of course, be edited once the scale has been created. Any fees that are not applicable to the new scale can be marked as inactive in that fee scale.

As with the default fee scale, there are three stages to creating a new scale:-

i) Name and create the fee scale itself.

ii) If you have copied an existing fee scale, edit the existing fee codes and adjust the prices accordingly. Click the **Enabled on Selected Fee Scale** box to remove the tick for any

fee codes that are not applicable to that fee scale and add any new fee codes that may be required.

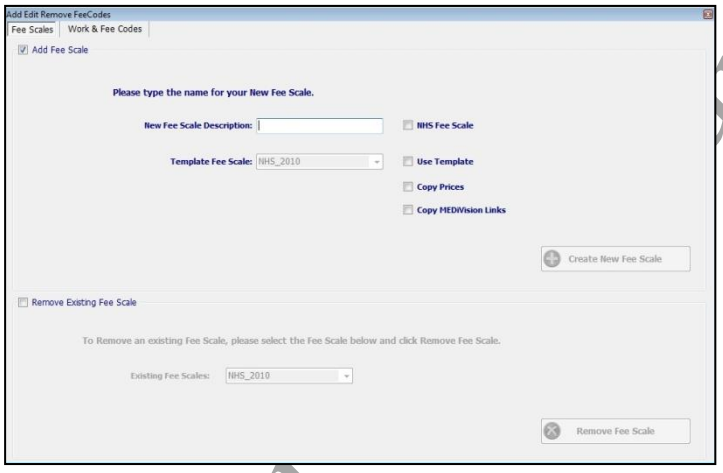
Or:

If you have started with an empty fee scale, add your fees.

iii) Make sure that each work code still has the correct default fee code entry linked to it.

Creating a New Private Fee Scale

1) Select **Pricing\Treatment Observations** from the **Maintenance** menu and leave the **Add** box ticked.



2) Type the name of the scale in the **New Fee Scale Description** box.

3) If you wish to copy fees from an existing fee scale, click the **Use Template** box and select the fee scale to copy from the drop down list in the **Template Fee Scale** box.

4) If you are copying fees from an existing fee scale and wish also to copy the prices from that fee scale, tick the **Copy Prices** box. If you do not tick this box, all prices will be changed to zero.

5) Click Create New Fee Scale.

Editing Fee Codes

1) Select **Pricing** and **Treatment Observations** from the **Maintenance** menu and click the **Work & Fee Codes** tab.

2) Leave the **Edit** box ticked.

3) Select the fee scale to be edited.

4) Select the relevant work code for the fee to be edited. All fee codes linked to the work code will be displayed in the **Fees** box.

5) Select the fee that you wish to edit (the fees are displayed in fee code order) and click the **Edit** button (or double-click the fee

code).

6) Click the **Stay Open** box if there is more than one fee code to be edited for that work code.

7) Make the required changes and click the **Update Fee** button. The only field that cannot be edited is the fee code itself.

8) Continue in this way until all fee codes for that work code are correct.

9) Make sure that the work code still has the correct default fee code linked to it.

10) Select the next work code and repeat steps 3-8 until all fees for each work code have been edited where required.

Deleting Fee Codes

1) Select **Pricing\Treatment Observations** from the **Maintenance** Leave the **Edit** box ticked.

2) Select any one of your fee scales.

3) Select the relevant work code for the fee to be deleted. All fee codes linked to that work code will be displayed in the **Fees** box.

4) Select the fee that you wish to delete and click the **Delete** button. 

DELETING FEE SCALES

1) Select **Pricing** and **Treatment Observations** from the **Maintenance** menu.

2) On the **Fee Scales** tab, click the **Remove Existing Fee Scale** box and select the scale to delete from the **Existing Fee Scale** box.

3) Click the **Remove Fee Scale** button.

4) The **Are you sure?** prompt is to ensure that you have time to reconsider and change your mind before the scale is deleted. If you were to recreate the fee scale once it has been deleted, the current fee codes and prices in your default fee scale will be used.

WORK CODES

Creating Work Codes

New work codes can be created but only for work that is not charted. Charting work codes are programmed into the software and cannot be changed.

1) Select **Pricing\Treatment Observations** from the **Maintenance** menu and click the **Work & Fee Codes** tab.

2) Click the **Add** box.

3) Type the code required in the **New Work Code** box (maximum 10 characters but the more concise the better).

4) Type in a description for the work code.

5) Click the **Auto Complete** button if you wish all fee codes that are to be linked to this work code to be automatically marked as complete as you add them to the estimate.

6) Click the **Create New Work Code** button. Make sure that you add at least one fee code for that work code.

7) Once the fee codes have been added for the new work code, set the default fee for the work code (see page 15).

Deleting Work Codes

NOTE: Reserved work codes cannot be deleted – see page 11 for the list of reserved work codes. If you delete a work code, it will be deleted for all fee scales.

1) Select **Pricing\Treatment Observations** from the **Maintenance** menu and click the **Work & Fee Codes** tab.

2) Click the **Remove** button.

3) Select the work code to be deleted in the **Work Code** box.

4) Click the **Remove Work Code** button.

Note: If you remove a work code while there are fee codes linked to it, then the fee codes remain in the table but are inaccessible unless the work code is recreated.

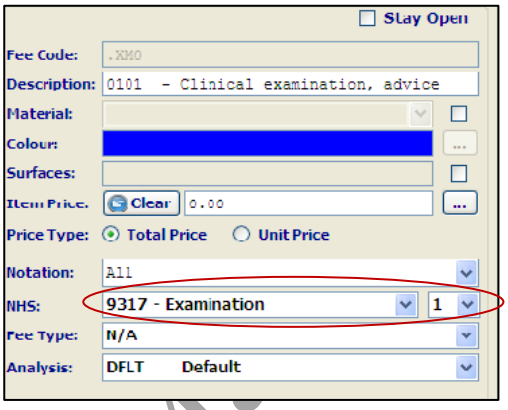
NHS FEE SCALE

In order to comply with the NHS rules for printing claim forms or transmitting claims directly to the DPB, an NHS specific fee scale will need to be used. For NHS practices, we will have installed a pre-configured fee scale for you that is based loosely upon the most recent available version of the NHS SDR, although many codes that are no longer valid have been removed.

Each time that new NHS regulations are implemented that affect the NHS Fee Scale, then a new NHS Fee Scale will need to be created on your system to incorporate these changes. Unless there are any program changes required, this can be created as outlined below.

The new fee scale can be created prior to the implementation date and the existing NHS Fee Scale should remain in place and will be applicable for any open courses that were started prior to the new regulations becoming effective. As there will be more than one NHS Fee Scale existing on your system at any one time, there is an option on the NHS tab in the Administration Menu/System Maintenance/Application Preferences to specify the NHS Active Fee Scale. This should be set to the new fee scale only on the date that the new regulations become effective, and before any new courses are opened.

There is the ability built into the software for you to create your own NHS fee scale, but this would require advanced training as there are specific codes that need to be linked to the fees so that the relevant banding is identified and the correct data is printed on a claim form/transmitted to the NHSDSA. We recommend, therefore, that - initially at least - this default fee scale is used to record NHS treatment.



If you are using the charting module, and have configured Materials/Colours for specific items of treatment, then these materials and colours will need to be assigned to this NHS Fee Scale, as well as your Private Fee Scales. This is done in the same way as described on page 13, but be careful not to change any of the existing settings in the NHS and Banding fields.

Whilst we have made every effort to ensure the accuracy of this fee scale, total accuracy cannot be guaranteed. You will, however, have the ability to view the claim form before it is printed/transmitted and be able to manually change any entries if you feel that it is necessary to do so.

CREATING A NEW NHS FEE SCALE

1) Select **Pricing** and **Treatment/Observations** from the **Maintenance Menu**.

2) On the **Fee Scales Tab**, leave the tick in the **Add Fee Scale** box.

3) Type a name for the fee scale in the **New Fee Scale Description** box**, eg NHS1204 –** where 12 is the year and 04 is the month**.** What you call it isn't really important – as long as you are able to identify the versions, although it would make sense to be consistent in your naming of the scales.

4) Click the **NHS Fee Scale** box.

5) Click the **Use Template** box and select the current NHS Fee Scale from the **Template Fee Scale** box.

6) Click the **Copy Prices** box and click **Create New Fee Scale**.

This generates a new NHS Fee Scale which at this stage is an exact copy of the current one. You now need to make any relevant price changes.

1) Click the **Work & Fee Codes** tab and leave the tick in the **Edit** box.

2) Select the new fee scale from the **Fee Scale** box.

3) To change the price of the bands, select the **NHS** work code. This will display each band fee in the **Fees Attached to Work Code** display box.

4) Edit the price of each band fee as applicable and click **Update Fee**. (Regulation 11 is 30% of the band 3 charge.)

PATIENT DETAILS SCREEN

CONVERSION OF EXISTING DATA

If you have a current computer system - whether this is a proprietary system, an Access database or an Excel spreadsheet, etc - we will endeavour to carry out, free-of-charge, a data conversion of your users, patient data, appointments and journal entries. The amount of data that we can convert does, of course, depend upon the type, quality and accessibility of the data available for conversion.

If you are an NHS practice with no computer, then you are able to obtain a file from NHS Dental Services based upon claims previously submitted by the practice, from which we can convert patient details. We would point out, however, that we have found that the data provided in this way is generally poor, in that there have been reports of duplicate, incomplete and inaccurate patient details.

MANUAL DATA ENTRY

In the absence of any data for conversion, then the records will need to be added manually.

The first thing that you will need to decide is the date upon which you wish to start using the system in a live situation.

Patients with Future Appointments Booked

From that live date, all future appointments will need to be transferred from your manual appointment book onto our dental system before you can begin booking live appointments on it. Patient details will need to be entered for these patients before their appointments can be transferred, so you should concentrate upon adding these patient details before any others.

You can, however, add these records as Express Patients which will allow you to record basic information only (exactly which data can be decided by yourselves). As the patients attend those appointments, you will be prompted to complete their registration. Automatic text reminders can be scheduled as you transfer the appointments. This is particularly useful for those patients who have pre-booked their next check-up 6 or 12 months in advance.

If you have decided not to use text messaging, you can send manual reminders if you wish.

Patients without Future Appointments Booked

Any patients who ring for an appointment before they have been registered on the system, can, of course, be added as they ring in.

Regarding the remainder of your patients, you can:

1) add them gradually over the course of, say, 6 months to a year in the order that they are due to attend their next check-up. You can then use the recall facilities available on the system to produce a list of patients who are due to attend the following month - but have not yet booked their recall appointment - and either :

- book the appointments for these patients and send a printed or SMS appointment confirmation; or
- print a label, letter or send a text message asking them to ring and book their recall appointment.

This way, you are adding the records gradually in the order that they need to be accessed and also concentrating on entering details for your active patients only.

2) Alternatively, some practices prefer to ask their staff, or employ a temporary data entry clerk, to gradually work their way through existing patient record cards and enter the details of any patient who has who has not already been registered and who been seen within a pre-determined number of years. Of course, this method may result in adding details for patients who may not return for treatment.

PATIENT REGISTRATION OPTIONS

Click the down arrow to the right of this **Patient Registration** icon on the toolbar, and you will be offered two options – **Full Registration** and **Express Registration**. You can select one of these options by clicking on the description name.

(1) If you select **Full Registration** – the usual registration screen will be offered with completion of the standard must-fill fields.

(2) If you select **Express Registration** - this screen will display only the fields ticked on the Express Registration Setup option (as explained on page 27).

There is a grey area to the left of each of these options. You can click on this grey area to place a tick alongside one of the options (clicking again will remove it). Whichever of these two choices has a tick by the side of it will be the default option selected when you click the **Patient Registration** icon itself (and not the down arrow).

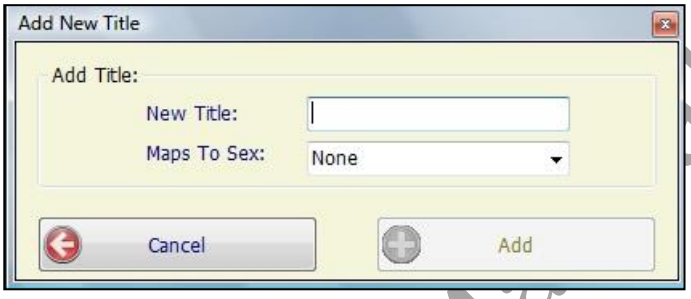
If you click the **Patient Registration** icon and no default option has been set, ie both of the ticks have been removed, the following message will be displayed.

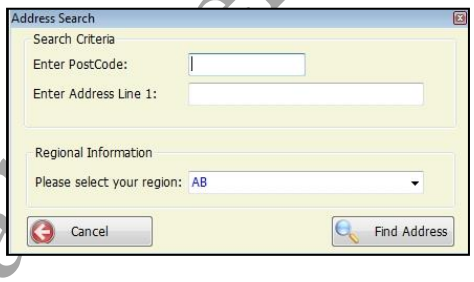
Select whichever registration method you require. If you leave a tick in the **Make Default** box, this will set your default for the next time the Patient Registration icon is clicked.

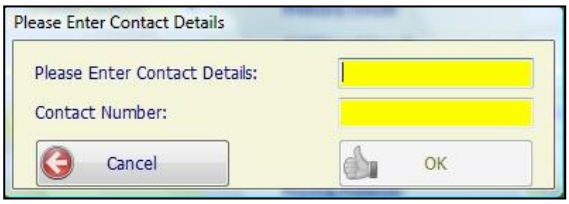
REGISTERING NEW PATIENTS (FULL REGISTRATION)

To create new patient details, click the **Full Registration** option, as explained above. Enter the patient details outlined below. Fields coloured yellow and marked with a red asterisk must be filled in. As you complete these must fill fields, the asterisk will be removed from the display.

Move between the fields by pressing the tab key or by clicking with the left mouse button.

Family Name	Type in a family name – usually the surname.
Title	Select a title from the drop down menu. Additional titles can be created by selecting **Patient Registration\Titles** from the **Maintenance** menu.  Titles can be associated with the sex field – and if they are, then the sex field will default automatically to the relevant choice.
Active Patient	A tick in this box indicates that this patient is an active patient and you will be able to filter for active patients when generating ad-hoc reports. The tick can be removed from the **Active Patient** box by clicking on it with the left mouse button.
First Name	Complete as appropriate. (For NHS transmissions there is a minimum requirement for two characters to be transmitted.)
Surname	Complete as appropriate.
Previous Name	A married woman's maiden name can be stored in the previous name field.
Sex	The sex field will default if linked to a title. Otherwise, select from the drop-down list.
DOB	The date of birth can be selected by using the drop down calendar or entered manually. **Calendar Selection**  • The left and right arrows allow you to move between previous and next month. • If you click on the month, a drop down list of each month of the year is available for selection. Click on a month to select. • If you click on the default year, you are able to scroll and select

<table>
<tr><td></td><td>the relevant year.
• Whichever date you eventually click on will be the date inserted into the date of birth field.
Manual Selection
• Click on each section of the date (or you can use and use the up and down arrow keys on your keyboard to change the selection).
• The day and year can be typed in if preferred.</td></tr>
<tr><td>NHS Number/NI Reference
Insurance Plan Number</td><td>Complete as appropriate.</td></tr>
<tr><td>Address Line 1
Address Line 2
Town
City
County
Postcode</td><td>The address can be typed in manually or entered using the postcode quick entry facility.
To use the quick entry postcode facility:-
• Click the search button to the left of the postcode field to display the address search screen. Alternatively, you can press F10 with the cursor on the first line of the address.
 
• Type the postcode (with or without the space, and in upper or lower case) into the Enter Postcode field and click the Find Address button or press the Enter key.
• If the postcode is valid, a part address will be displayed ready for selection. Double click the entry or press the Enter key.
• This will display the part address on the patient screen with the cursor positioned in front of the street name. Complete the address by typing in the house number or house name.</td></tr>
<tr><td>Home Address/Work Address</td><td>Click the relevant option.</td></tr>
<tr><td>Ethnicity</td><td>Select from the drop down list. Ethnic regions can be added using the System Maintenance/Edit Ethnic Regions/Add Ethnic Regions option on the Edit menu. Can be left as none specified if preferred.</td></tr>
<tr><td>General Notes</td><td>General notes about the patient can be stored in this field.</td></tr>
</table>

Future/Previous Appointments	Previous and future appointments are displayed automatically at the bottom of the patient details screen. If you click on one of the future appointment dates, then you will be navigated to that date in the appointment book - perhaps to cancel the appointment. It is possible to define rules to classify persistent failed to attends, and a warning symbol can be displayed alongside the previous appointments box for those clients who qualify. To define this rule, select **System Maintenance\Application Preferences** from the **Administration** menu. On the **Services** tab, set the number of appointments and number of days to define your own requirements for a persistent FTA. Currently, you will need to regularly run a routine that will update the patient records in accordance with these rules. Select **System Maintenance\Housekeeping\Refresh Persistent FTA** from the **Administration** menu to do this. Eventually, we will be incorporating a scheduled task that will run this routine for you so that the records will be automatically updated at regular intervals. There will also be an option that will allow you to produce a list of FTAs in a date range – either to a report or to letters.
Home Phone Mobile Phone Work Phone	Enter the relevant telephone numbers. Alongside the mobile number field, there is a **Contact by SMS** tick box. You are able to send mobile phone text reminders for check up appointments. If this box is ticked, the patient will be included in any text reminders that you may choose to send. If the patient does not wish to be reminded by text message, click this box to remove the tick.
Additional Contacts	This field allows you to store name and numbers of additional contacts - next-of-kin, for example. Click the + button and enter the contact name and number. Click **OK**.  Add further contacts in the same way.
Primary E-mail Additional E-mail	Complete as appropriate.
Contact Preference	You can record the patient's preferred method of contact in this field. Select from the drop down list.
Occupation	Complete as appropriate.
Fee Scale	Select the fee scale that applies to this patient. This field can be left blank if preferred. If a fee scale is selected, this will be the default scale offered at the start of each course of treatment for this patient.

Paying Patient	• If the patient pays for treatment, either Private or NHS, select **Patient not exempt** from the drop down menu. The **Maximum Charge** field will remain inactive. **If the patient is an NHS patient and is:-** • fully exempt from charges - select the appropriate exemption from the drop down menu. The **Maximum Charge** field will remain inactive. • partially exempt from charges – select the appropriate exemption from the drop down menu and type the payment amount in the **Maximum Charge** field.
Default Dentist	Select the usual dentist for this patient. If a dentist is selected, this will be the default dentist offered at the start of each course of treatment for this patient. If a default dentist is not specified, then the dentist would need to be selected manually at the start of each course of treatment.
Referred By	A list of referring practices can be maintained on the system and the relevant option displayed in this field. New referral codes can be added using the **Patient Registration** Options**/ Referral** Options on the **Edit** menu. Alternatively, you could also use this field to record how the patient heard about your practice, eg Yellow Pages.
Position in Family	It is possible to link patients together into families to allow family appointment booking. Select the relevant family position for the patient. Additional family titles can be created using the **System Patient Registration** options**/ Family Positions** option from the **Edit** menu. If no other family members attend the practice, select **Other**.
Family Members	If family members are linked, all other family members are displayed on each patient's record.
Next Recall/Default Length	The patient's recall date is displayed in this field. It can be updated manually and it is also automatically updated when a new course of treatment is opened – and it can be updated when the course is completed. There is the ability to send out recall reminders based upon this date. The default recall interval can be set on the **System Maintenance/ Application Preferences** option on the **Administration** menu. Click the **Recall** tab and type in the default interval.
Hygienist Recall/Length	You can store a separate recall date and recall interval for the hygienist in this field.

- Once the patient details have been completed, click **Register Patient**. If one of the must-fill fields has not been completed, then the **Register Patient** option will remain inactive. Check your data entry if this happens.
- Once the record has been saved, you will be prompted that patient registration is complete. Click **OK**.

Family Members

You are able to link family members so that when you make an appointment you are able to select which members of the family wish to attend for that appointment. You can also left click one of the family members on a patient details screen to select it, and right click to select **View Details** to navigate to that patient's details.

Adding a New Family Member to an Existing Record

1) Display the patient's details and click the **New Family Member** button.
2) This clears the screen in readiness for you to enter the new patient's details. Those field that are likely to be the same for the new patient as they were for the original one will be left in place to speed up the entry of the data.
3) At the left-hand side of the bottom of the patient details screen, you will be prompted that patient registration is in progress.
4) Must-fill field are indicated by a red asterisk. Fill in the relevant details and click the **Add to Family** button.

5) You will be then prompted that the family update is complete. The original record will be redisplayed.
6) Repeat steps 1-4 for each family member.

Removing a Family Member

Individual patients can be removed from an existing family – the record is not deleted but the patient will no longer be a member of that family.

1) Left click on the family member to select that member.
2) Right click and select **Delete Family Member**.
3) Click **OK** at the **Are you sure?** Prompt.
4) You will be prompted that the family member has been removed. Click **OK**.

Merging Family Members

1) Display the record for one of the family members to be merged and click the **Merge Family** button.
2) You will then be prompted to search for and select the record for the other family member.

3) Both family members will then be displayed as follows.

4) Select the correct family position for each patient from the drop down list.

5) Choose which family name is to be used by clicking the relevant option.

6) Click the **Merge** button.

EXPRESS REGISTRATION

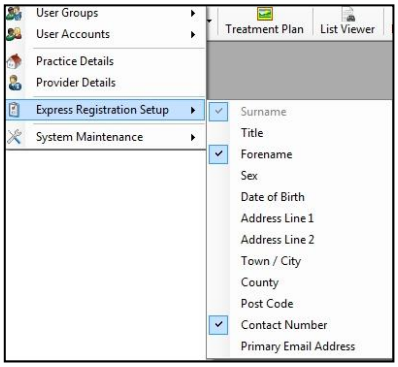
In order to book an appointment for a new patient, it is necessary to register the patient first. There is, however, an express registration facility that enables you to record minimal information about the patients until they have attended for their first appointment, at which time the normal must-fill fields must be completed on their patient details screen.

Note: If you are updating an express record and you are prompted for a possible duplicate entry, then if you select the existing record instead of updating the express record, then the express record will be deleted.

You can choose which fields appear on the express registration screen. The only field that is automatically included is the **Surname** field.

CONFIGURING THE EXPRESS REGISTRATION SCREEN

1) Select the Patient Registration\Express Registration Mandatory Fields option from the Maintenance menu.



2) Click each option that you would like to be <u>essential</u> fill fields on the express registration screen.

3) In addition to the fields you select, a text box is displayed for any general notes that you may wish to record. Entries in this box are optional. Any entries that you do make will be displayed in the **General Notes** section of the full patient details screen.

REGISTERING AN EXPRESS PATIENT

1) Select the **Express Registration** option from the dental system toolbar – see page 21.

2) Whichever fields have been selected on the **Express** Registration **Setup** option will be displayed for completion. <u>All</u> of these fields must be completed.

3) An optional **Notes** field will be included by default. This field can be left blank. If notes are

added, they will be displayed in the **General Notes** field on the full patient details screen.

4) The contact number will be transferred to the full patient details screen according to which contact option is selected, ie home, work or mobile.

5) If you include the address lines on the express screen, the postcode search will be available to use.

6) If you include the title and sex fields on the express screen, the sex will default to that saved against the title.

7) When you have completed the entries, click **OK.** The registration will be saved and the partially completed patient details screen will be displayed. This symbol will be displayed in the top right-hand corner of the patient detail screen. The patient details can remain in that form until that patient attends for their first appointment.

When an express patient's details are displayed, the following options are available:

1) View appointment history – click the **Appointment History** tab.

2) Navigate to the appointment book to manually search for an appointment – click the **Appointment Book** tab.

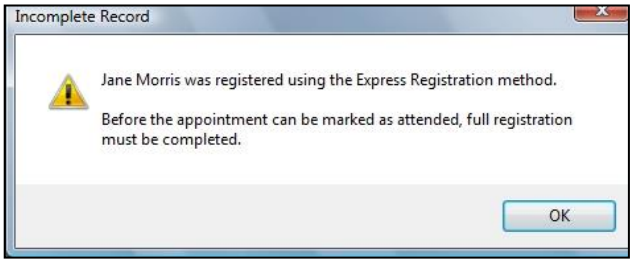
3) Use the Appointment Finder to search for the first available appointment – click the **Appointment Finder** tab.

   If you subsequently select an appointment slot, the patient's details will be inserted by default.

NOTES:

- If you attempt to edit an express patient's details before they attend their first appointment, you will need to complete all of the standard must-fill fields before you are able to save any changes. If you have started to update the record but do not wish to complete the update, click the **Abandon Changes** button before attempting to close the record or navigating to the appointment book or appointment finder.
- You can cancel and re-book appointments for express registered patients.

Attending Appointments for Express Patients



When you attend an appointment for an Express Registered Patient, you must update the patient details to include all of the standard must fill fields. Before the appointment is marked attended, a warning message will appear and the patient details screen displayed ready for completion. **The appointment will not be marked attended without updating the record.** When the details have been updated, you will be returned to the relevant date and time in the appointment book and the appointment will be marked as attended. The patient will then be classed as fully registered.

NOTE: If you close the record without updating it, the patient will NOT be marked as attended.

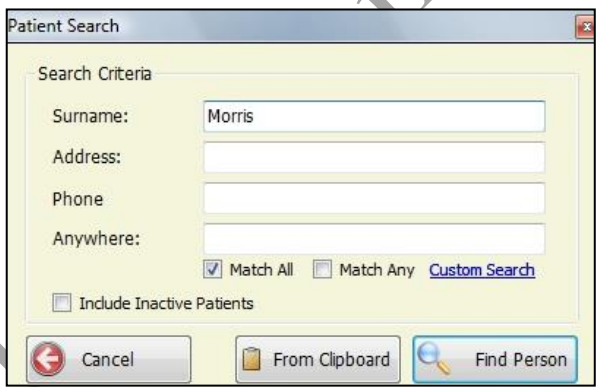
Failed to Attend Express Patients

For those express registered patients who do not attend their appointment, or who cancel their appointment and do not rebook, it is possible from time to time to delete these records from your system. The option to **Purge Incomplete Registration Records** can be found on the **Administration** menu – **Express Registration Setup**.

SEARCHING FOR PATIENT DETAILS

1) Click **Find Patient** on the toolbar.

2) Type in the information that you know about the patient. You can complete any combination of the **Surname**, **Address** and **Phone** fields and, if you leave the **Match All** box ticked, you can search for all of your patients who match all of the criteria entered.



- The **Surname** field is a **beginning with** search.
- The **Address** field is a **containing** search.
- The **Phone** field is a **beginning with** search. You can type in the phone number without the spaces.

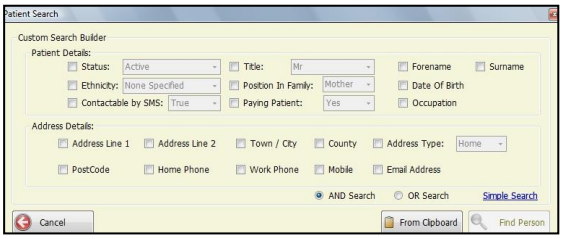
3) The **Anywhere** field is a containing search and will search for the data that you have entered where this appears on any field on the client record. You can type in more than one word – leave one space between each word.

   Note: You can either use the **Surname**, **Address** and **Phone** fields **OR** the **Anywhere** field, but not both. If you enter anything into the **Anywhere** field, all other entries will be cleared. If you use the **Anywhere** field, therefore, you must type all of the entries in that field, even if one of them is a surname.

4) Click the **Find Person** button.

Custom Search

The custom search provides you with more advanced search options. Click the **Custom Search** link to display the following screen which allows you to search for patients based upon any of the displayed fields.



Click the selection box alongside the required field and:-

1) for those fields with a drop down menu, select the required option from the menu; or

2) for those fields that are completed with a free text entry, enter the relevant value when prompted.

Notes:

- You can select more than one option and, if you do so, then those patients who meet all of the selected criteria will be displayed when you click the **Find Person** button.
- Click the **From Clipboard** option if you wish to limit the search to those patients in the current clipboard (see notes below).

Using the Clipboard

You can open more than one patient record at a time. Each time that you open a patient record while another record is still open, the new record will be displayed in place of the original one, but the original one will remain open in the background.

Each time that you access a patient record, that patient's name is added to the clipboard. You can display the clipboard by clicking the **Clipboard** icon on the toolbar at any time and all recently accessed records will be displayed, even records that have since been closed. Click the **Clipboard** icon again to close it.

The length of time that a patient's details remain on the clipboard can be customised per user by selecting the **Manage Groups**/**Users**/**User Preferences** option from the **Administration** menu.

On the clipboard, records that are open are coloured green and records that have been recently closed are coloured black.

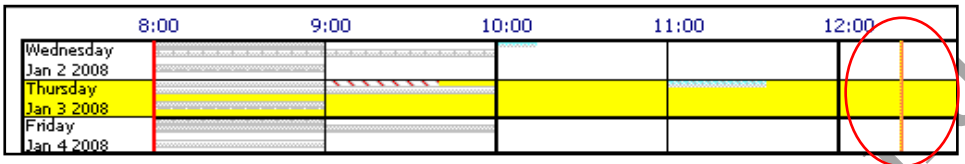
You can left click on an entry in the clipboard to select that entry and then right click it to display the **Clipboard** menu options and navigate, as follows:

Searching the clipboard will display a list of all patients stored in your clipboard – so if you have recently accessed the patient record that you are searching for, depending on your clipboard settings, you should be able to select the patient from this list.

- Click the **Clipboard** button and
- Double click (or down arrow + enter) the list entry to display the record.

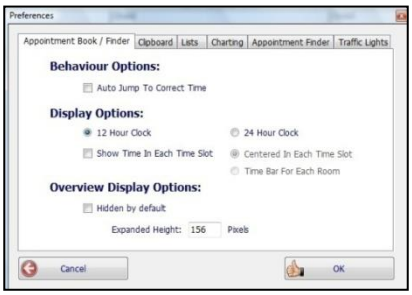
VIEWING THE APPOINTMENT BOOK

By default, each time that you open the appointment book, today's date will be displayed. At the top of the appointment book screen, there is an overview that displays the status of the previous, current and following days – ie each appointment booked will be displayed in the category colour for that appointment. Each of these days will be divided horizontally into the number of rooms displayed. There is also an amber coloured line that represents the current time of day. You can click anywhere on the current day section to scroll to that time in the appointment book without having to use the standard Windows scroll bars.



You can use the overview screen to move through the diary – if you click on the previous day on the overview screen, the appointment book will change to the previous day's display. Similarly, if you click on the next day on the overview screen, the appointment book will change to the following day's display.

The overview screen can be resized or closed if not required.

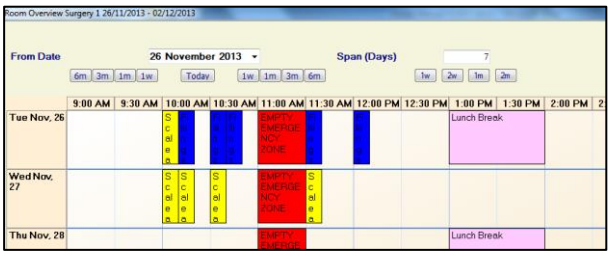


- **RESIZE OPTION** – select **Manage Groups and Users\User Preferences** from the **Administration** menu. On the **Appointment Book/Finder** tab, in the **Overview Display Options** section, increase the number of pixels to increase the size of the display or decrease the number of pixels to decrease the size of the display.
- **HIDE BY DEFAULT OPTION** – on the same tab, click the box to hide the overview screen by default for that user.
- On the appointment book display, click **Hide Overview** to temporarily close the overview screen. The **Hide Overview** link will be replaced with a **Show Overview** link. Click this to redisplay it.

MULTI-DAY OVERVIEW

You can view the overview screen for multiple days for an individual room.

1) Click the **Globe** icon on the status bar at the top of the room.



2) The **From Date** will default to the date from which the view was selected and the **Span** will default to 7 days.

- The **From Date** can be changed by clicking the down arrow and selecting a date from the inbuilt Windows calendar or by clicking an option on the movement bar.
- The **Span (Days)** can be changed by manually typing in the number of days you wish to view or by clicking the Span selection bar. (The maximum number of days that can be selected manually is 93 – but how this will display will depend upon the size resolution of your monitor.)

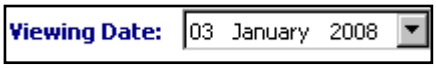
CHANGING THE DATE

Today's date is displayed by default when you select the **Appointment Book** option. The date currently being viewed is displayed on the right-hand side of the screen, just underneath the movement bar. In addition to using the **Overview Screen** to move to the next or previous day as previously described, you can change the date viewed by using the viewing date calendar or the movement bar on the right hand side of the screen.

Movement Bar

Today	**Display today's date**		
1d	**Back one day**	**1d**	**Forward one day**
1w	**Back one week**	**1w**	**Forward one week**
1m	**Back one month**	**1m**	**Forward one month**
3m	**Back three months**	**3m**	**Forward three months**
6m	**Back six months**	**6m**	**Forward six months**

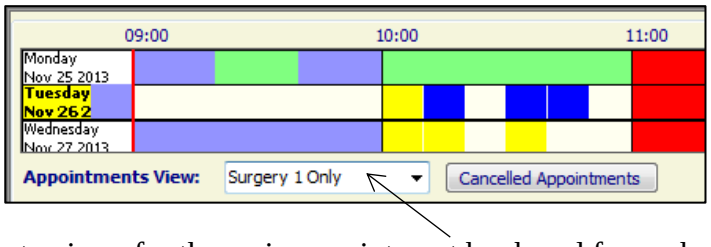
Calendar - see page 22 for details of how to use the calendar to select the required date.



The bottom part of the screen comprises of the rooms that are available for booking. Each column is the equivalent of a room and each room is broken down into bookable slots. The length of the slots can vary according to your own requirements – select **System Maintenance/Application Preferences** from the **Administration** menu and click the **Appointment Book** tab.

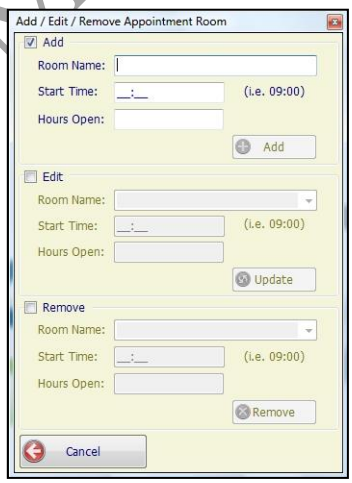
CONFIGURING THE APPOINTMENT BOOK

Rooms should be created according to how many consulting rooms (or dentists, if you prefer) that you have available – users can be linked to a room so that each time an appointment is booked into that room, then the correct provider (dentist) will be automatically selected for that appointment.



It is possible to create views for the main appointment book and for each view you can specify which rooms will be displayed when that view is selected.

TO CREATE A NEW ROOM



1) Select the **Appointments\Rooms** option from the **Maintenance** menu. By default there will be a tick in the **Add** box – leave this box ticked.

2) Type in the room name, default start time and the number of hours that you wish the room to remain open and click the **Add** button.

Note: If you wish to associate the new room with a provider, this should be entered on the user name details. Select the **Manage Groups and Users** option from the **Administration** menu (either by editing an existing user or adding a new user).

TO EDIT AN EXISTING ROOM

1) Select the **Appointments\Rooms** option from the **Maintenance** menu and click the **Edit** box.

2) Make the required changes and click the **Update** button.

TO DELETE A ROOM

1) Select the **Appointments\Rooms** option from the **Maintenance** menu and click the **Remove** box.

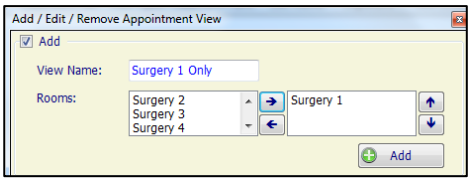
2) Select the room to be deleted from the drop down box and click the **Remove** button.

TO CREATE A NEW VIEW

Views can be created and selected in the appointment book so that only rooms associated with that view will be displayed.

1) Make sure that all of the rooms to be included in the view have been created.

2) Select the **Appointments\Views** option from the **Maintenance** menu**.** By default there will be a tick in the **Add** box – leave this box ticked.



3) Type in a name for the view.

4) Click on one of the rooms to be included in the view and click the right arrow to move the room name from the left-hand to the right-hand box.

5) Repeat until all of the relevant rooms have been selected and click the **Add** button.

6) This view will then be available for selection in the appointment book.

7) If that room has been associated with a provider (dentist/hygienist) then the room name and the provider name will be displayed at the top of the room column.

TO EDIT A VIEW

1) Select the **Appointments\Views** option from the **Maintenance** menu and click the **Edit** box.

2) Make the required changes and click the **Update** button.

TO DELETE A VIEW

1) Select the **Appointments\Views** option from the **Maintenance** menu and click the **Remove** box.

2) Select the View to be deleted from the drop down box and click the **Remove** button.

Notes:

- Deleting a view does not delete any rooms previously associated with that view.
- A room can be added to more than one view.

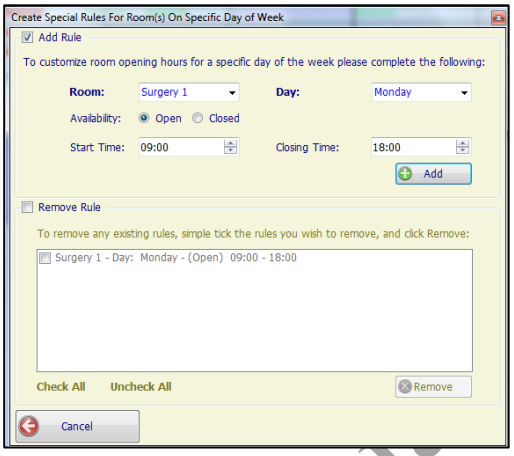
TO BLOCK OFF TIMES IN A ROOM

If the room remains open for the same length of time every day, then it is not necessary to add custom days rules. If the open times vary according to the day of the week, however, the normal start and end time of each room on specific days can be specified, as follows.

- Custom **days** can be added whereby you can specify different start and end times for a room for a particular day of the week. These times would then apply for that day for every week.
- Custom **dates** can be added whereby you can specify different start and end times for a particular date only. This option can be used to specify a one-off change of hours on a particular day or to record bank holidays and/or annual holidays. The custom dates, therefore, are the exception to the normal or custom days.

Select the **Appointments/Custom Rules/Room Rules** –**Customize Days** or **Customize Dates** – from the **Maintenance** menu.

Custom Days



To Add a Rule

1) **Room** - select the room name from the drop-down list.

2) **Day** – select the first day from the drop-down list.

   All existing rule entries for that room and that day will be displayed. (If you are amending one, remove the existing rule and add it again otherwise the blocked off sections may be duplicated – see notes below.)

3) **Open** – if the room is to be open for any part of the day, click the **Open** button and enter the **Start Time** and **Closing Time.**

4) **Closed** – if the room is to be closed all day, click the **Closed** button.

   Note: A room that is closed for the day will not be displayed at all when that day is being viewed in the appointment book – only those rooms that are open for all or part of the day will be displayed. If none of the rooms are open, however, ie on a Bank Holiday, then all of the rooms will be displayed but with all appointment slots closed.

5) Click the **Add** button to add the rule.

6) Repeat for the other days.

To Remove a Rule

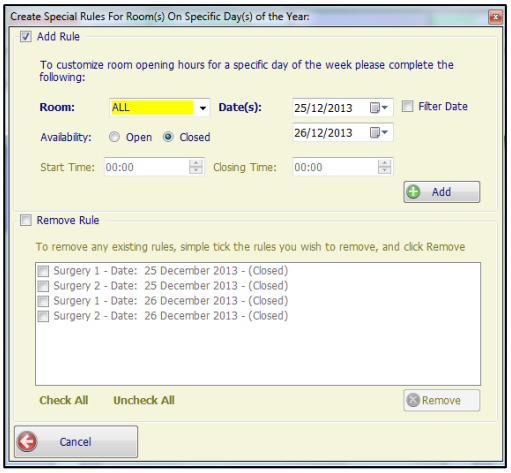
1) Display the **Customizing Days** option as above.

2) Click the **Remove Rule** box.

3) Tick the rule(s) to be removed and click the **Remove** button.

Note: Check All selects all of the custom days rules and **Uncheck All** deselects all of the custom days rules.

Custom Dates



This option works in the same way as **Customising Days** as outlined above, but has a date range selection so that you can use this for blocking off a range of dates for annual holidays, etc.

Also, there is a **Filter Date** option for the **Remove** Rule section so that you can view the current rules for the specified dates. If this box is not ticked, then all current date rules for that room will be displayed in the **Remove Rule** display box.

BLOCKING OFF EMERGENCY/MEETING/BREAK SLOTS

In addition to these standard opening times, it is possible to reserve non-appointment slots for emergency appointments, meetings, breaks and lunch times. A pattern can be set up using these options and that pattern copied forward for as many weeks as is required. The pattern can comprise of one or more weeks but it must be in multiples of one week, beginning on a Monday.

To close off slots:

- select the required day;
- right click on the start of the required slot and
- select from the following options.

Emergency Slots	• Right click the start time of the emergency slot and select **Insert Emergency Zone** from the options available. The date and time and room will be confirmed. • Type in the required length of the slot and confirm the unit of measurement (mins/hours) and click **Book**.
Meetings	• Right click the start time of the meeting and select **Insert Meeting** from the options available. The date, time and room will be confirmed. • Type in the required length of the slot and confirm the unit of measurement (mins/hours). • Type the description of the meeting in the **Description** box. • Leave the status as **Not Started** and click **Book**. (The status can be manually changed from **Not Started** to **In Progress** to **Completed** as applicable by right-clicking the slot and selecting **Edit Meeting**. Change the status and click **Update Meeting**.)
Lunch and Break Times	• Right click the start time of the break, and select **Insert Lunch** or **Insert Break** from the options available. The date and time and room will be confirmed. • Type in the required length of the slot and confirm the unit of measurement (mins/hours). • Select the user from the drop down box and click **Book**.

EDITING EMERGENCY/MEETING/BREAK SLOTS

1) Right click the slot and select the relevant **Edit** option.

2) Make the changes and click **Update**.

NOTE: These slots can be dragged and dropped to new slots if required.

REMOVING EMERGENCY/MEETING/BREAK SLOTS

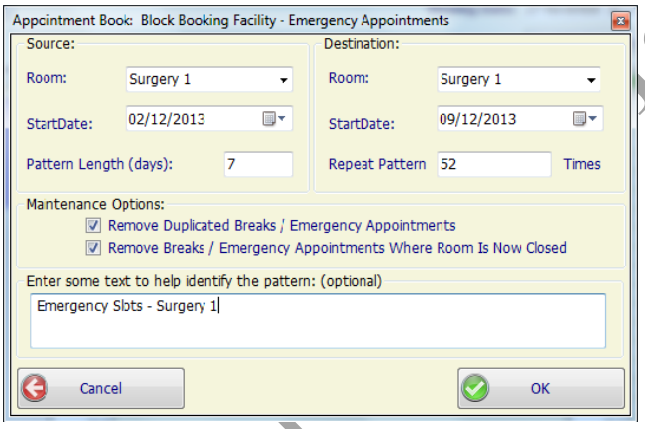
Right click the slot and select the relevant **Remove** option.

COPYING FORWARD EMERGENCY (MEETING OR BREAK) SLOT PATTERNS

1) Set up your pattern for these slots in your appointment book. Patterns should start on a Monday and be in multiples of 7 days.

2) Select the **Appointments/Block Book/Emergency Appointments** (or **Meetings** or **Break Times**) option from the **Maintenance** menu.

This screen is broken down into two sections:-



1) Source This relates to the pattern that has been set – you specify the room, the start date of the pattern and the length of the pattern in days.

2) Destination This relates to the first date that the pattern is to be copied onto – you specify the room, the first date to which the pattern is to be copied and the number of times the copy is to be repeated.

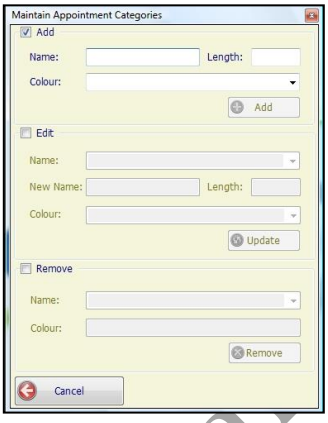
In this example, the pattern for emergency slots for room Surgery 1 has been set up for one week, starting on Monday 2nd December. As the pattern is 7 days, we are copying the pattern from the 2nd December to the following Monday, the 9th December, and repeating this 52 times.

A similar procedure can be followed to block book break, lunch and meeting times.

APPOINTMENT CATEGORIES

When you are booking appointments you must specify an appointment category. Each category has an appointment length and also has a colour linked to it . When you book an appointment, the default appointment length will be offered but you will be able to override this if required. The colour associated with that category will be displayed in a thin band on the left hand side of the appointment details.

New Categories



1) Select **Appointments/Categories** from the **Maintenance** menu. Leave the **Add** box ticked.

2) Type in a **Name** for the category.

3) Type in a default appointment **Length**.

4) Choose an associated colour from the drop down box in the **Colour** field.

5) Click the **Add** button.

NOTES:

You can select a category as the default category for your appointments which can be changed where applicable. To do this, select **System Maintenance/Application Preferences** from the **Administration** menu. Choose the default category from the drop down list on the **Appointments** tab.

Editing and Deleting Categories

Categories can be edited or deleted from the same screen - just click the **Edit** box, make the necessary changes and click **Update** or click the **Remove** box, select the category to delete in the **Name** box and click **Remove**.

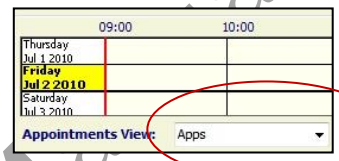
USING THE APPOINTMENT BOOK

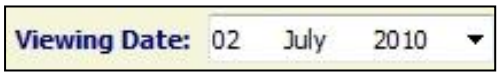
MANUALLY ENTERING APPOINTMENTS

1) Patients must be registered before appointments can be booked – either as fully registered or express registered patients.

2) Click **Appointment Book** on the toolbar or on the **Patient Detail** screen. By default, the viewing date will be today's date and only open rooms will be displayed. If you wish to view all rooms, including those that are not open on the viewing day, there is an application preference – just remove the tick. **(Administration Menu\System Maintenance\Application Preferences\Appointment Tab\Hide Closed Days)**

3) Make sure that the correct **View** is displayed and select the date in the **Viewing Date** window or use the movement bar to scroll through the book.





Today	**Display today's date**	**1d**	**Forward one day**
1d	**Back one day**	**1w**	**Forward one week**
1w	**Back one week**	**1m**	**Forward one month**
1m	**Back one month**	**3m**	**Forward three months**
3m	**Back three months**	**6m**	**Forward six months**
6m	**Back six months**		

4) Scroll through the appointment book to find a suitable appointment.

5) Double click the slot required or right click the slot and select **Enter Appointment**.

6) Specify the **Category** and confirm the length of the appointment.

7) Select the **Provider** if this isn't already displayed.

8) If you navigated to the appointment book from the **Patient Detail** screen, the patient details will already be displayed. Otherwise, click **Patient Lookup**, to search for and select the patient.

9) If it's a family appointment, click the **Family Booking** button and select which family members will be attending, otherwise leave the **Individual Patient Booking** button selected. Family bookings will display an image of two heads on the right hand side of the appointment details once the appointment has been confirmed. You can view which family members will be attending the appointment by hovering your cursor over the family booking symbol on the appointment slot.

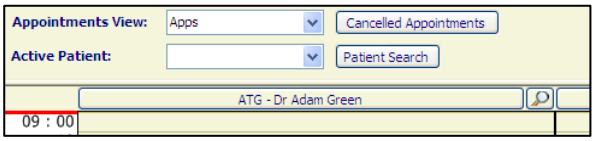
10) Type any other relevant information in the **Additional Information** box – optional. (If you enter more than one line of text, press the **Enter** key at the end of each line to ensure that this word wraps properly on the Daylist Report.)

11) Click **Book Appointment**.

NOTE: The appointment details will be displayed on the **Future Appointments** section of the **Patient Detail** screen.

SEARCHING FOR APPOINTMENTS

Quick Search



At the top of each room in the appointment book, there is a magnifying glass icon.

1) Click this to search for the first available slot in that room.

2) Specify the slot length and whether you wish to use any available emergency slots and click **OK**. This will display the earliest available slot for that room.

   - Click **Jump to Slot** if the appointment offered is acceptable.
   - If one of the other appointments on the same day is acceptable, double click that slot or single click and **Jump to Slot**.
   - Search again if all appointments for that day are unsuitable. You can click **forward one day**, **forward one week** or **forward one month**. At any relevant point, you can click **Previous** to return to a previous selection.

3) This will display the selected slot, ready for you to book the appointment.

4) Continue from item 5 on the previous page.

Appointment Finder Search

1) Click **Appointment Finder** on the toolbar or on the **Patient Detail** screen.

2) Search for and select the patient if you have clicked the toolbar. The patient details will default if you have navigated from the **Patient Detail** screen.

3) Select the room – you can only search in one room at a time.

4) Select the booking interval by one of the following methods:-

Next Available After:	**ASAP** will search for the next available appointment; Use the drop down arrow to select **Weeks** and insert a number in front to look for the first available appointment after x number of weeks. Use the drop down arrow to select **Months** and insert a number in front to look for the first available appointment after x number of months. OR
Require Appointment After:	Select a date from the calendar to look for the first available appointment after that specific date.

5) Click the box alongside the option required and specify your requirements.

6) Select the appointment length.

7) Specify the patient availability.

8) Tick the **Include Emergency Slots** box if relevant.

9) Click the **Find** button to display the first suitable, available appointment.

- Click **Book** if the appointment offered is acceptable.
- If one of the other appointments on the same day is acceptable double click that slot or single click and click **Book**.
- Search again if all appointments for that day are unsuitable. You can click **forward one day**, **forward one week** or **forward one month**. At any relevant point, you can click **Previous** to return to a previous selection.

10) When a suitable appointment has been selected, confirm the appointment:-

For a single appointment

Click on the **Further Appointment** box to remove the tick and click **Book Appointment**.

For a series of appointments

- If a further appointment is required for the same patient(s), leave the tick in the **Further Appointment** box and click **Book Appointment.**
- Remember to change the room if applicable. You can reset the date to start looking from today's date instead of from the previous appointment by clicking **Reset**.
- Remove the tick in the **Further Appointment** box before clicking **Book Appointment** for the last appointment in the series.

11) Once the last appointment has been booked, a list of the relevant appointments will be displayed for you print or to confirm to the patient.

BOOKING A TREATMENT PLAN

See notes on page 93.

EDIT OR RESIZE AN APPOINTMENT

1) Right click the appointment and select **Edit Appointment**.

2) Make the necessary changes and click **Confirm Changes**.

DOUBLE BOOK AN APPOINTMENT

1) Right click the appointment slot and select the **Double Book** option.

2) Enter the relevant details and click **Book Appointment**.

3) Both appointments will be displayed side by side.

BOOK INTO AN EMERGENCY SLOT

Patients can be booked into emergency slots if this becomes necessary.

1) Right click the emergency slot and select the **Book Appointment** option.

2) Enter the relevant details and click **Book Appointment**.

The emergency slot and the appointment will be displayed in the same way as a double booking, ie with both the original emergency slot and the appointment being displayed alongside each other.

CANCEL/CANCEL AND REBOOK AN APPOINTMENT

Right click the appointment and select:-

- **Cancel** – to cancel the booking; OR
- **Cancel and Rebook** – to cancel the existing appointment and rebook for another date and/or time. If you select this option, original appointment details will be redisplayed when you double click the new appointment slot. At the **Are you sure** prompt, click **OK** to move the appointment or **Cancel** if you change your mind and wish to leave the appointment in its original position.

Notes:

If you can see the existing and new appointment slots on the screen at the same time, you can drag the appointment from its existing position and drop it into its new position.

You can view a patient's future appointments from the **Patient Detail** screen. If you click one of these appointments, the appointment slot will be displayed in the appointment book ready for you to edit or cancel, if required.

You can view a list of cancelled appointments by clicking the **Cancelled Appointments** button on the appointment book viewer. If the patient has a future appointment, the **Future Appointment** column will be ticked. You can restore appointments, should you need to, by clicking on one of the entries and clicking the **Restore Selected** button.

ATTENDING APPOINTMENTS

Express registered patients will need to have their appointment details updated before their appointments can be marked as attended.

If you are using a waiting list, right click the appointment and select **Send to**. Select the relevant list and the patient will be added to that list and the appointment marked attended. Once attended, the colour of the appointment will change depending upon your chosen colour scheme. (The **Navigate** option when selected from the waiting list, will mark the appointment as completed.)

It is possible to manually mark appointments in the appointment book as attended, even if you choose not to use a waiting list. If you are using lists, however, this option is not normally activated otherwise someone may inadvertently mark an appointment as attended but not put the patient onto the waiting list.

If you are not using a waiting list, appointments can be marked attended and completed as follows.

Mark an Appointment Attended

Right click a slot and select **Mark Attended**.

Mark an Appointment Unattended

Right click a slot that has already been marked as attended and select **Mark Unattended**.

Mark an Appointment Completed

Right click a slot that has already been marked as attended and select **Mark Completed**.

Mark an Appointment Incomplete

Right click a slot that has already been marked as completed and select **Mark Incomplete**.

If you have marked the wrong appointment both as attended and complete, you would need to mark it as incomplete first before you would be able to mark as unattended.

PAST APPOINTMENTS

You can right click on past appointments and navigate from there to the patient's record.

TEXT REMINDERS FOR APPOINTMENTS/CANCELLATIONS

It is possible to send text reminders for appointments/cancellations. You can either manually search for reminders to be sent or schedule automatic text reminders at the point of booking an appointment – see the section on Text Reminders on page 113

LISTS

Management (to-do) lists can be set up to manage outstanding tasks for patients and/or members of staff. Certain lists are built into the system and will already be set up when the system is supplied (ie Waiting for Dentist list, Lab Management lists, etc) but you are able to configure additional lists which are appropriate for your own practice, eg Emergency Appointment Waiting list and Warning Lists.

These lists can be configured so that you can navigate from entries on the list to another part of the system for that patient. The navigation details are specified when setting up the list.

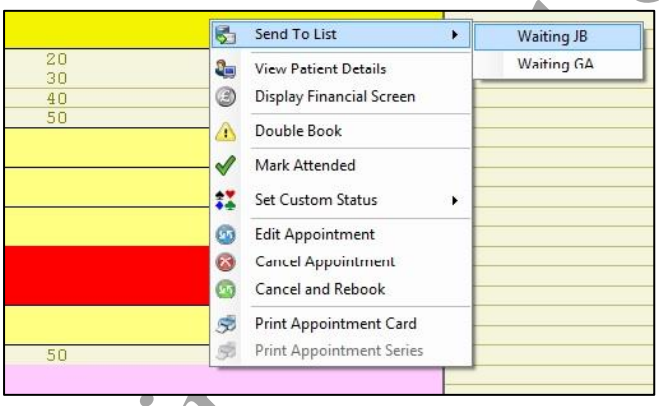
Additionally, you can choose to move or copy entries from one list to another by choosing the **Move to** or **Copy to** option from the menu options.

Management lists can be grouped together and the relevant group names (eg Reception, Consulting) will be displayed in the **List Viewer** for selection.

ADDING TO WAITING FOR DENTIST LIST FROM THE APPOINTMENT BOOK

Names are added to this list from the appointment book by sending the patients' details, as they arrive, to the **Waiting for Dentist** list.

1) Right click the appointment slot and select **Send to List**.



2) This will display all lists that have the **Appointment Book** option selected in the **Receive From** box in **Step 2** on the **List Generation Wizard**. Click the relevant list to add the patient to the list.

3) This option also updates the status of the appointment to be **Attended** and the colour of the appointment will be changed to the relevant colour for attended patients.

SELECTING FROM WAITING FOR DENTIST LIST

1) Click **List Viewer** on the **Dental System Toolbar**

2) Click on the relevant list in the **List Viewer.**

3) Right click on the list entry for the relevant patient and click **Navigate**.

4) Click either **Patient Details Screen** or **Work Screen** as required.

5) You will be navigated to your selected **Navigate** option and the patient's name will be deleted from the waiting list.

NOTES

- If you wish to view the patient's record without selecting them and removing them from the waiting list, right click and select the **Open Screen** option.
- You can manually add patients to the list:-
  a) in the **List Viewer** by selecting the list, clicking **Add Patient to List** and searching for and selecting the patient.
  b) from the **Patient Details Screen** by clicking the **Lists** link, clicking on the relevant list and clicking **Add Patient to Selected List**.

CUSTOMISED LISTS

In addition to the management lists that are built into the system, customised lists can be created. Navigation and movement between lists can be set up in the same way as the standard lists. Individual entries can be configured to be deleted once navigation has taken place.

- Warning lists can be set up so that when you view a patient's record or book an appointment for a patient, a warning can be displayed – either a general warning that the patient is on a list or a more specific customised warning message which can be typed in when the patient is added to the list.
- You could maintain a list of patient's who have a future appointment booked but who would be willing to attend at short notice if a cancellation arises.
- The lists can also be used as message boards for individual staff members, perhaps between part time reception staff.

These are just several examples of how these lists can be utilised to monitor procedures and improve communications but there are bound to be many more uses more specific to individual practices.

CREATING A NEW LIST

1) Select **Lists** from the **Maintenance Menu** to display the **List Configuration Wizard**.

2) Lists are allocated to groups to make them easier to manage.

- To add a new list to an existing group, click on the group in the **List Groups** box.
- To add a new group, type the group name in the **Group Name** box (to the right of the **List Groups** box) and click **Add**
- To delete a group, click the group name and click **Remove**. Any existing lists assigned to that group would need to be deleted before the group is removed.

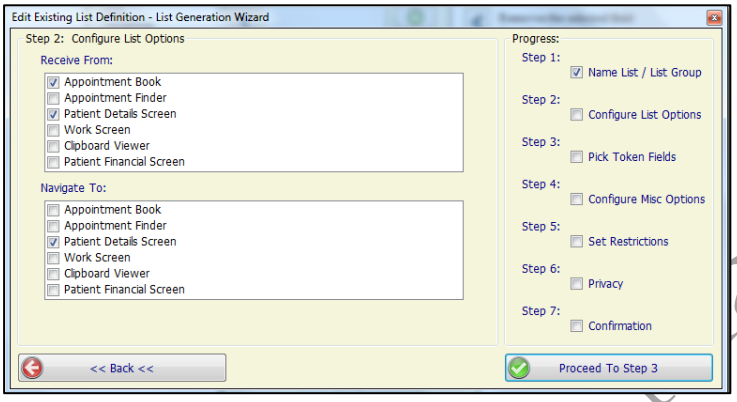
3) To view the configuration of an existing list, click the relevant group and select the list in the **Name** box. The configuration can be edited and saved at this point.

Step 1 – Choose Group Name

1) The selected group will already be displayed in the **Group Name** box. This can still be changed at this stage by clicking the drop down arrow and selecting a different group.

2) Type the name of the list in the **List Name** box and click **Proceed to Step 2**.

Step 2 – Configure List Options



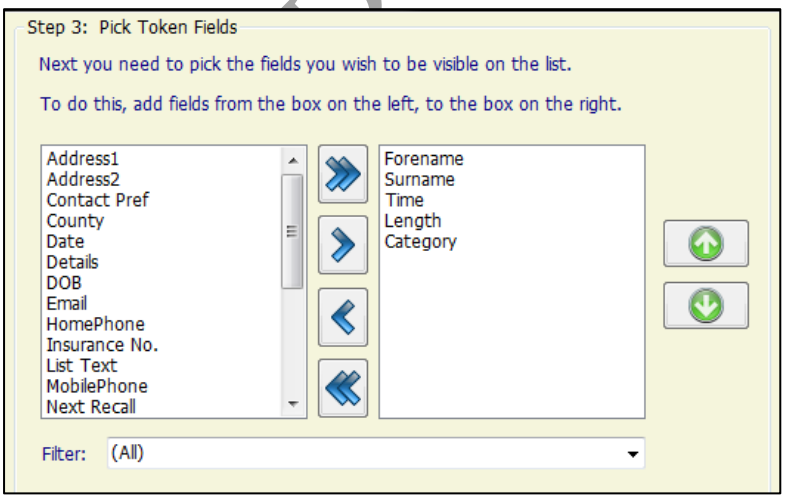
1) **Receive From:** Click the option(s) from which you want to add patients to the list.

2) **Navigate To:** Click the option(s) to which you want to navigate from the list.

3) Click **Proceed to Step 3.**

Step 3 – Pick Token Fields

1) This step allows you to select what patient information will be displayed on your list. The box on the left-hand side displays all available fields and the box on the right-hand side identifies the fields that will be displayed on the list. To move or remove an individual display field, select a field and press one of the movement keys.




Moves all fields to the display box


Moves the selected field to the display box

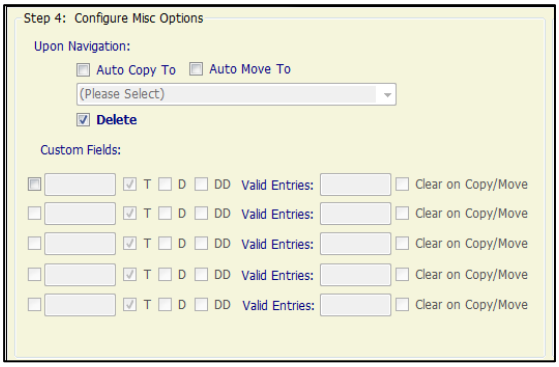

Removes the selected field from the display box


Removes all selected fields from the display box.

2) Once the required fields are in the display box, use the **Up** and **Down** buttons to select the required order. The order that the fields appear in the show box is the order that the data will appear on the list.

3) Click **Proceed to Step 4**.

Step 4 – Configure Misc Options



Upon Navigation

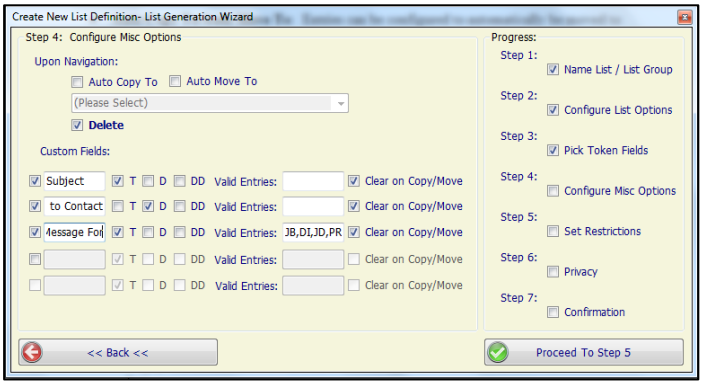
- **Auto Copy To/Auto Move To**: Entries can be configured to automatically be moved or copied to other existing lists upon navigation.
- **Delete** – automatically removes the entry from the list if the **Navigate** option is selected.

Custom Fields

It is possible to create up to 5 user-defined (custom) fields to appear on a list. To do so:

1) Click the first available custom field to activate it and type the name of the field into the text entry box to the right of the tick box.
2) You can define the format of the field as:
   a) An alphanumeric text field;
   b) A date field; or
   c) A drop-down selection box using pre-defined choices.
      - If you wish to type free text into the field, tick the (T) box.
      - To format the field for date entry, tick the (D) box.
      - If you wish to create a drop down list of available entries for this field, tick the (DD) box and type the valid entries into the **Valid Entries** box, separated by a comma and with no space before or after the comma.

        (See example below.)



Clear on Copy/Move

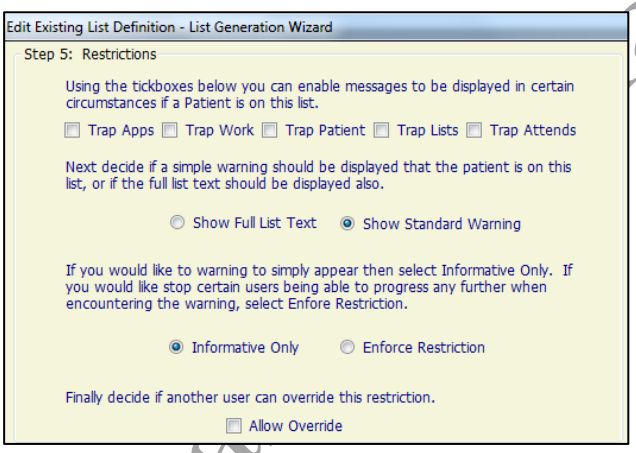
If you wish to copy or move an entry from one list to another including the customised data, then you must ensure that a data field with the same label exists in exactly the same position on each relevant list.

If you wish to copy or move an entry from one list to another but excluding any customised data, then tick the **Clear on Copy/Move box** alongside the relevant custom field**.**

3) Click **Proceed to Step 5.**

(See page 50 for instructions on entering data into defined data fields.)

Step 5 - Restrictions



You can set up a list to apply restrictions to a client's account whereby you can either display a message when the following options are selected (or apply restrictions to prevent these options from being selected) for each patient added to the list.

Restricted Actions:-

This action can be triggered when any of the following options are selected:-

Trap Apps	Appointment Booking Details
Trap Work	Work Entry Screen
Trap Patient	Client Details Screen
Trap Lists	List Entry
Trap Attends	Attending Appointments

Warning Options:

- **Show Full List Text** – If this option is selected, the list detail text will be displayed as a message on the screen.
- **Show Standard Warning** – Select this option if you wish just to be prompted that the patient is on the list.

Required Actions:

- **Information Only –** Select this option if you just wish the warning options to be displayed with no restrictions.
- **Enforce Restriction –** Select this option if you wish to prevent the user from continuing with any of the specified actions.
- **Allow Override** – If this option is selected, certain users will be allowed to override the restriction. Individual users should be given permission (**Administration Menu – Manage Groups/Users/User Preferences**) to do so.

EDITING LISTS

1) Select **Lists** from the **Maintenance Menu** to display the **List Configuration Wizard**.
2) Click the list that you wish to edit and click **Edit** alongside the **Lists** box
3) Proceed through each step and make the necessary alterations where required.

DELETING LISTS/GROUPS

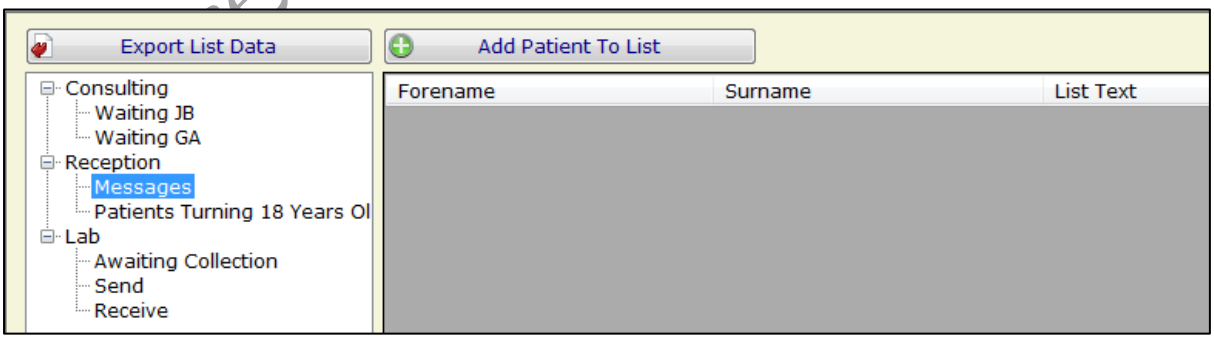
1) Select **Lists** from the **Maintenance Menu** to display the **List Configuration Wizard**.
2) Click the list that you wish to delete and click **Remove** alongside the **Lists** box**.**
3) When all lists have been deleted from a group, you can click the group that you wish to delete and click **Remove** alongside the **List Groups** box.

ADDING PATIENTS TO LISTS

Patients can be added to lists in one of three ways:-

a) From the List Viewer;
b) From the Patient Details Screen; or
c) From the Session Finalisation Screen when adding work.

From the List Viewer



1) Select **List Viewer** from the dental system toolbar.

2) Click **Add Patient to List** and search for and select the patient**.** This will add the patient to the list.

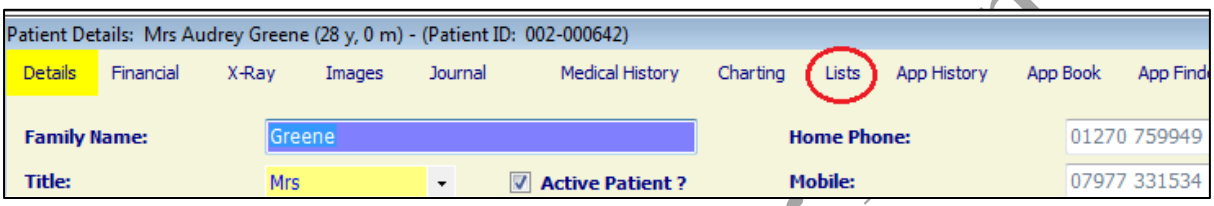
3) If you have added the **List Text** field to your list, or created any custom fields, right click the entry and select **View/Edit Details**. This will allow you to update any fields that you wish.

4) **Emergency** – click this box if the entry is an emergency. This will highlight the list entry in red.

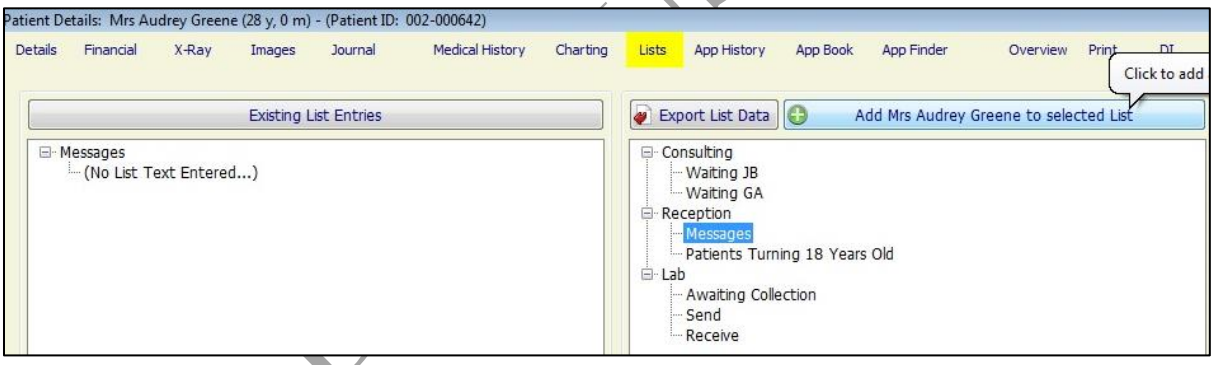
5) Click **OK**.

From the Patient Details Screen

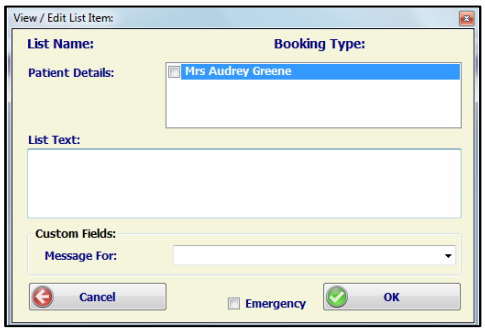
1) Display the patient's record and click the **Lists** link at the top of the screen.



2) Select a list and click the **Click to Add** button on the right hand side of the **Lists** screen to add the patient to the list. The entry will be displayed on the **Existing List Entries** section on the left hand side of the **Lists** screen.



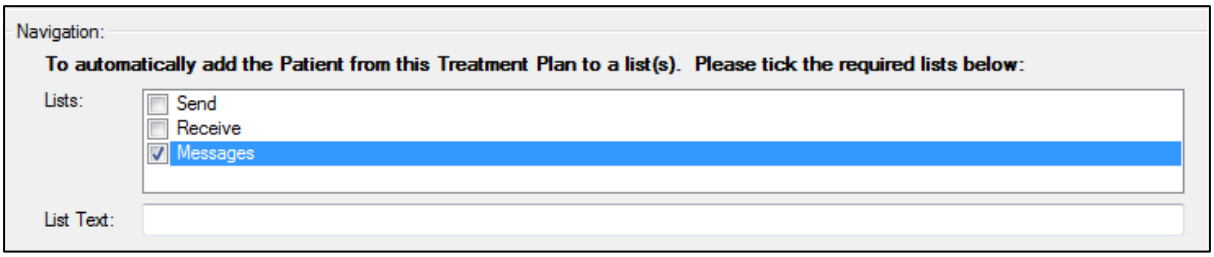
3) If you wish to update list text or any custom fields, right-click and select **View/Edit Details**.



From the Session Finalisation Screen

NOTE: Only lists that have **Work Screen** ticked in the **Receive From** box in **Step 2** in the **List Navigation Wizard** will be displayed for selection.

1) On the **Session Finalisation Screen**, in the **Navigation** section, click a list to add that patient to the list.



2) If you wish to add list text, type this in the **List Text** box.

3) When you click **OK** on this screen, the patient will be added to the selected list.

4) If there are custom fields on the list, these will need to be updated from the list viewer or patient details screen (see previous page).

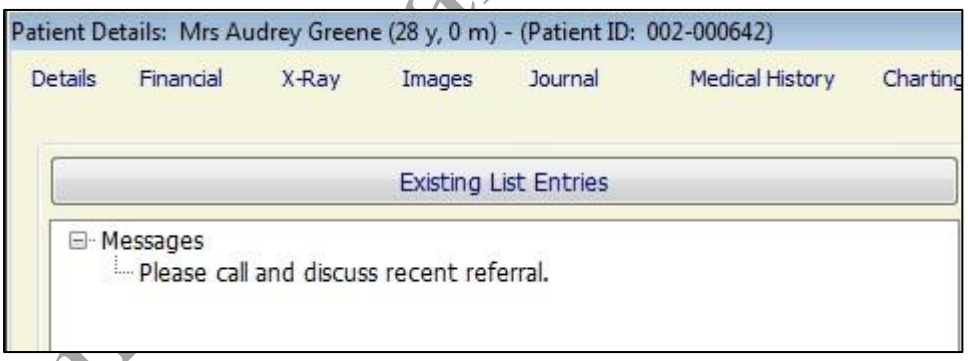
VIEWING LIST ENTRIES

From the List Viewer

Click the **List Viewer** link on the Dental System toolbar and click on the required list. This view displays all entries on a list.

From the Client Screen

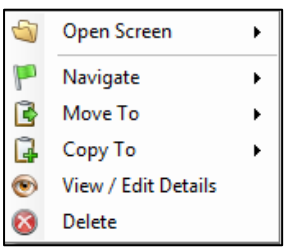
Display the **Patient Details** screen and click the **List** link. This will display the lists to which that patient has been added on the left hand side of the screen.



The same right click menu options are available from this screen as from entries in the List Viewer – see below.

LIST MENU OPTIONS

Right click on a list entry and the following options are available:



Open Screen – Select this option to move to either the Patient Details screen, Appointment Book, Appointment Finder and Work Screen for that patient without affecting the list entry in any way.

Navigate – This option also allows you to move to selected screens for that patient but, depending upon how the list is configured in Step

4 of the **List Configuration Wizard**, this may affect the list entry – ie **Auto Copy To**, **Auto Move To** and **Delete**.

Move To – Select this option to manually move an entry from one list to another.

Copy To – Select this option to copy an entry to another list, leaving the original entry in place.

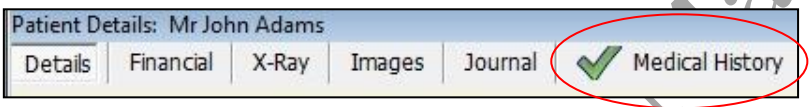
View Edit Details – Select this option to amend any of the details on the list entry, eg to add list text or update custom fields.

Delete – Select this option to delete an entry from the list.

MEDICAL HISTORY

The medical history questionnaire is user-definable. You are able to specify whether a question is critical and whether you require additional information to be recorded for a particular condition. Once this has been configured, medical history can be entered from the patient details screen. If the patient answers **Yes** to a critical condition then, once saved, a warning will be displayed when you next view the patient details.

- If the medical history has been entered but with nothing abnormal detected, a green tick will be displayed on the **Medical History** tab.



- If the patient has answered **Yes** to at least one question but no critical condition has been recorded, a blue tick will be displayed on the **Medical History** tab.
- If medical history has never been entered for this patient, then no symbol will be displayed on the **Medical History** tab.

MEDICAL HISTORY QUESTIONNAIRE

Questions can be broken down into two sections – main question and sub items , eg:-

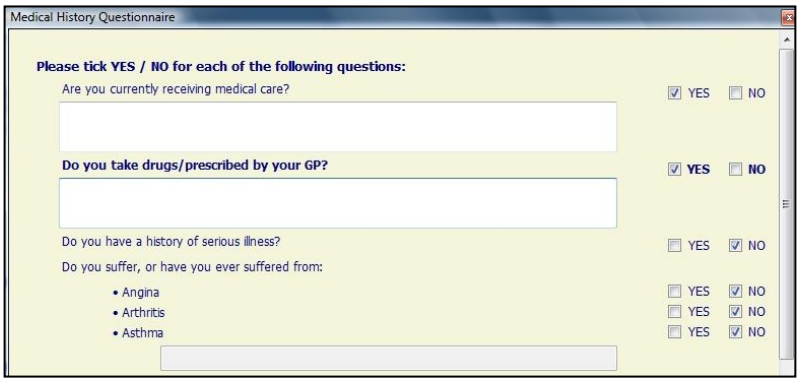
EXAMPLE 1

Main Question only Are you currently receiving medical care?

EXAMPLE 2

Main Question Entry Do you suffer, or have you ever suffered, from any of the following:-

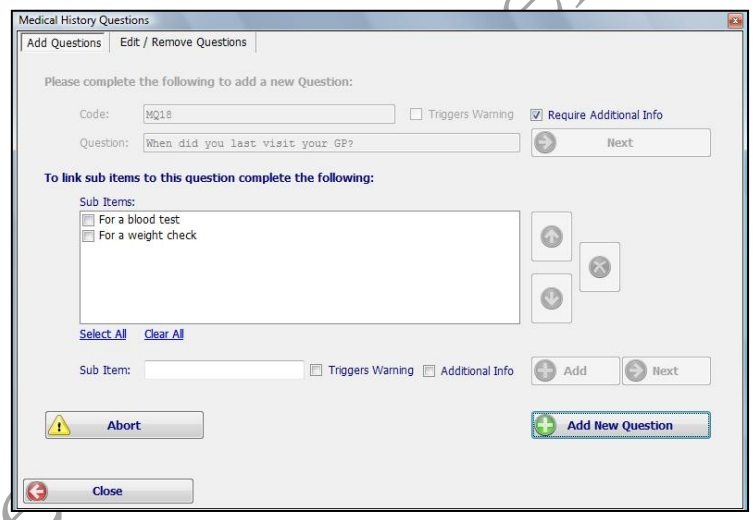
Sub Item Entries Angina?
Arthritis?
Asthma?



When entering medical history, main sections with no sub sections will have the **Yes/No** boxes alongside the main question. If sub sections are included, the **Yes/No** box will only appear alongside the sub questions.

To Create your Questions:-

1) Select **Medical History** from the **Maintenance** menu.
2) Make sure that the **Add Question** tab is selected.
3) Each question should be allocated a code – ie MQ1, MQ2, etc. Type the code for the first question in the **Code** box (you will be able to sort the questions into a different order once they have been created).
4) Tick the **Trigger Critical Warning** and **Require Additional Info** where appropriate.
5) Type the text for the question in the **Question** box and click the **Next** button.
6) The cursor will then move to the sub section. If this section is irrelevant, click the **Next** button and click the **Add New Question** button.
7) To add a sub section to a main section, click on the small sub section box and type in the text, tick the **Trigger Warning** box if applicable, and click **Add.** Continue adding sub section text until all entries relevant have been made and then click **Next**.



8) Click **Add New Question** to save the entry.
9) You can then continue to add entries to the main and sub sections as outlined above. The sub items can be resorted by clicking on the item to be resorted and clicking the up or down arrows accordingly.
10) When you have completed all of the entries, click **Close**.

To Edit or Delete Questions

1) Select **Medical History** from the **Maintenance** menu and click the **Edit/Remove Questions** tab. The top section of the screen displays the main questions and the lower half of the screen displays the sub items – where relevant.
2) Click on the question to be edited or deleted. If there are sub items for the selected question, they will be displayed in the lower display box.

3) To delete the question (together with any sub sections) click the **Delete** button alongside the relevant question. 

4) To delete a sub item, click the item to be deleted and click the **Delete** button alongside the relevant sub section.

5) To edit a question, click the question and edit the text in the **Edit selected question** box and click the **Update** button.

6) To edit a sub item, click the sub item and edit the text in the **Edit selected sub item** box and click the **Update** button.

To Add a New Sub Item to an Existing Question

1) Select **Medical History** from the **Maintenance** menu and click the **Edit/Remove Questions** tab.

2) Click on the relevant main question.

3) Type the text for the new sub item into the **Add New Sub Item** box and click the **Add** button.

4) This will be added to the bottom of the list. You can re-sort by clicking the item and clicking the relevant up/down buttons.

5) When the medical history questionnaire is complete, click the **Close** button.

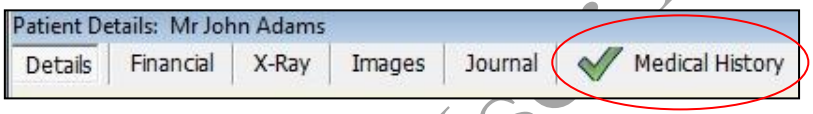
RECORDING MEDICAL HISTORY

The medical history questionnaire is user-definable. You are able to specify whether a question is critical and whether you require additional information to be recorded for a particular condition. Once this has been configured, medical history can be entered from the **Patient Details** screen.

MEDICAL HISTORY ALERTS

If the patient answers **Yes** to a critical condition then, once saved, a warning will be displayed when you next view the patient details.

- If the medical history has been entered but with nothing abnormal detected, a green tick will be displayed on the **Medical History** tab.

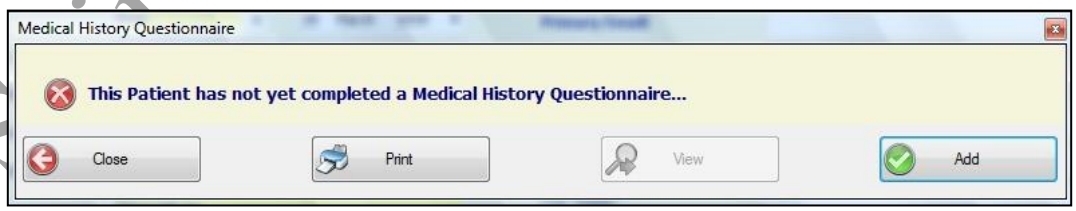


- If the patient has answered **Yes** to at least one question but no critical condition has been recorded, a blue tick will be displayed on the **Medical History** tab.
- If the medical history has never been entered for this patient, then no symbol will be displayed on the **Medical History** tab.

RECORDING MEDICAL HISTORY

Medical history can be viewed, added or edited either from the **Patient Details** screen or from the **Charting** screen.

1) To record medical history for the first time, click the **Medical History** tab on the **Patient Details** or **Charting** screen. The following **Options** screen will be displayed. The **View** option will be disabled until there is medical history to view.



2) Click the **Add button**.

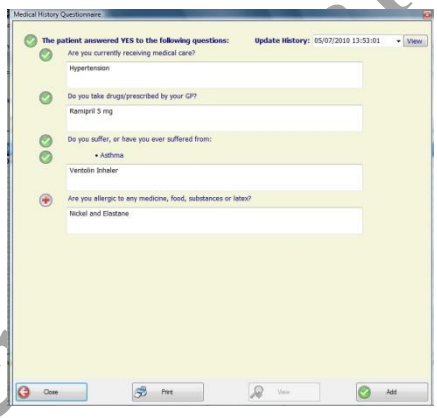
- If you have accessed medical history from the **Patient Details** screen, you will be asked to confirm your user details. Select your name from the drop-down list and click **Confirm**.
- If you have accessed medical history from the charting screen, the user will default to the user entering the work.

3) Complete the questionnaire – the information boxes will not become active unless you first click the **Yes** box. When complete, click the **Add** button.

- Click **View** to view a summary of the medical history – see overleaf.
- Click **Add** to add more history.
- Click **Print** to print a blank or completed questionnaire (see page 58).
- Click **Close** to close the screen.

Note: A user permission exists to allow users to view or edit medical history.

VIEWING PREVIOUS MEDICAL HISTORY

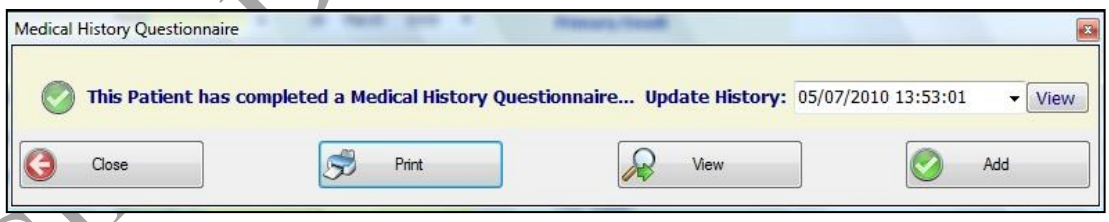


If you access medical history after previous entries have been saved, the same prompts will appear as when you first added medical history, except that now the **View** option will be enabled. If you select this option, the summary screen will be displayed. Each time that an addition or an amendment is recorded in the medical history, the time and date of the changes are recorded and displayed at the top of the summary screen. The **Update History** field always displays the date and time of the most recent changes.

You can view these changes from the medical history summary screen by selecting the relevant date from the **Update History** field and clicking the **View button**. Changes are also stored in the patient's journal, although not displayed by default. If you wish to display medical history changes in the patient's journal, click the **Exclude Medical History** box to remove the tick**.**

TO UPDATE MEDICAL HISTORY

1) To update the history once it has been saved, click the **Medical History** tab and the following options screen will be displayed.



2) Click the **Add** button and, if prompted to confirm the user, select your name from the drop-down list and click **Confirm**.

3) Make the changes and click the **Add** button.

4) The **Update History** field will be updated with the current date and time.

Notes:

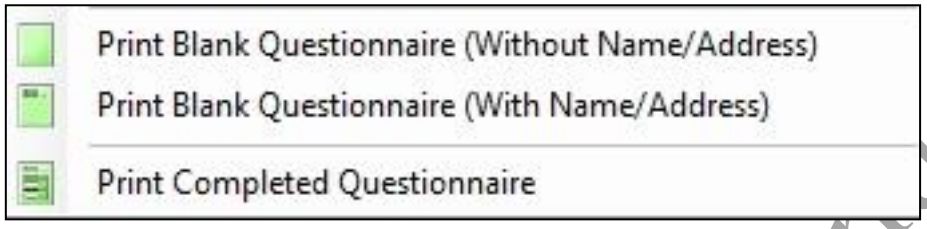
- If you click the **Add** button without making any changes, the date and time will be recorded but, if you view these changes, a message will be displayed that no medical history changes were recorded during this update.

- The **Update History** field will not be updated if you click the **Close** button.

PRINTING MEDICAL HISTORY

1) When you click the **Medical History** tab, either from **Patient Details** screen or the **Charting** screen, you will be offered the following options to print a medical history questionnaire.

2) Select the relevant option from the **Print** menu.



CHARTING/WORK ENTRY NOTES

The work entry screen can be accessed from:-

1) the **Treatment Plan** option on the dental system toolbar;
2) the **Work** or **Charting** tab on the patient record; or
3) your **Dentist Waiting List**.

NOTE: If you are using **Lists**, you can configure your lists to allow you to navigate from an entry on a list either to the patient record or directly to the work entry screen. You can right-click any entry on a list and select the relevant navigate option.

TREATMENT PLAN SESSION SELECTION SCREEN

The first screen displayed is the **Treatment Plan Session Selection** screen.

If you have accessed this option directly from the dental system toolbar, the Patient Search screen will be displayed ready for you to search for and select the relevant patient.

Base Chart

If this is the first time that you have seen this patient, then the **Base Chart** option will be selected by default ready for you to chart dental history.

Start New Plan

If there is already a base chart but no open course of treatment for this patient, then the **Start New Plan** option will be selected by default.

Edit Existing Plan

If there is already a course of treatment open, then the **Edit Existing Plan** option will be selected by default. You can overwrite the default option if required.

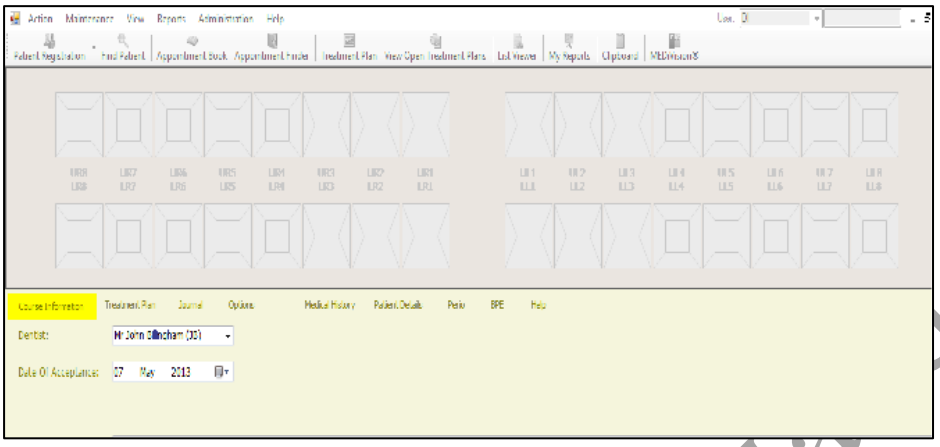
You can, of course, overwrite the default options where necessary.

Any existing journal entries will be displayed in the **Journal** box.

Continue

Select your required **Treatment Plan Session** option and click the **Continue** button and the **Course Information** tab will be displayed, ready for completion.

COURSE INFORMATION TAB – BASE CHART



1) **Dentist** - The patient's default dentist will be selected. This can be changed if required by selecting an alternative dentist from the drop-down list.

2) **Date of Acceptance** – This is the date that will be recorded against the course history.

3) **Journal Entry** – Again, any existing journal entries will be displayed. You can record a new entry in the patient's journal at this stage in the **Journal Entry** box – type in free text - with word-wrap facility.

   JOURNAL NOTES:

   - As you complete work, an entry will be automatically written to the patient's treatment journal. Manual notes can also be added and images linked. These entries will be date and time stamped.
   - For speed of display, only the last 12 months will be displayed by default. You can remove this filter by clicking on the filter box beneath the journal display to remove the tick.
   - Courses are separated by a horizontal line.
   - The journal can be further filtered, by course, by specifying the course required from the **Filter Journal by Course** box.

4) **NHS Exemption and Max Charge** – Not applicable at this stage.

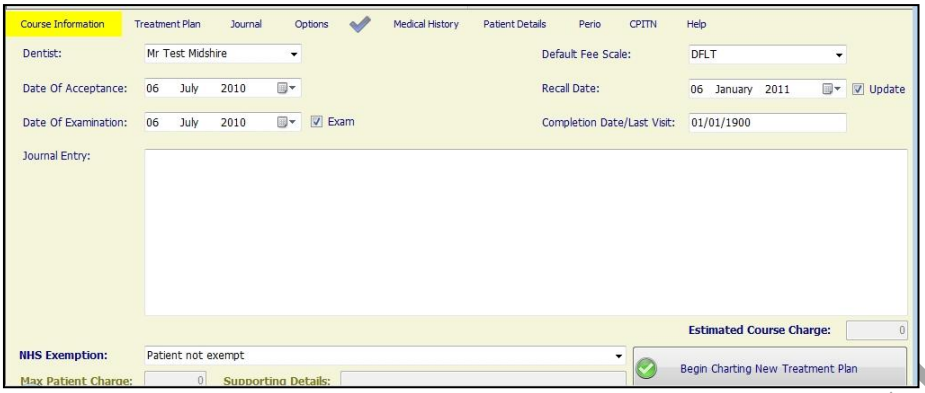
5) Click **Begin Base Charting Session**.

The **Options** tab will be selected ready for you to begin charting the patient's dental history. (See page 64 for charting instructions.)

6) When the base chart is complete, click either:-

   - **Save and Exit** if you are just charting the base chart and not continuing to chart a new course of treatment; or
   - **Save and Start New Treatment Plan** if you wish to chart a new course of treatment.

COURSE INFORMATION TAB – START NEW PLAN



1) **Dentist** – Select the dentist carrying out the work for this visit from the drop-down list. This will default to the **Default Dentist** specified on the patient details screen, but can be changed if applicable.

2) **Default Fee Scale** – Displays the default fee scale that has been recorded on the patient record. It can be changed if applicable.

3) **Date of Acceptance/Date of Examination** – Displays today's date by default but can be changed if applicable.

4) **Exam -** This box will be ticked by default. If it is left ticked, an examination will be added to the work entry screen. If you remove the tick (by clicking on the box) an examination will not be added to the work entry screen.

5) **Recall Date** - Each time that you start a new course of treatment **after** the patient's current recall date, the recall date will be updated as per the **Interval** specified on the **Patient Details** screen. In these circumstances this new recall date will be displayed on this screen, which can be edited manually if required.

   Each time that you start a new course of treatment **before** the patient's current recall date, then the recall date will not be automatically updated and the current recall date will be displayed on this screen. In these circumstances, however, there will be an **Update** box available that you can tick to manually update the recall date if required. The recall date can also be edited manually at this stage if required.

   Notes:

   - It is possible to specify that you wish your recalls to update based upon the completion date of a course. In these circumstances, the date will still roll on when you start a course of treatment, but it will be updated again when you complete the course. As you complete a course of treatment, this final recall date will be displayed for acceptance. This new date can be edited manually at this stage.
   - The recall date can be edited manually at any stage from the **Patient Details** screen.

6) **Estimated Charge** – This field will be updated as pending work is added to the treatment plan.

7) **NHS Exemption/Max Charge -** These fields are not applicable unless the fee scale is set to NHS. For an NHS course, these fields will display whatever is stored on the

patient details screen. They can be edited, however, if necessary. The maximum charge will only become active if a partial exemption code has been entered.

8) Click **Begin Charting New Treatment Plan**. This will display the **Treatment Plan** tab, ready for you to begin the course. (See page 64 for charting instructions.)

TREATMENT PLAN TAB

From the **Treatment Plan** tab, you can:

- Add a Treatment Plan to generate an estimate of planned work, either by using the Charting Module to chart where applicable and to record what work has been carried out per course - or by using the Billing Module to record only what work has been carried out.
- Sort your planned treatment per course into the order in which you plan to carry out the work and, optionally, add visit headers to the plan to enable this to be used to book future appointments. (If you choose not to add visit headers, it is possible, on the **Finalisation Screen**, to type in manually the future appointment requirements which can be accessed by reception on the **Account Overview** screen.)
- Mark when the work is complete and generate an invoice – either one invoice per visit or one invoice per course.

The following links are also accessible from the **Treatment Plan** tab.

- BPE Charts (see notes on page 73)
- Perio Charts (see notes on page 74)
- Journal (see notes on page 80)
- Medical History (see notes on page 79)
- Patient Details (see notes on page 80)

Examination

If the **Exam** box has been left ticked on the **Treatment Course Details** screen, then an examination will be added to the pending work screen by default.

Depending upon how your .XM work code for examinations has been configured when adding your fees, this may be for a specific fee, in which case the full fee code and the relevant charge will be displayed automatically.

If, however, you have specified that you wish to choose which examination fee is to be charged, rather than to default to a specific fee, then you will be prompted to choose which fee is to be charged. Select the relevant fee from the drop down list provided. and click the **Update** button.

Note:

If you add an examination by mistake, this can be removed by selecting the treatment line, right clicking and selecting **Remove Selected Line.** If you have auto completed the exam, you will have to mark it pending before this option is offered.

COURSE INFORMATION TAB - EDIT EXISTING PLAN

1) If there is a pending course of treatment for the patient, on the **Treatment Plan Session Selection** screen, **Edit Existing Plan** will be highlighted – defaulting to the most recent open course of treatment.

2) Click **Continue** to continue with the outstanding treatment.

3) Before the **Treatment Plan** tab is displayed, you will be prompted to confirm which dentist is carrying out the treatment on this visit.

NOTE: You can choose to edit a previous course by selecting the relevant course from the drop-down box or choose to start a new course by clicking the **Start New Plan** button.

4) Previous journal entries will be displayed on the journal display screen.

5) Click **Continue**. This will display the **Treatment Plan** tab, ready for you to continue adding work. (See page 64 for charting instructions.)

From this screen, you can:-

- produce and print an estimate for pending work and subsequently mark this work as completed as the work is carried out; and/or

  Note: If any one item of treatment is NHS, then the estimate layout will default to an NHS layout where costs are broken down into NHS and Private. If the treatment is purely private, then a private estimate layout will be automatically used. Both of these layouts can be customised.
- configure a treatment plan that can be used to book appointments.

As work is completed, the system will generate a charge to the patient, invoices can be printed, payments recorded and receipts printed. An aged debt report is maintained and statements can be sent to patients who have accounts outstanding.

CHARTING

MATERIALS AND COLOURS

Materials and Colours on Base Charts

Materials can be assigned to base chart entries and colours linked to materials so that base charting options are displayed in that colour to easily distinguish different types of fillings, crowns, etc.

Materials and Colours on Subsequent Courses of Treatment

Materials and colours are assigned to items charted on subsequent courses of treatment by linking a material/colour on a particular fee code. Once the materials table has been configured for base charts, then these materials and colours will be available for selection when adding or editing fee codes.

TOOTH NUMBERING

You can choose to number the teeth in one of two methods:-

1) Palmer Tooth Notation, eg UR1, UR2.
2) FDI Tooth Notation, eg 11, 12.

Select the **Treatment Plan** tab from the **Administration** menu/**System Maintenance/ Application Preferences** to save your preferred notation method.

Supernumerary Teeth

On the **Base Chart**, you can select to display up to 4 supernumerary teeth.

Supernumerary: 1 adds UR9 to the chart
2 adds UL9 to the chart
3 adds LR9 to the chart
4 adds LL9 to the chart

TOOTH SELECTION

There is an option that allows you to specify which tooth will be selected by default when a chart is displayed (**Administration** menu/**User Accounts**/**User Preferences**/**Charting** tab). Subsequent teeth can then be selected either by using the keyboard or by clicking with the mouse.

Keyboard Selection

Use the arrow keys on the keyboard to move between teeth.

Mouse Selection

Click with the left mouse button to select the required tooth.

CHARTING OPTIONS

The following options are available for charting:

Display Only Options

OPTION	DISPLAY
Distal/Mesial Movement and Distal/Mesial Rotation	An arrow will be displayed indicating the direction of the movement, the length of which will vary according to the distance entered on the Movement Distance prompt (measurement 1-4). An arrow will be displayed indicating the direction of the rotation.
Un-erupted/Part-erupted and	Each time that you hit the letter E, the display toggles between these 3 status levels.

Fully-erupted	
Fracture	The letters FR will be displayed above upper teeth and below lower teeth.
Root Present	Shades the tooth in yellow.
Watch	Puts a coloured border around the tooth. Displays a text box so that you can record the reason for watching the tooth (optional). Click the tick symbol to save the text entry. Click the cross to cancel.
Toggle Permanent/ Deciduous	Toggles between permanent/deciduous tooth notation. Any treatment recorded against a deciduous tooth will be removed from the display of the permanent tooth but you will still be able to view the history of the deciduous tooth in a previous course.
Missing Tooth	Generally used to indicate a tooth is missing on the base chart. This removes the tooth from the chart. It will allow you to add an artificial tooth at a later date.

Chargeable Options

Understanding Work Codes and Fee Codes

If you are charting on a base chart, this will record the status of the tooth as it was before you carried out any treatment at the practice and, therefore, no fee code is required.

Before charting chargeable treatment on a pending course, however, it is necessary to understand the relationship between **Fee Scales**, **Work Codes** and **Fee Codes.**

You can have as many fee scales as you wish and these should have been set up before you start charting. Fee codes can exist in more than one fee scale with a different price in each scale. The fee scale that is appropriate for each patient is saved on the patient details screen and this is the fee scale that will default for each new course of treatment. It is possible, however, to enter treatment from mixed fee scales if this is appropriate.

Fee scales comprise of **WORK CODES** that are linked to **FEE CODES**, ie fee codes generate the relevant charge and work codes are used to filter your fee codes for a particular type of code.

For example:

Work Code	**Linked Fee Codes**	
C - Crown	C0	Porcelain Bonded Jacket Crown
	C1	Porcelain Jacket Crown

OPTION	DISPLAY
Artificial Tooth	Displays the letter A on each artificial tooth.
Bridge Retainer	Displays the letter B on each retainer.
Crown	Displays the letter C on each crown.
Filling	Displays a filling symbol on each surface filled or to be filled. This symbol can either be round or square, depending upon your preference (User Preference).

Implant	Displays the letter I on each implant
Bridge Pontic	Displays the letter P on each pontic.
Root Canal Treatment	Displays the letters RT above upper teeth or below lower teeth.
Fissure Sealant	Displays as a filling symbol. You could display this in a specific colour by linking a material to the fee code that you would use to add a sealant.
Veneer	Displays the letter V on each veneer.
Extraction	Displays the letter X on each extracted tooth. If an artificial tooth is inserted, then this X is replaced by a letter A. **Note**: You can mark the tooth as missing if you prefer to have the tooth removed from the chart, although this option is usually only used in base charts to indicate that the tooth was already missing when the patient first attended the practice.

CHARTING METHODS

To chart on a tooth, first select the tooth and then select the required charting option.

Selecting a Tooth

The first tooth will be selected automatically which, by default, will be UR8. There is an option, however, that allows individual users to specify which tooth will be selected by default when a chart is displayed (**Administration** menu/**User Accounts**/**User Preferences**/**Charting** tab).

Subsequent teeth can then be selected either by using the keyboard or by clicking with the mouse.

Keyboard Selection

Use the arrow keys on the keyboard to move between teeth.

Mouse Selection

Click with the left mouse button to select the required tooth.

Charting Treatment

There are three methods of adding charting options to a patient's record. You can use any one, or any combination, of the following methods. **Having first selected the tooth**, you can enter the treatment required by:-

1) Using **HOT KEYS,** ie using a particular key on the keyboard to represent an item of treatment;

2) **RIGHT CLICKING** on a selected tooth and choosing an option from the charting menu; or

3) using the **TOOLBOX**.

Hot Keys

You can press the following keys to select the relevant charting option.

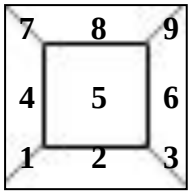
KEY PRESS	CHARTING OPTION
A	Artificial Tooth
B	Bridge Retainer
C	Crown
E	Toggles between Un-erupted/Partially Erupted and Erupted
F	Fracture
I	Implant
P	Bridge Pontic
R	Root Present
T	Root Canal Treatment
S	Fissure Sealant
V	Veneer
W	Watch
X	Extraction
1-9	Fillings (see notes below)
+	Distal Movement
–	Mesial Movement
)	Distal Rotation
(	Mesial Rotation
!	Toggle Permanent
?	Toggle Deciduous

Hot Keys for Fillings

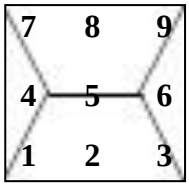
Numeric Keypad

You can use the numeric keypad to specify the filling surfaces. The system will recognise the relevant surface depending upon which tooth has been selected. For example surfaces 5 and 6 on tooth UR5 would be an MO and on UL5 would be a DO.

Pre-Molars/Molars



Incisors/Canines

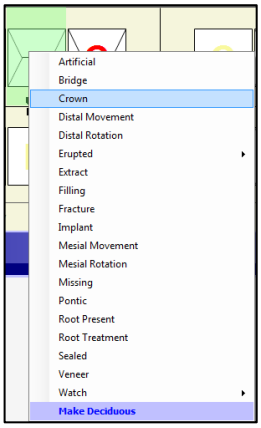


Press the relevant numeric key/s to represent the surface/s to be filled and press **Enter**.

- If you are charting a single surface filling, press the relevant number key for the surface to be treated and then press the **Enter** key. You will then be prompted for a fee code.
- If there are multiple surfaces in one filling, press the numeric keys for all of the surfaces first before pressing the **Enter** key – this will join the surfaces together, compress the treatment lines on the estimate into one line and prompt for a fee code.

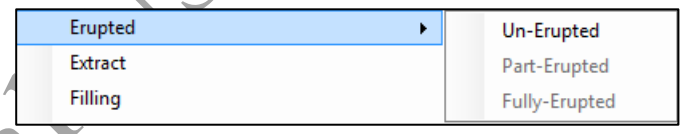
Right Click Menu

Select a tooth, right click on it and choose an option from the menu displayed.



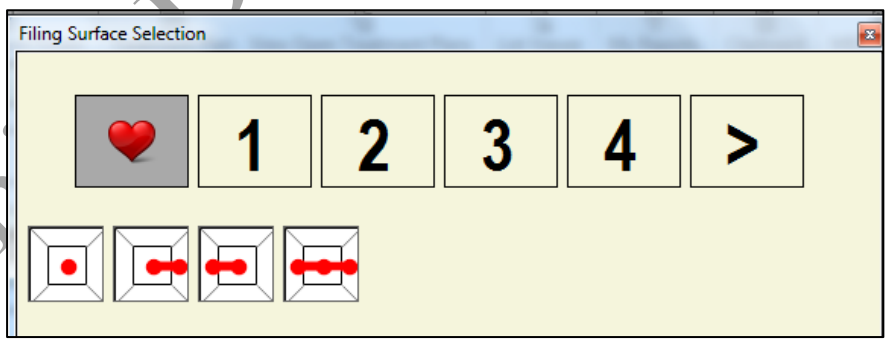
Erupted allows a toggle between un-erupted, part-erupted and fully-erupted.

Watch allows you to add a watch status to the tooth or, if it already exists, to edit, view or remove the watch status.



Right Click Filling Option

If you select the Filling option from the right click menu, you will be presented with a **display** of filling patterns from which to choose. These can be configured by yourselves to display a list of your favourite, ie the most common, options (see below).



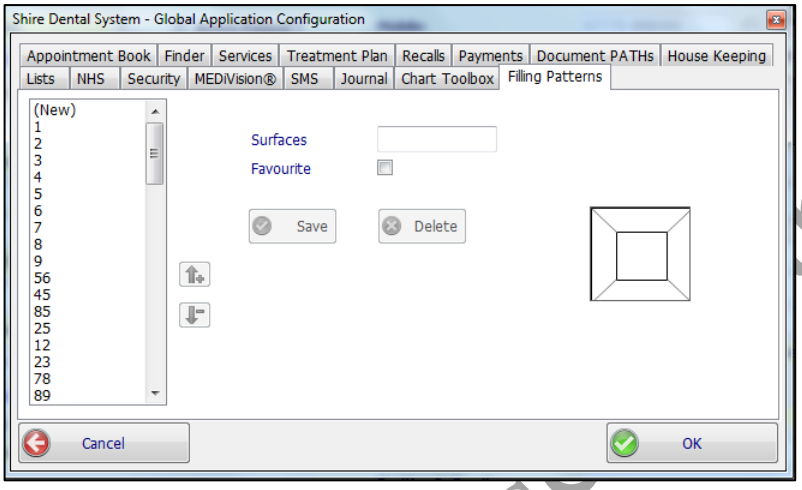
For the less common options, you can filter for the number of surfaces, ie if you click the number 1, all one-surface filling patterns will be displayed for selection. Once you have selected the filling pattern, for chargeable treatment you will be prompted for a fee code.

Note: On your fee scale, if you have specified the number of surfaces on your filling fee codes, then those codes that have a different number of surfaces saved against then to the surfaces specified on the filling pattern, will not be displayed for selection. The fee codes

that will be offered for selection are those codes that do have the same number of surfaces as specified on the filling pattern together with any of the filling fee codes where the number of surfaces is irrelevant or has not been saved at all.

To Set Up Your Favourite Filling Patterns

i) Select **Administration Menu\System Maintenance\Application Preferences** and click the **Filling Patterns** tab.



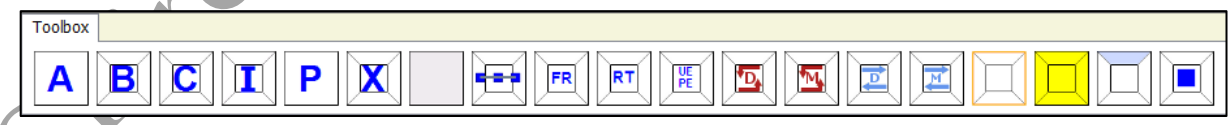
The numbers in the left-hand box relate to filling surfaces. As you click on them you will see that the relevant surfaces on the tooth image are displayed.

ii) Click on your favourite patterns and click the **Favourite** box and click **Save** for each of them.

iii) When complete, click **OK**

Toolbox

- Click the **Show Treatment Toolbox** link just below the chart.
- To add charting options from the toolbox to the chart, click on a tooth and click on an option from the toolbox. A key to the toolbox options is listed overleaf.



Note: Tool Tips, which are small windows that show descriptive text, will be displayed when you hover the pointer over one of the options on the toolbox.

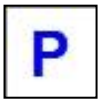
Toolbox Key – Standard Options

Artificial Tooth

Bridge Retainer

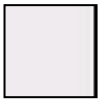
Crown

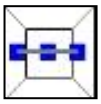
Implant



Bridge Pontic

Extraction


Missing


Filling

Fracture

Root Treatment

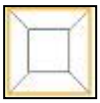
Unerupted/Part Erupted/Erupted

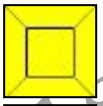
Mesial Rotation

Distal Rotation

Distal Movement

Mesial Movement


Watch


Root Present


Veneer


Sealed

Note: If you select the filling tool from the toolbox, you will be presented with a selection of filling patterns from which to choose - as with the filling option from the right click menu (see previous notes) .

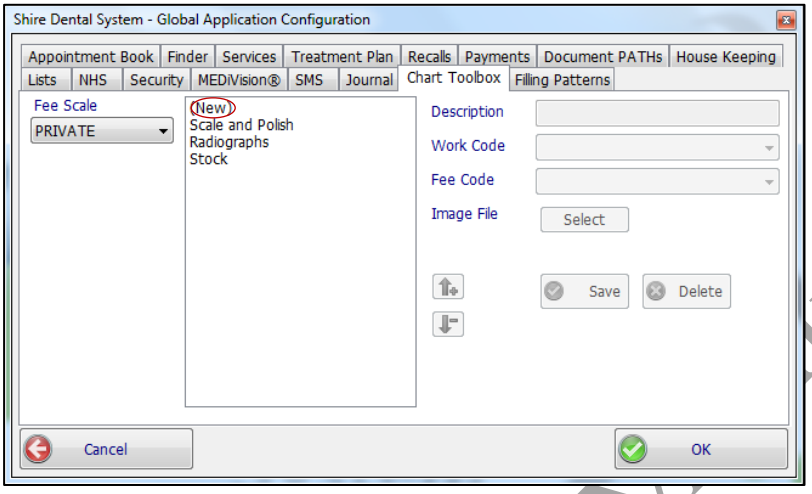
Adding Options to the Toolbox

The Toolbox can be customised per fee scale, ie you can add your own toolbar buttons that are linked to treatments that are not already included in the standard charting toolbox. This is particularly useful for adding work that is not chartable, ie Scale and Polish or Radiographs or, on an NHS fee scale, to link to Other Treatment or Other Services options. Clicking such options on the toolbox can either link you to:

- a **work code,** in which case you will be prompted to select a fee code, or to
- a specific **fee code,** whereby the fee code will be added automatically - unless there is a choice of tooth notation, in which case the treatment entry box will remain open for you to select the relevant notation before clicking **Add**.

To customise your toolbar:

1) Select **Administration Menu\System Maintenance\Application Preferences** and click the **Chart Toolbox** tab.



2) Select the **Fee Scale** and any existing customised options for that fee scale will already be displayed. To add a new one, click **New** in the description box (in the centre of the screen).

3) Type in a description and specify the work code (and fee code if applicable).

4) Click **Save**.

5) Repeat for each new option and click **OK** when complete.

Note: The button will be added to the toolbox with the work code, by default, displayed as the name of the button. You can, if you prefer, link the button to one of your own images that has been saved on your server and specify the link to the image by clicking the **Select** button and browsing for the image.

Charting on Multiple Teeth

You can use the **Ctrl** key with any of the charting options to select multiple **non-consecutive** teeth to add the same charting option to all selected teeth.

1) Select a tooth.

2) Hold down the **Ctrl** key.

3) Select a charting option.

4) Click on all of the other relevant teeth and then release the **Ctrl** key to add that option to each of the selected teeth.

You can use the **Shift** key to select a range of **consecutive** teeth to add the same charting option to all selected teeth:

1) Click on the first tooth in the sequence.

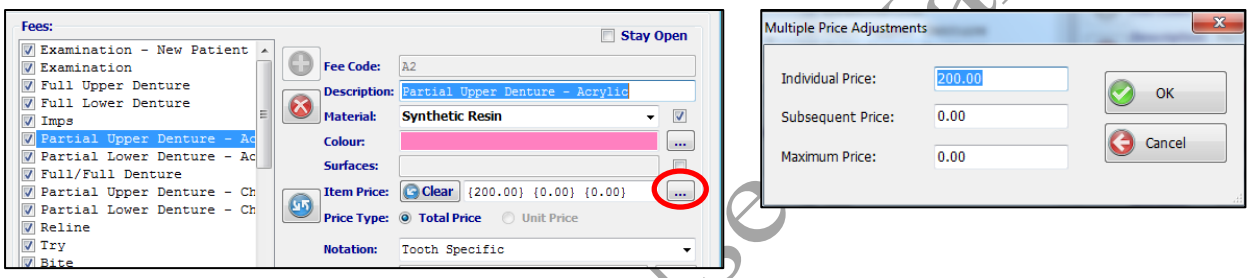
2) Hold down the **Shift** key.

3) Select a charting option.

4) Click the last tooth in the sequence and then release the **Shift** key to add that option to the first and last tooth selected and all of the teeth in between.

These options are particularly useful for extractions and dentures.

You will only be prompted once for the fee code and that fee code will be applied to all of the selected teeth. For partial/full dentures that are tooth specific, therefore, make sure that the total price is charged for the first tooth and that you have the fee code set up to charge zero on second and subsequent teeth, where applicable. It usually works better to have separate fee codes for upper and lower teeth (for NHS dentures, this is essential as they are counted separately for Part 5a).



When setting up your fee scales, the price defaults to the same price for second and subsequent teeth, but this can be changed by pressing the button outlined above and overtyping with zero. It is possible in this same option to set a maximum price for a fee code too.

Materials and Colours

On Base Charts

Materials can be assigned to base chart entries, where applicable, by selecting the material, when prompted, as you chart the treatment. Colours can be linked to materials so that base charting options are displayed in that colour to easily distinguish different types of fillings, crowns, etc.

Whereas on a base chart, materials have to be selected at the point of entry, materials and colours can be assigned to items charted on subsequent courses of treatment by linking a material/colour to a particular fee code.

The materials and colours table can be configured to your own requirements. See page 9 for more detailed instructions.

Deleting a Chart Entry

On a Base Chart, you can select a tooth and press the **Delete** key to undo the last action on that tooth. Continue pressing the **Delete** key to undo previous actions. You can also right click on the tooth, select **Undo** and select which action to undo.

On a treatment plan, the availability of this option depends upon whether the treatment has already been completed and/or invoiced. You can also delete an entry by clicking on the line of treatment and pressing **Delete**.

Viewing Tooth History

You can view the history of a tooth by selecting the tooth and pressing the space bar.

Recording Pending Treatment from the Chart

As outstanding work is charted on a current course of treatment, a line entry will be added to the estimate. The colour of this line of treatment will depend upon its status – by default, it will be displayed in red to show that it is outstanding and, as the work is completed, the colour of that line of text will be changed to black. These colours, however, are customisable per user – **Maintenance Menu, Manage Groups and Users, User Preferences, Charting tab**.

Before the work is added to the estimate, you will be prompted to select a fee code from the list of codes linked to the relevant work code. If only one fee exists for that work code - or if you have selected a specific default fee code for that work code - then that fee code will be automatically added to the **Treatment Plan** screen.

If more than one fee code is available for that work code, you will be prompted to select the relevant fee code from the drop down list.

Fee codes can be edited once they have been added to the treatment plan by double clicking the relevant line on the plan and choosing an alternative fee from the drop down list. You can change the fee scale at this stage if required and the price can be edited in the same way.

BPE CHARTING

Click the **BPE** link from the **Treatment Plan** screen and check that the correct dentist is selected in the drop down box. This is important, as this is what will be recorded in the journal.

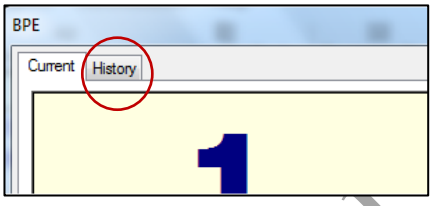
1) CREATE A NEW CHART

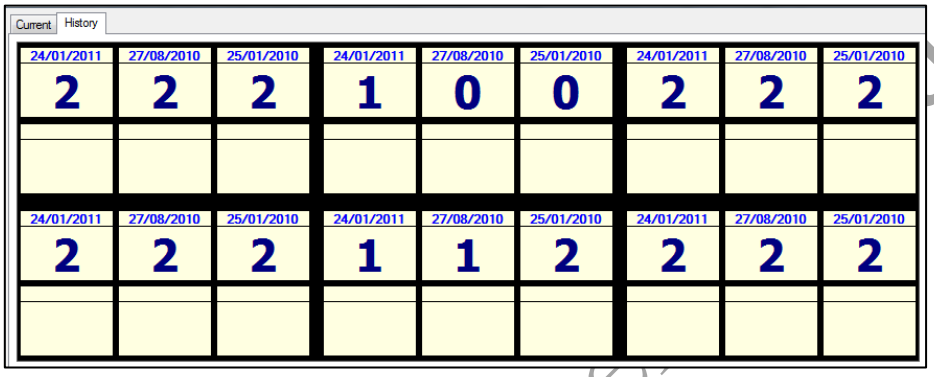
- Click **New**.
- If a previous chart exists, you will be prompted to use the results of the previous chart as a basis for the new chart. This would allow you to overwrite any of the scores that have changed. Click **Yes** or **No**, as applicable.
- You can navigate around the segments using the **Tab** key to move in a clockwise direction or **Shift+Tab** keys to move in an anti-clockwise direction. Alternatively you can use the mouse to click on the appropriate segment.
- Record the BPE score in each segment. If you navigate using the tab key, each existing score will be highlighted for you to overwrite. If you navigate with the mouse, you can double click to select a value to be overwritten.
- Click **Save.**

2) OPEN AN EXISTING CHART

- Select a chart to view and click **Open**.

- The selected chart will be displayed.
- The **Now Viewing Exam** box on the bottom right of the screen will confirm the date and time that the chart was created.
- You can toggle between charts by clicking the down arrow alongside the **Now Viewing Exam** box and selecting the required chart.
- You can view multiple results alongside each other by clicking the **History** tab on the top left of the screen.





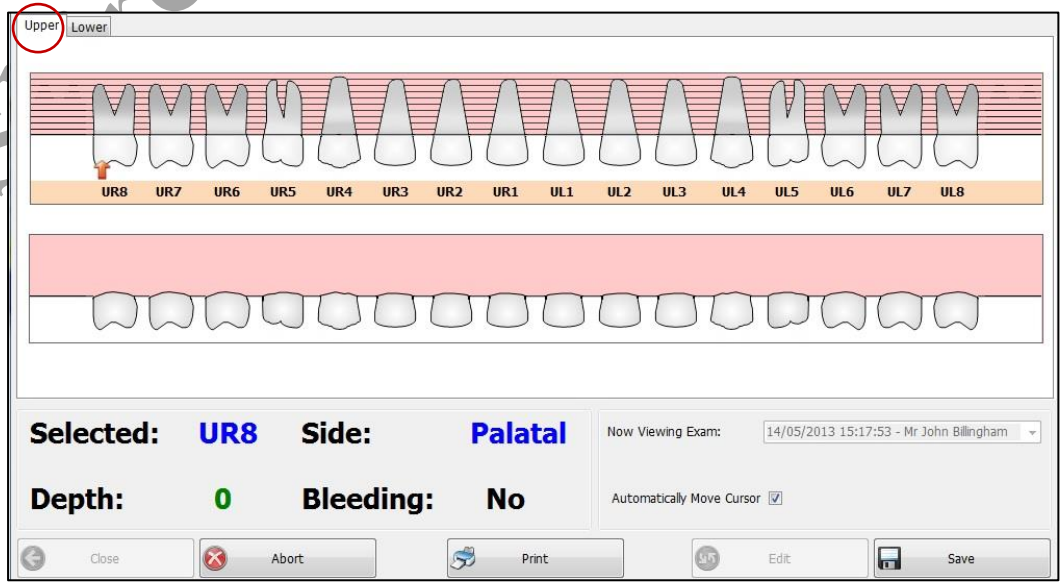
In this view, each sextant is sub-divided into six sections, with each section representing a different score for that sextant. The date that each individual value was recorded is displayed above each score. In this way, you can view how the score has changed for each individual sextant over a period of time.

- You can edit a previous score by first clicking the **Edit** button, making the necessary amendments and clicking **Save**.

FULL PERIODONTAL CHARTING

1) CREATE A NEW CHART

- Click **New**.



- Upper and lower teeth are displayed on separate screens. Toggle between the two by clicking the **Upper** or **Lower** tab on the top left of the screen.

- The upper chart on the **Upper tab** displays the palatal facing teeth and the lower chart displays the buccal facing teeth.

- The upper chart on the **Lower tab** displays the buccal facing teeth and the lower chart displays the lingual facing teeth.

- As you click on a tooth, the **Selected** and **Side** fields will be updated to confirm the tooth notation.

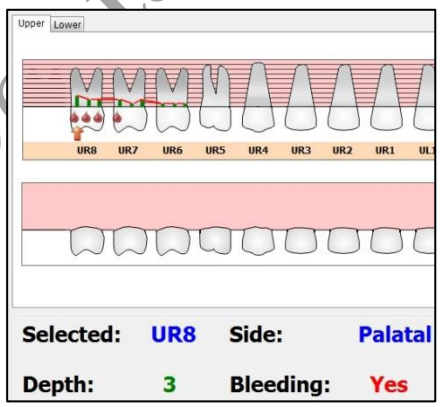
You can record six pocket depths per tooth – three on each side of the tooth.

d) Select a tooth and type in a depth value of between 1-9 on the relevant side of the tooth, As you type in a value, a graphical representation of the pocket depth will be displayed.

e) If the **Automatically Move Cursor** box is ticked, as you type in the pocket depth, the cursor will move automatically to the next pocket position. If the **Automatically Move Cursor** is not ticked, you should use the arrow keys or click with your mouse to move the cursor to the next position. To add or remove the tick, click on the box.

You can also record bleeding on probing.

f) To record bleeding on probing, press the letter B on the pocket position.



g) Prior to saving, the values can be cleared by clicking **Abort**.

h) When complete, click **Save**.

i) Click **Close** to exit the chart.

j) The chart can be printed by clicking **Print**.

2) OPEN AN EXISTING CHART

As with a BPE chart,

- Select a chart to view and click **Open**.
- The selected chart will be displayed.
- The **Now Viewing Exam** box on the bottom right of the screen will confirm the date and time that the chart was created.
- You can toggle between charts by clicking the down arrow alongside the **Now Viewing Exam** box and selecting the required chart.
- You can edit a previous pocket depth/bleeding on probing indicator by first clicking the **Edit** button, making the necessary amendments and clicking **Save**.
- Prior to saving, the edited values can be cleared by clicking **Abort**.

ADDING NON-CHARTABLE TREATMENT USING THE TOOLBOX

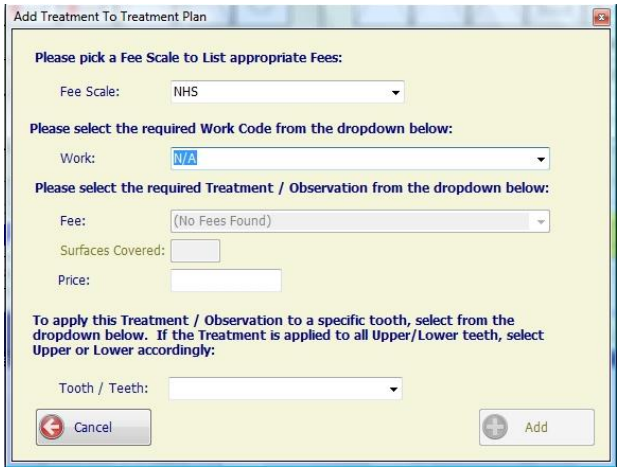
For work that is not chartable, ie not tooth specific or for those practices that do not use the charting module, work can be added manually to the treatment plan.

For those practices that do use the charting module, to speed up the entry of non-chartable treatment, you can add customised tools to the **Toolbox** as outlined previously in these notes (see page 70). Therefore you can add a button that you can click that is linked to a specific work code. If a fee code is set to default for that work code, or if only one fee code exists for the work code, then the fee would be added automatically (unless the code has been set up as tooth specific in which case you will be prompted for the tooth notation). If there is a choice of fees, you will be prompted to select the relevant fee code. You can choose to link the button directly to a specific fee code, however, if you wish. This is particularly useful for Scale and Polish and Radiograph fee codes.

If you prefer not to use the **Toolbox**, you can add non-chartable work as follows. If you are using the Billing Module only, this is also the way to add treatment.

USING THE BILLING MODULE OR MANUALLY ADDING NON-CHARTABLE WORK

1) Click the **Add Manually** button.
2) Check that the correct **Fee Scale** is displayed and select a work code from the **Work** drop-down list. (If you know the work code, you can type the work code and press **Enter**.) This will filter the list of fee codes for all codes related to that work code.
3) Select the fee code from the **Fee** drop-down list.
4) The **Surfaces Covered** field will be auto completed where applicable, ie where your fee codes have been configured with the number of surfaces specified.
5) The usual price will be displayed – this can be edited if required.
6) Type in the tooth notation for tooth specific charges or select the notation from the drop-down list.



7) Click the **Add** button.
8) A treatment line will be added to the estimate for the item of work.

Editing Lines of Treatment

Once a line of treatment has been added (but not yet completed or invoiced):

- The fee scale, fee code, price and number of units (where applicable) can be edited by double clicking the line

- It can be removed by clicking on it and either pressing the **Delete** key or right clicking and selecting **Remove Selected Line**.

If the treatment has been completed, you can edit in the same way but you would need to right click the line and select **Mark Line Pending** before these options became available.

If the treatment has been invoiced, then you can remove the invoice and mark the line pending by right-clicking and selecting **Delete Invoice and Mark Line Pending**.

Re-ordering Lines of Treatment

The order in which pending work is displayed on the screen can be re-sorted by clicking on the treatment line to be moved with the left mouse button, holding down the left mouse button and dragging it to the required position. **Completed work cannot be re-sorted so the work should be re-ordered before you start marking treatment as complete**.

If you plan to use the treatment plan to book future appointments, then all completed work should be displayed at the top of the plan before any pending work and the pending work should be sorted into the order you wish to complete it.

Marking Treatment Complete

All work added remains pending until you mark it as completed - unless you have selected the **Auto Complete** option on the **Work and Fee Codes Configuration** screen. The auto complete option is useful for examinations and possibly radiographs for the Charting Module and all treatment for Billing Options.

To mark individual lines of treatment as completed, select the relevant line of treatment to highlight it and then right click and choose the **Mark Treatment Complete** option. The colour of the treatment line to show the status of it. By default, pending work is displayed in red and completed work is displayed in black. These colours are customisable per user – see page 73 - under the section **Recording Pending Treatment from the Chart** for more details.

To mark all lines of treatment as completed, select any treatment line, right click and then choose **Complete All Items on Plan**.

Configuring the Treatment Plan for Appointment Booking

If you have added all pending work to the treatment plan, it is possible to use the treatment plan to book the relevant appointments required to complete the course of treatment.

If you are using the Billing Module and only recording completed work, then this section is not applicable and the visit header section can be ignored.

You will be able to use the treatment plan to manually search for the appointments or use the **Appointment Finder** option whereby the system can search for the first available appointment. For the **Appointment Finder** booking option to be most effective, your appointment rooms should be linked to a provider. You will also need to add non-chargeable treatment to the plan where this treatment requires a visit, ie you would need to add a fee for a crown prep with a zero charge to be able to book an appointment for such a visit.

Visits will be booked in the order that they appear on the screen so it is important that you re-order the lines of treatment by dragging and dropping them into the correct order before setting up the visit headers and saving the treatment plan. Completed treatment will, of course, be ignored when appointments are being booked so all incomplete treatment should be moved to the bottom of the plan.

Visit Headers (Visit Information)

By default, only one visit header (today) will be inserted into the treatment plan. The dentist will be the dentist specified in the **Course Information** details. The appointment length will default to the standard appointment length for the practice and the interval will be set at 1 day.

If another visit is required you should left click the first line of treatment to be carried out at the new visit and click the **Insert Visit** button. This will add a new visit header above the selected line of treatment.

By default, the visit will be for the same dentist and length of time as Visit 1 and with an interval of one day, which means that the first appointment offered would be the next day. These visit details can be edited by double clicking on the visit header.

Performer: A different dentist name can be selected from the drop down box.

Visit Length: This can be overtyped or you can use the up and down arrow boxes to increase or decrease the appointment length.

Booking Interval: This specifies how many days interval should be left after today (or the previous visit if you have added more than one visit) before an appointment is offered for selection, for example you can specify to leave an interval of 14 days between an appointment for a crown prep and a crown fit.

Click **Update** to save the changes.

Visit headers can be removed by clicking on them and clicking the **Remove Visit** button.

You can drag and drop treatment from one visit to another. If the line that has been moved is the only treatment in that visit, the empty visit header will be deleted.

GUIDANCE ON NHS CLAIMS

For guidance on what codes to add to transmit the relevant data on EDI claims – please see notes under the Section NHS - WEBEDI TRANSMISSIONS on page 148.

MEDICAL HISTORY LINK

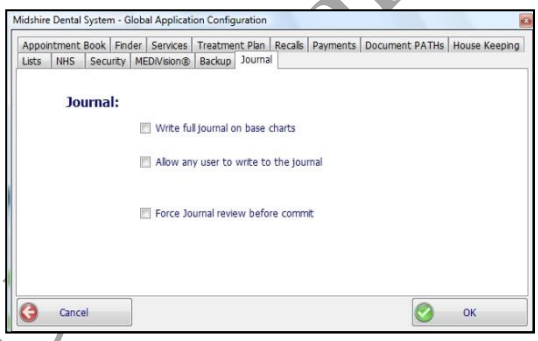
You can view and update the patient's medical history by clicking on the **Medical History** link as well as from the **Patient Details** screen. (See page 70 for instructions on viewing and editing the medical history).

PATIENT DETAILS LINK

To view the Patient Details screen from the charting screen, click the **Patient Details** link. There will be limited options from this screen – the **Patient Details** screen will be in viewing mode only and not editing mode. To return to the charting screen, either click the **Charting** link from the **Patient Details** screen or close the **Patient Details** screen.

JOURNAL ENTRIES

Default Journal Options



There are default options that can be set regarding journal entries. These can be found in the **Administration Menu/ System Maintenance/Application Preferences/Journal** tab.

- **Write full journal on base charts**. If this option is selected, all charted work on the base chart will be written to the journal. If not selected, a line will appear in the journal that the base chart has been completed.
- **Allow any user to write to the journal**. If this option is not selected, the only users offered when the **View** or **Edit Journal** option is selected from the **Patient Detail Screen** would be those where the **Type** field was saved as **Principal**, **Associate**, **Therapist** or **Hygienist**. If this option is selected, the full list of users would be offered.

  Even if this option is selected, however, you can still limit who has the ability to view or edit the journal by activating the relevant user permissions to **View Journal**, **Add to Journal.**

  There is also a permission to **Edit Journal (where applicable) –** the limitation for this option is that the journal can only be edited on today's date and by the same user who made the original entry. Both versions of the entry will be stored in the table (for medico-legal reasons – and could be accessed if required) but only the edited version will be displayed on the patient's record.
- **Force journal review before commit**. If this option is selected, the journal will be displayed automatically when you click **Save and Continue.** If not selected, it will not be displayed by default, but you can choose to view the journal by clicking the **Review Journal** button on the **Session Finalisation** screen.

  On the **Journal Review** screen, you can deselect any entries that you do not wish to be displayed in the journal. Any entries that are deselected, will still be written to the table but not displayed on the patient's record. You can also edit the description field of any entries displayed before they are saved.

Editing and Adding to the Journal when Charting

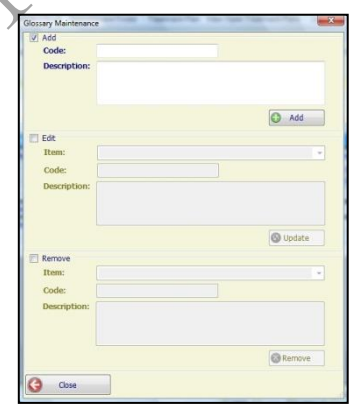
Each item of completed work will by default be written to the journal. You can, however, choose not to write away individual lines by, on the Journal Review, clicking on the box alongside that entry to remove the tick before clicking the **OK** button.

JOURNAL ENTRIES CAN BE EDITED ONLY ON THE DAY THAT THEY WERE ADDED AND ONLY BY THE USER WHO ADDED THE ENTRY, PROVIDED THAT USER HAS PERMISSION TO DO SO.

You can also edit the default description of a journal entry by clicking on the description and making the required changes.

To add free text to the journal, click on the **Add Comment** box, type in the text and click the **Add to Journal** box.

Journal Glossary



You can create journal glossary entries for commonly used phrases.

1) Select **Glossary** from the **Maintenance** menu and leave the **Add** box ticked.
2) Type a code in the **Code** box, enter the text in the **Description** box and click **Save**.
3) You can edit an existing entry by clicking the **Edit** box, amending the text and clicking the **Update** button.
4) You can delete an existing entry by clicking the **Remove** box, selecting the entry to delete from the drop-down list and clicking the **Remove** button.

To add a glossary entry to the journal, click the **Glossary** button on the edit journal screen, select the glossary item and click **OK** and click **Add to Journal**.

Linking Documents

To link a document to the journal, the document must be saved on the server in a location that is available for browsing from the dental system.

Note: Documents and images can also be linked directly to the patient's record by selecting the **DI** link at the top of the patient details screen.

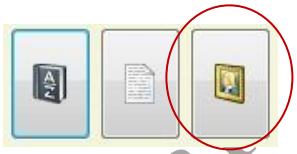
1) Browse to the location.
2) Select the document type from the file type box to the right of the **File name** box.
3) Either double click the document in the file display screen or select the document from the **File name** box and click the **Open** button.
4) At the **Add to Journal?** prompt, click the **Yes** button.

5) An entry will be written to the journal with a document logo displayed alongside it.

6) To view the document, double click the left mouse button anywhere on that line entry.

Linking Images

To link an image to the journal, the image must be saved on the server in a location that is available for browsing from the dental system.



1) Click the **Image Link** button.

2) On the browse screen, click the **Browse** button to the right of the **Image** field.

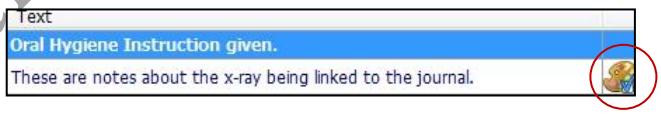
3) Search for and select the image and click the **Open** button. This will display the path of the image in the **Image** field.

4) Select the tooth notation from the drop down list in the **Tooth** field. The **Performer** will default to the dentist carrying out the treatment for the current visit.

5) Select the type of image being linked from the drop down list in the **Image Type** field.

6) Add any notes that might be relevant to the image in the **Notes** text field and click **OK**.

7) An image logo will then be displayed in the journal, alongside any relevant notes.



8) To view the image, double click the left mouse button anywhere on that line entry.

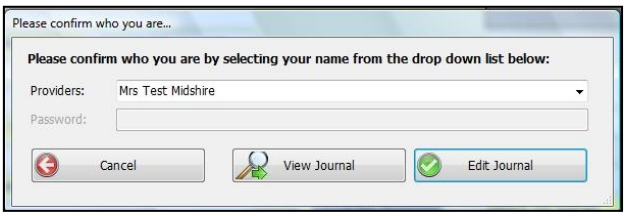
All journal entries from the charting screen will automatically be recorded against the dentist who has carried out the treatment for that visit.

Viewing and Editing the Journal from the Patient Details Screen

The journal can also be viewed and edited from the **Patient Detail** screen.

1) Display the **Patient Details** screen and click **Journal**.

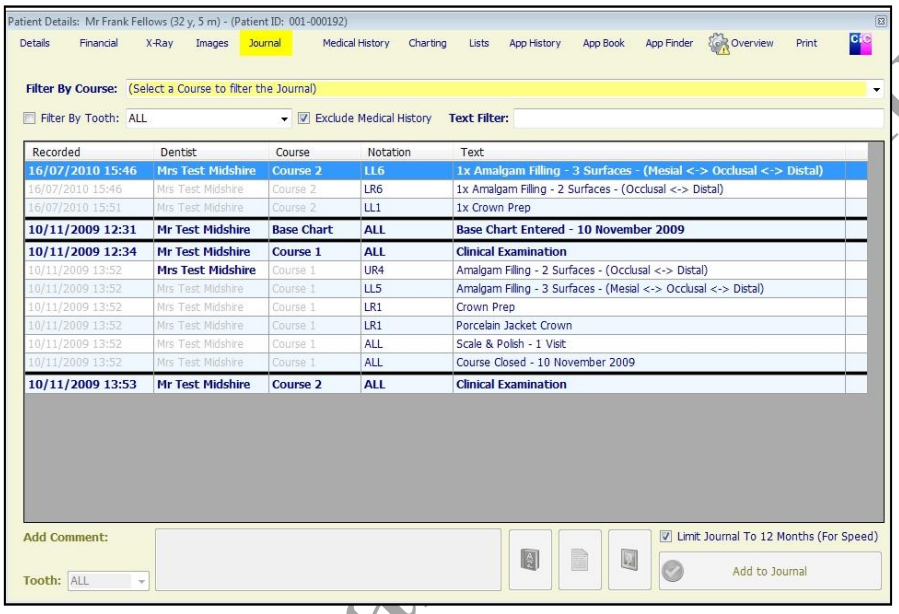
2) The system will prompt for a user name as follows:-



Select the relevant user from the drop down list and select either **View Journal** or **Edit Journal**. User permissions to view or edit the journal will become effective when selecting these options for that user.

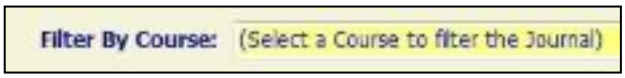
By default, the user list will display only those users where the **Type** field on the **User Account Maintenance** screen is recorded as **Principal**, **Associate**, **Therapist** or **Hygienist**. You can, however, choose to display all users in this drop down box – see **Journal Options** on page 80.

Viewing the Journal

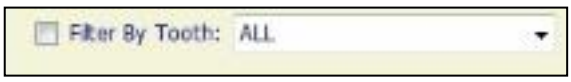


By default all entries for the last 12 months will be displayed – with the exception of medical history notes. Medical history notes can be included – see below – and you can remove the tick from the **Limit Journal to 12 Months** box if you wish to view older entries.

- You can filter by course. Select the relevant course from the drop down list.

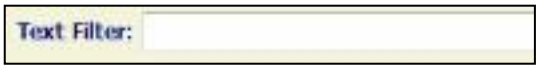


- You can filter by tooth. Click the box and select the tooth from the drop down list.



- You can include medical history by removing the tick in the **Exclude Medical History** box.

- You can filter by text by typing some text in the **Text Filter** box. As you type, only the entries matching your text will be displayed.



The following information will be displayed for each entry.

- Date and time recorded

- Dentist who carried out the work
- Course of treatment
- Tooth notation

Editing the Journal

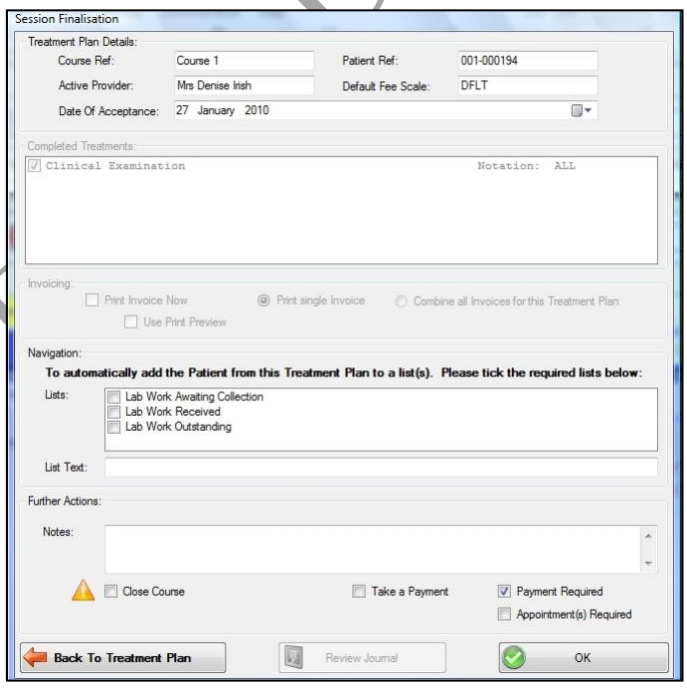
JOURNAL ENTRIES CAN BE EDITED ONLY ON THE DAY THAT THEY WERE ADDED AND ONLY BY THE USER WHO ADDED THE ENTRY, PROVIDING THAT USER HAS PERMISSION TO EDIT THE JOURNAL - USER PERMISSION: CAN EDIT JOURNAL (WHERE AVAILABLE).

When you select the **Edit Journal** option, the journal will be displayed in the same way as it is when it is viewed whilst charting. You can edit an entry – with the above restrictions – by right-clicking on the line and selecting **Edit Journal Entry** or **Delete Journal Entry,** or add new entries as outlined previously on page 81.

When all of the work and visits have been configured on the **Treatment Plan** screen, click **Save and Continue** to display the **Session Finalisation** screen.

FINALISING THE WORK ENTRY

The following finalisation screen is displayed, ready for producing the invoice for the completed work. This screen is divided into 5 sections – (1) **Treatment Plan Details**, (2) **Completed Treatments**, (3) **Invoicing**, (4) **Navigation** and (5) **Further Actions**.



Treatment Plan Details

This section is displaying the treatment details. The only field that you can edit in this section is the **Date of Acceptance**. This is the date that will appear in the journal, on any NHS claim and on the invoice and can be edited if you are entering work that was carried out on a previous date.

Completed Treatments

Each fee will be listed on this section with a tick box to the left of each fee. This tick box will be ticked by default.

If you leave the ticks in place, when you click **OK**, one invoice will be raised to include all items of treatment carried out at this visit only. You would choose this option if you wanted to invoice the patient separately for each visit.

If you remove the ticks, (click once to select the treatment and again to remove the tick) the work will be held over until the patient next attends. When you enter further work and return to this screen, all items of treatment carried out at both visits will be displayed, with ticks once again defaulting alongside each item. If you leave the ticks in place, when you click **OK,** one invoice will be raised to include all items of treatment carried out at both of the visits. You would choose this option if you wanted to raise only one invoice for multiple visits.

Invoicing

This section controls the printing of invoices. You can choose to print the invoice from this screen – but if you choose not to, you can still print the invoice from the **Financial tab** when taking a payment.

Tick the **Print Invoice Now** box if you wish to print an invoice and select the relevant print option.

or

Tick the **Use Print Preview** box if you wish to preview the invoice. You can print the invoice from the print preview display

and select one of the following options:-

Print Single Invoice – will print only the invoice for the items of treatment that have just been ticked in the **Completed Treatments** section and will not include any items of treatment that were completed in a previous visit.

Combine all Invoices for this Treatment Plan – will produce a consolidated printout of all invoices for treatment completed during this visit, and previous visits, for this course.

Navigation

Lists

This section allows you to add the patient to one or more of your lists. If you wish to do so, tick the relevant list/s. You can add list text by typing the text in the **List Text** box.

Further Actions

Notes

Any notes typed in here will be displayed on the account overview screen. It enables the dentist to send a message about this patient to reception so that it can be seen when they are

taking a payment/booking an appointment. If you are not configuring your treatment plans for appointment booking, then this is where most practices send a message to reception showing the details of appointments to be booked.

Close Course

If all pending work has been completed you will be prompted to close the course each time the finalisation screen is displayed. This is, of course, optional depending upon the circumstances (see notes below). If you wish to close a course with treatment pending, click this **Close Course** box.

Take a Payment

To go straight to the **Financial tab** on the **Patient Detail** screen to record a payment, tick the **Take a Payment** box.

Payment Required/Appointment(s) Required

To add a payment request to the patient's **Account Overview** screen, click the **Payment Required** box.

To add a book appointment request to the patient's **Account Overview** screen, click the **Appointment(s) Required** box.

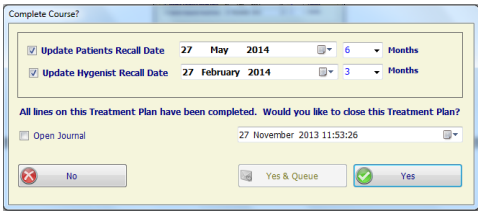
> **Note:** You can default a tick in the Payment Required and Appointment(s) Required boxes if preferred. (**Maintenance Menu, System Maintenance, Application Preferences, Treatment Plan tab**).

When all of the relevant options have been selected, click **OK**.

COMPLETING THE COURSE

If all lines on the treatment plan have been completed, the following prompt will be displayed.

The Dentist Recall and Hygienist's recall dates will already have been updated when the course was opened. If you have your application preference to **Update Patient's Recall Date Upon Closing of Treatment Course** activated, both recall dates will be re-calculated accordingly and the amended dates displayed.



If you do not wish either of them to be updated, remove the tick from the box beside the relevant option.

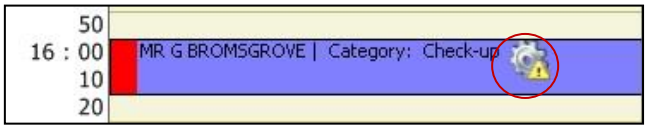
Select **Yes** or **No** as appropriate. (The **Yes & Queue** option is only applicable to NHS courses.) If you wish to write an entry into the journal before the course is closed, click the **Write Journal Entry** box before clicking the **Yes** button. You can default a tick in the **Write Journal Entry** box if preferred. This is a User Preference (**Maintenance Menu, Manage Groups and Users, User Preferences, Charting tab**).

If you select **Yes,** today's date and time will be recorded as the date that the course was closed, unless you edit the date by clicking the down arrow alongside the date/time display and click on an alternative date.

If your system is set to updating recall dates upon completion of a course and not the start of a course, the updated recall date will be displayed. You can edit this date manually before accepting.

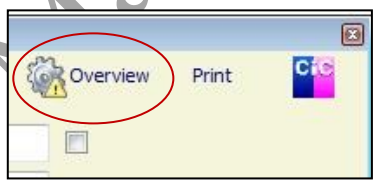
OVERVIEW SCREEN – PAYMENTS AND BOOKING FURTHER APPOINTMENTS

On the patient finalisation screen, if the **Payment Required** and/or **Appointment Required** boxes have been ticked in the consulting room, then the patient's appointment details will be updated as shown below.



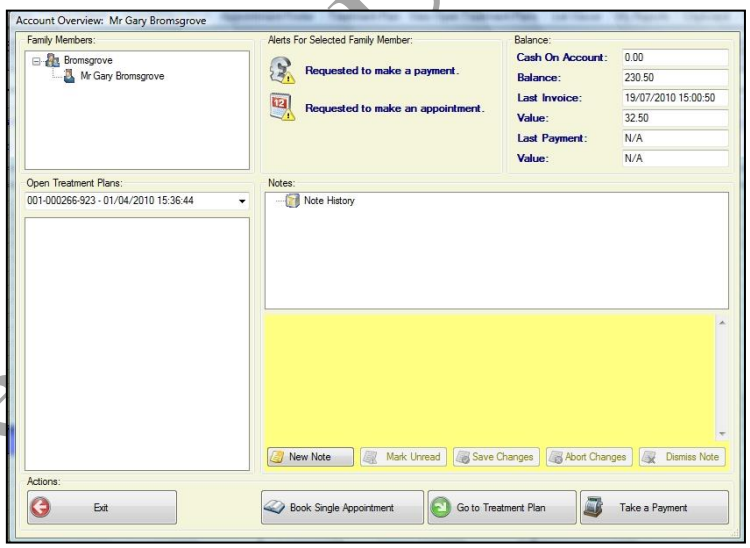
This is an indication to the receptionist that the dentist has finished adding the work and that there are actions required before the patient leaves the practice. You should double-click the appointment, to see what actions are required. This will display the patient's **Overview** screen.

Note: You can also view the patient's **Overview** screen from the **Patient Detail** screen.



FAMILY MEMBERS

All family members will be displayed in this section.



ALERTS FOR SELECTED FAMILY MEMBER

This section shows whether the **Payment Required** or **Appointment Required** has been selected on the **Finalisation** screen in the consulting room. You can choose to select these options in any order, and you will be returned to the **Overview** screen after each action. When everything has been carried out for the patient, click the **Exit** button to close the **Overview** screen.

BALANCE

This section displays the account information for the patient.

OPEN TREATMENT PLANS

If an appointment is required and a treatment booking plan has been set up in the consulting room, the treatment booking details will be displayed in this section.

NOTES

This section will display any notes that were added by the dentist on the **Finalisation** screen.

PAYMENTS

If you are using the full reception system, and generating invoices for your patients, you are able to record payments. You can also produce a cashbook report to enable you to reconcile your till receipts. You can then maintain an aged debt list and send out statements to patients who owe you money.

Even if you are not using the system to record work, you can still record payments from your patients. You will obviously not be able to produce a list of debtors or send out statements, but you will still be able to print a cashbook. In these circumstances, as you record a payment, an automatic invoice will be raised for that patient, equal to the value of the payment, to maintain a zero balance on the patient's account. To use this option, you need to tick the **Payment Trigger** box on the **System Maintenance/Application Preferences** on the **Administration** menu.

To Set Up Payment Methods

Payment methods can be maintained using the **Pricing\Payment Methods** options on the **Maintenance** menu.

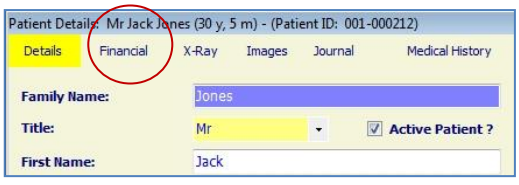
To Add a Payment Method

Leave the **Add** box ticked, type in a new payment method and click the **Add** button.

To Delete a Payment Method

Click the **Remove** box, select the method to be deleted from the drop down list and click the **Remove** button.

If you are recording a payment for a patient who has not attended the practice today, then search for and display the patient's record, click the **Financial** link and click the **Record Payment** button**.** You can then proceed as outlined below.



If you are recording a payment from the **Overview** screen, you can either click the payment symbol on the alert section of the screen or the **Take a Payment** button in the bottom right hand corner of the screen. You will then be navigated to the patient's **Financial** screen.

Recording Payments from the Overview Screen

Complete the payment details as follows:-

Date	The date will default to today's date but can be edited if required.
Method	Select the payment method from the drop down selection list. This will generate a summary on the cash book report of how much has been taken for each payment method. If a payment is made by more than one method, then the value for each method will need to be recorded separately.
Payment Amount	Type in the amount of the payment received, excluding any discount you may wish to give.
Discount	If you wish to give any discount, type in the amount to be discounted.
Amount Tendered/ Change	These fields are optional. They will allow you to type in the amount tendered. The system will then calculate and display how much change is due to the patient.
Taken by	Select the member of staff who is recording the payment from the drop down list of users. This is a must-fill field – you will not be able to process the payment until your username has been selected. You can activate a user password on this field – **Administration menu/System Maintenance/Application Preferences/Security**.
Payment for	Select the dentist/hygienist/therapist to whom the payment is to be allocated from the drop down list. This will generate a summary of the value of payments taken for each provider on the cash book report. If you are taking a payment for 2 different providers, these will need to be entered separately so that the summary can be accurately calculated.
Show Inactive Members	Tick this box to include deleted users in the **Payment for** field.
Stock	Tick this box if you wish to record a payment for stock that you wish stock sales to be itemised separately on the cash book summary page. The **Payment Amount** should be the total amount of the payment, including the stock value. The stock value should be the total value of the stock sold.
STK is a reserved work code and you can add your products to the fee scale, linked to this work code, as if they were fees. If any one of these products is added to the	

treatment screen, and you select the Take Payment option on the Treatment Plan Finalisation screen, then the value of the total payment amount (including the stock) and the proportion of that payment that relates to the stock value will be calculated automatically and displayed for confirmation. If you click OK, then the Stock box will be ticked automatically on the payment entry screen and the values will be entered for you. If you click Cancel, then the Stock box will still be ticked but you will need to type in the values manually. **Note: If you record a payment for stock that has not already been added to the treatment screen, then the payment will be processed correctly but the patient's balance will be in credit. You will need to add the stock after the payment has been processed, otherwise the balance will incorrectly remain in credit.**	
Narrative	The narrative will be displayed as the description of the transaction on the payment details screen. • **Payment Thank You** is the default narrative for positive payments. • **Refund** is the default narrative for refunds. This narrative can be overwritten if required.
Open Till Drawer	This will default to being ticked if you have a till drawer that has been linked into your Dental System. You can click on this box to remove the tick if you do not wish to open the till drawer when you confirm the payment.
Print Receipt	If the **Print Receipt** box is ticked, a receipt will be printed. Remove the tick if you do not wish to print a receipt. **Note:** There is a **Print Receipt by Default** box on the **Payments** tab on the **System Maintenance\Application Preferences** option on the **Administration** menu. This option determines whether the **Print Receipt** box will be ticked by default on the **Payments** screen.

When all of the payment details have been entered, click **Record Payment**. You will then be returned to the **Overview** screen to continue with any further options.

Recording Payments from the Financial Screen

A list of all payments and auto invoices/credit are displayed on the **Financial** screen for each patient. A receipt can be printed/re-printed by clicking on the relevant payment details on this display and clicking print/reprint. Invoices can also be reprinted in the same way.

Note: There is a link on the **Financial** screen – **Frequently asked questions** – which gives guidance of how to correct or reverse payments that have been recorded incorrectly. Click this link for guidance on how to deal with such occurrences.

Payments can also be recorded directly from the **Patient Detail** screen. Display the patient's record, click the **Financial** link, click the **Record Payment** button and proceed as for the **Overview** screen.

Refunds

If you need to issue a refund for a payment recorded incorrectly, record a negative payment, ie precede the **Payment Amount** with a minus symbol. If the account is in credit – ie the balance is a negative amount – recording a negative payment for that amount will return the account to a zero balance.

Credits

To raise a credit for a patient, display the **Financial** tab and right click on the invoice for which the credit is to be raised and select **Raise Credit**.

If you wish to raise a credit for a particular item of treatment on that credit, click the item and the amount to be credited will default into the **Credit Value** box. This value can be edited, if required.

If the credit is not for a particular item of treatment, you can just type in the credit value. Enter this as a positive value, and not a negative value.

You can print or reprint a credit note by right clicking on the line and selecting the relevant option from the menu.

To Delete an Invoice

You can activate the ability to delete invoices – user permission applies. To delete an invoice, right click on the invoice and select delete. The patient balance will be adjusted accordingly and the invoice will be moved onto the archive section of the **Financial** screen. Dental charts will not be updated if you delete an invoice for work that has been charted.

Note: You can now delete an invoice from the Treatment Entry Screen – right click and select **Delete Invoice and Mark Line Pending**.

APPOINTMENTS

If there is a treatment booking plan in existence, the details of that plan will be displayed in the **Open Treatment Plans** section. All completed work will be displayed in green and will include the date and time that the work was completed and all pending work will be displayed in red.

To book an appointment from the treatment booking plan, click the **Go to Treatment Plan** button. To book a one-off appointment manually, click the **Book Single Appointment** option.

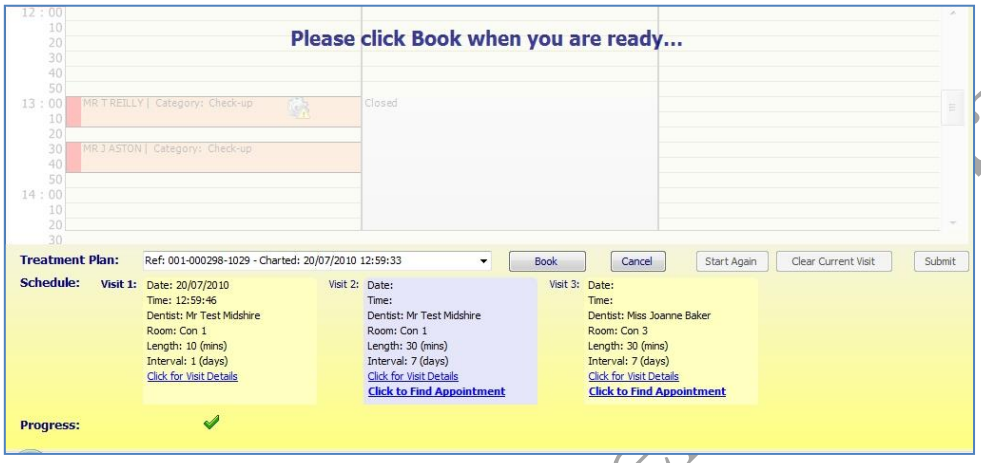
Book Single Appointment

This option will navigate to the appointment book ready for you to search for and book an appointment manually. See notes on page 39.

Go to Treatment Plan

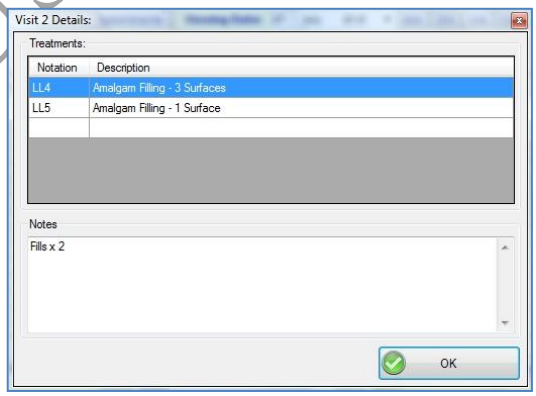
If you wish to book one or more of the appointments set up on a treatment booking plan, select this option. You will be navigated to the appointment book and the treatment plan will be displayed ready for booking.

Completed or already booked appointments will be displayed with a tick below them to show that the booking is not outstanding and the first pending appointment will be highlighted.



1) Click the **Book** button to begin the booking process.

2) The visit details for the first pending appointment will be displayed and the appointment book will take into account the booking interval and display the earliest date for that appointment . Any notes added to the **Visit Header** will be displayed in the **Notes** section. Click **OK** to remove this display from the screen. (If you wish to redisplay this screen before beginning the booking process, click the **Click for Visit Details** link.)



3) At this point, you can either search for the appointment manually and, as each appointment is confirmed, the treatment plan will be updated with the appointment details or click the **Click to Find Appointment** link to use the appointment finder.

Manual Booking

1) Search for and confirm the appointment when prompted. On the **Confirm Appointment** screen, make sure that the **Further Appointments** box is ticked if you wish to continue booking the plan.

2) The next pending appointment will be displayed. The appointment screen will take into account the booking interval and display the earliest available date for the next appointment. You can use the movement bar (see page 39) to move to another date if required and, when you have selected a suitable slot, double click the slot, select the category for the appointment and click **Book**.

3) Continue booking the plan in this way until you have booked all of the appointments you wish to book from the plan. (You can book one appointment from the plan and leave the others pending until the next visit if you wish.)

4) When all of the appointments on the plan have been booked, or if you manually remove the tick from the **Further Appointments** box to indicate that do not wish to book any further appointments on the plan, you will be prompted to submit the treatment plan (ie save the bookings so far). Click **Yes**.

5) Any appointments on the plan not yet booked will remain pending on the plan until you choose to book them, probably at the next visit.

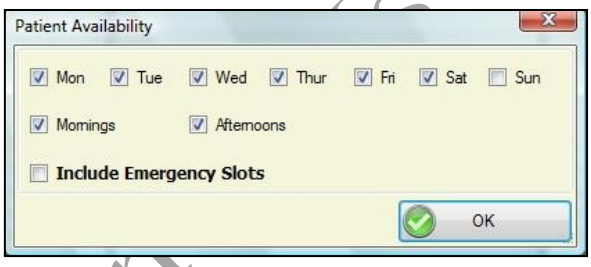
6) Once you have submitted the treatment plan, a list of all appointments booked will be displayed. Click the **Print** button to print the appointment details and/or click **OK** to remove the list from the screen.

7) You will then be returned to the **Overview** screen to continue with any further options. Click **Exit** to close the **Overview** screen.

Click to Find Appointment

1) Use this option if you wish to pass the treatment plan booking details to the **Appointment Finder**.

2) The following **Patient Availability** screen will be offered for selection.



By default, Monday to Saturday will be selected, together with both Mornings and Afternoons. If a day or morning/afternoon session is deselected, then that day or session will not be included in the search.

Also by default, emergency slots will not be included in the search. You can click the **Include Emergency Slots** box if required.

Click **OK**.

3) The details regarding the **Appointment Room, Interval** & **Length** will be passed from the **Treatment Plan** to the **Appointment Finder**. Click **Find**.

4) The first suitable slot will be displayed.

- Click **Book** if the appointment offered is acceptable.
- If one of the other appointments on the same day is acceptable double click that slot or single click and click **Book**.
- Search again if all appointments for that day are unsuitable. You can click **forward one day**, **forward one week** or **forward one month**. At any relevant point, you can click **Previous** to return to a previous selection.

5) Select a **Category** for the appointment.

6) Any notes that were added to the **Visit Header** will be displayed in the **Additional Information** section.

7) Further Appointments

- If this is the last appointment on the plan, the **Further Appointments** box will not be ticked and you will be prompted to **Submit** (ie save) the plan when the booking has been confirmed.

- The **Further Appointments** box will be ticked by default if there is another visit included on the plan. When the appointment is confirmed the first suitable appointment will be displayed for the following visit.

- At any point on the **Appointment Confirmation** screen, you can remove the tick from the **Further Appointments** box and you will be prompted to submit the plan. Any visits still outstanding can then be booked at a later date.

8) Click the **Book** button and you will either be prompted to submit the plan or continue to book the remaining visits.

9) At any point before you submit the plan, you can:-

- Click Cancel to cancel out of the treatment plan. However, please note that if you do click Cancel, then all current changes will be lost from the plan (any appointments that have previously been submitted will be saved). If you want to save the bookings so far, and not continue booking the remaining outstanding visits, click Submit instead of Cancel.
- Clear Current Visit to cancel the last booked visit; or
- Start Again to clear all current bookings and start booking again.

10) Once you have submitted the plan, the **Appointment Confirmation** screen will display a list of all appointments just booked.

- Click the **Print** button to print the appointments to your assigned appointment printer;

OR

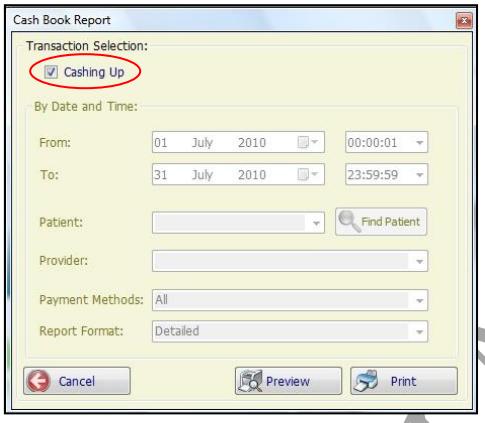
- Click the **Print Preview** box before clicking the **Print** button to preview the printout on the screen. You can print the appointment from the **Print Preview** screen if you wish.

REPORTS

CASHBOOK REPORT

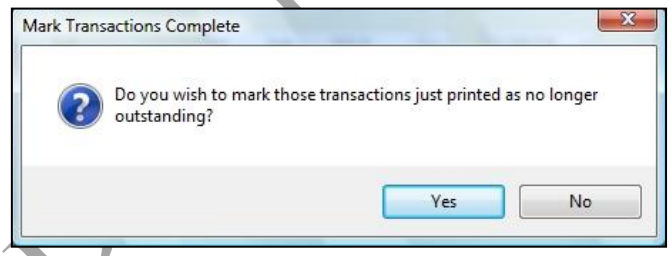
If payments are being recorded, a **Cashbook Report** can be printed, either for reconciliation of your till receipts on a daily or other regular basis or for general reporting purposes.

To print the report, select the **Financial\Cashbook Report** option from the **Reports** menu.



Cashing Up

Each time that you print a cashbook report with this box ticked, only those transactions since the cashbook was last updated will be included and you will be offered the following prompt:-



If you click **Yes**, then those transactions just printed will not be included the next time that you print a cashing up report.

If you click **No**, then those transactions just printed will still be included the next time that you print a cashing up report.

Click the **Print** button to print the report.

You can preview the report without clearing down the outstanding transactions. To do so, click the **Preview** button. If you then click **Print** from this preview display, you will not be offered the option of clearing down outstanding transactions.

The report will produce a list of every transaction since you last cashed up, in the order that the payments were taken, giving you a payment transaction number, patient name, payment date, payment method, payment amount, discount allocated (if applicable), payment narrative (eg Payment thank You) and the user who recorded the payment.

There will also be a summary at the end of the report that breaks down how much has been taken:

(a) for each payment method and
(b) for each performer

Any items of stock will not be included in the amount taken for each performer, but will be itemised separately.

Printing the Report by Date and Time

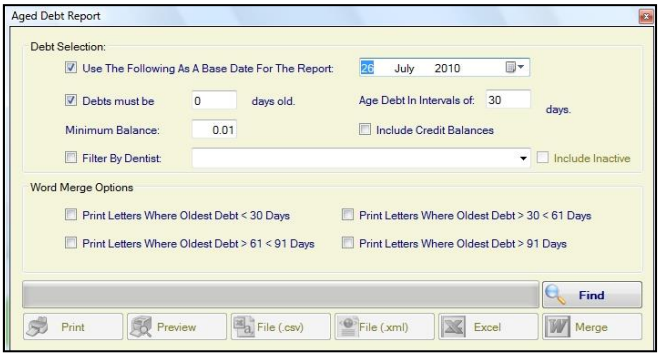
If you remove the tick from the **Cashing Up** box, you have the ability to specify a date and time range between which all transactions will be included. Removing the tick from the **Cashing Up** box will not affect subsequent cashing up in any way.

From **To**	Set the start and end dates and times.
Patient	If you click the **Find Patient** button and select a specific patient, then the report will only display the payments for that particular patient. Otherwise, payments for all patients will be included.
Provider	Defaults to **All** providers but you can display payments for a selected provider by selecting that provider from the drop down list.
Payment Methods	Defaults to **All** payment methods but you can display payments taken by a selected payment method only by selecting that method from the drop down list.
Report Format	The report can be printed in either **Detailed** or **Summary** format. A **Detailed Report** will list every payment in the selected range, with totals at the end. In addition, this report will have a final page that will summarise the amounts received for each payment method. A **Summary Report** will just display the final payment method summary only.

Click either the **Preview** or **Print** button, as required.

AGED DEBT REPORT

This report prints a list of patients who owe you money and gives an aged analysis of each patient's debt. Select **Financial/Aged Debt** from the **Reports** menu.



Debt Selection

Base Date	By backdating the base date, you can exclude from the report all transactions added after the specified date. The base date will default to today's date and, therefore, all debts will be included.
Debts must be …	If you type a value in this field, then the debts must be at least that many days old to be included in the report. Debts younger than the value entered (in days) will be ignored.
Exclude if over …	If you type a value in this field, then debts must be equal to or less than that number of days old to be included in the report. Debts older than the value entered (in days) will be ignored.
To produce a current aged debt report that includes all debts, irrespective of their age, then leave the Base Date set to today's date and the ageing fields set at zero.	
Note: There is a separate option to allow you to print statements to all patients who owe you money – see page 100. Data can be exported from the **Aged Debt Report**, however, to Microsoft Word which would allow you to send letters, instead of - or as well as - statements, to all patients who owe you money. You can use a combination of the **Debts must be** and **Exclude if over** fields, to write individual aged debt letters to patients according to how long the debt has been outstanding, ie if you set the **Debts must be** field at 30 and the **Exclude if over** field at 60, it will only include those debts between 30 and 60 days old. This would allow you to send a different letter to those patients whose debt – or part of the debt - are over 60 days old.	
Intervals	Debts can be broken down into pre-defined intervals. By default the ageing analysis will be displayed in 30 day intervals, ie current (<30 days), 30-59 days (<60 days), 60-89 days (<90 days) and greater than 90 days (>90 days). You can edit this interval if required, for example you could age your debts in 7 days intervals, if preferred.

Minimum Balance	This will default to zero and all debts will be included in the report. You can enter a minimum balance and, if you do so, only those debts equal to or greater than that minimum balance will be included in the report.
Include Credit Balances	This box will default to not being ticked and will not include patients with a credit balance. If you wish to include credit balances, tick this box before running the report.
Filter by Dentist	By default the report will include debts for all dentists. If you wish to filter by dentist, click the **Filter by Dentist** box and select the dentist from the drop down list.
Include Inactive	If this box is ticked, inactive users will be included in the drop down list. Otherwise, only current users will be offered for selection.

Output Options

Once you have specified your selection criteria, click the **Find Patients** button. This will select the patients who meet your selection criteria and allow you to select one of the following output options.

Print

Prints the report to your default report printer.

Preview

Previews the report on the screen, from where you can select to print to your report printer.

File (.csv)

Writes the information to a comma separated value file which can be imported into an external application or used as a hit file for a mail merge. Records will be separated by hard returns and fields within each record separated by commas. You be prompted for a file name and save location.

File (.xml)

Writes the information to an xml file. This is a relatively new format that is not yet commonly used.

Excel

Opens the data in MS Excel spreadsheet. You will be prompted for a file name and save location following which the data will be displayed as an Excel spreadsheet.

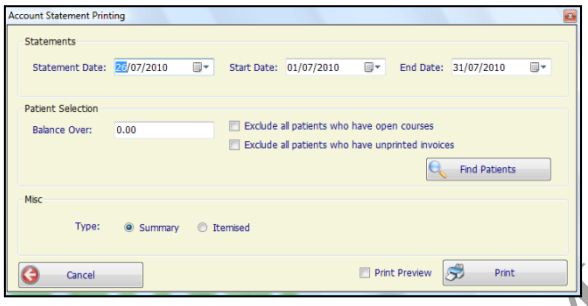
Word Merge

Allows you to merge directly from the dental system into MS Word for aged debt letters. A template would first need to be created in Word before this option could be used. Contact our Support Department for advice on setting up this template.

STATEMENTS

Statements can be printed for each patient who owes you money. Each transaction raised between the start date and end date would be listed on the statement (invoices, credits, payments and refunds). Default statement layouts will be included with the system but these can be customised by yourselves.

1) Select **Financial/Account Statement Run** from the **Reports** menu.



STATEMENT OPTIONS	
Statement Date	This is the date that will be printed on the statement. It will default to today's date but can be overwritten if required.
Start Date	The start date specifies the date of the first transaction to be included in the statement print for those patients who owe money. A brought forward amount will be displayed showing the amount that was outstanding on the account on the start date. The start date will default to the first day of the current month.
End Date	The end date specifies the date of the last transaction to be included in the statement print. A carried forward amount will be displayed showing the amount that is/was owing at the end date. The end date will default to the last day of the current month.
PATIENT SELECTION OPTIONS	
Balance Over	You can exclude statements for patients with a balance below a specified amount by typing in that amount. If this is left at zero, it will include all patients who owe money, irrespective of the amount they owe.
Exclude all Patients who have Open Courses	Click this box if you wish to exclude statements for patients with open courses of treatment. If you wish to include all patients, even those with open courses of treatment, leave this box unticked.

Exclude all Patients who have Unprinted Invoices	Click this box if you wish to exclude statements for patients with invoices held for printing later. If you wish to include all patients, even those with held invoices present, leave this box unticked.

2) Click the **Find Patients** button. This will display the patients who meet the specified criteria.

3) To print statements for all of the patients displayed, click **Check All**. This will place a tick in the check box by the side of each patient's name. You can then deselect individual patients by clicking on the check box for those patients. If you have clicked **Check All** by mistake, you can deselect all patients by clicking **Uncheck All**.

   To print for selected patients only, click the check box beside each of the required patients' names.

MISCELLANEOUS OPTIONS	
Statement Message	Any message typed into this box can be displayed on the statement. You can include a token on the statement layouts that will determine where this statement message will print.
Type	There are two default statement layouts included with the system – **Summary** and **Itemised**. **Summary** Summary print includes a single line entry for each transaction, ie invoice/credit/payment/refund. **Itemised** An itemised print includes a breakdown of all treatment for each invoice/credit as well as a single line of entry for each payment/refund.

4) To preview the statement on the screen, click the **Print Preview** box and click the **Print** button.

   On the **Print Preview** display screen, you can:-

   - print the statement;
   - zoom into the display or
   - view 1, 2, 3, 4 or 6 pages at a time

   by clicking the relevant icon on the toolbar.

5) Click **Close** on the toolbar to close the preview and return to the previous screen.

6) To print the statement without previewing it, leave the **Print Preview** box unticked and click the **Print** button.

RECALLS

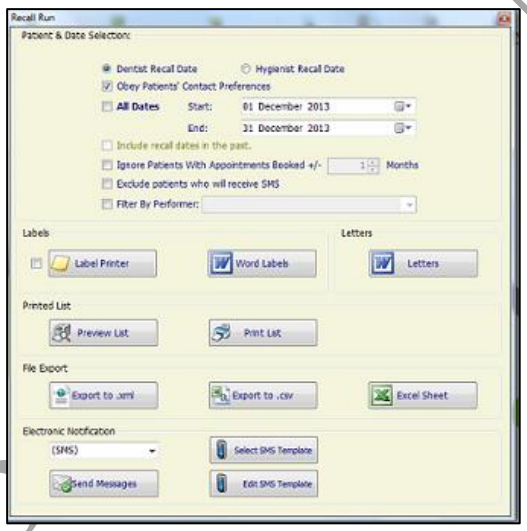
Each time that a new course of treatment is opened (or closed if the practice preference is set to update recalls on closing) the system will add the default period for that patient (as displayed on the **Patient Details** screen) to today's date to generate a new recall date.

The next recall date is displayed on the **Patient Details** screen and can be edited manually from there if required.

You can search for patients with a recall date within a specified period and for each patient selected, you can:-

- Print labels, letters and/or a report.
- Export the data to an **xml** or **csv** file.
- Export directly to a Microsoft Excel spreadsheet.
- Send a text message or email.

To access the recalls option, select **Recall Run** from the **Reports** menu.



The system generates two recall dates – one for the dentist and one for a hygienist. The recall run should be run separately for dentists and hygienists.

PATIENT AND DATE SELECTION	
Dentist Recall Date/ Hygienist Recall Date	Select whether you wish to search on the dentist or hygienist recall date.
Obey Patient's Contact Preference	Checks for preferences on the patient details screen. If there is no tick alongside this field, then the patient will not be included at all in the recall run.
All Dates	If there is a tick in the **All Dates** field, reminders will be sent to all patients, regardless of when the reminders are due.

	Remove the tick and select a **Start** and **End** date if you wish to send reminders in a specified date range.
Ignore Recall Dates in the Past	If this box is ticked, then the recalls will be selected based upon the day and month only. That way, if a recall is missed one year, the patient will be automatically reminded the following year also.
Ignore Patients with Appointments Booked	Tick this box to exclude patients who are due a reminder if they already have an appointment within a specified number of months, either before or after their due date. Specify the required number of months.
Exclude patients who will receive SMS	Tick this box to exclude patients who have the **Mobile Preference** box ticked. Only applicable if you intend to send text reminders to these patients separately.
Filter by Provider	If you wish to filter the recalls by provider, click this box and select the provider from the drop down list. **Note:** If you are searching for hygienist recalls – do not filter for the hygienist as a provider as this option filters on the patient's default dentist and would, therefore, return no results.

These last two options below would allow you to print labels or letters to patients who would not receive an Email or SMS text message. If you are not using Email or SMS, then leave these two boxed unticked.

Once you have specified the patient and date requirements, select the required output of your report.

Printed Output

LABELS	
Labels	This will print labels to a label printer. If you do not have a label printer, then you can still print labels using the **Labels (Word Merge)** option.
Labels (Word Merge)	This will print onto a page of A4 labels on your default reports printer. There is a direct link into MS Word. You need to create a label template in MS Word before you can

	start using this option. If you do not have a copy of MS Word, you could export the data to a csv file and use this to print labels using any other word processing package that supports mail merge. Field tokens to be included in the merge are as follows:- Title, Forename, Surname, Address1, Address2, Address3, Address4, Postcode.
Reminders (Mail Merge)	You can print a reminder letter using a direct mail merge into MS Word, as with the A4 label option. As with the labels, you will need to create a letter template in MS Word before you can start using this option. Field tokens to be included in the merge are as follows:- Title, Forename, Surname, Address1, Address2, Address3, Address4, Postcode, RecallDate
Preview Button	Tick this box before clicking either of the above options to preview the results before printing.
PRINTED LIST	
Preview List	Select this option to preview a report of all patients whose recalls are due in the specified date range. Once the preview has been displayed, the report can be printed by clicking the print icon at the top of the preview screen.
Print List	Select this option to print a report without previewing it first.

File Output

FILE EXPORT	
Export to .xml	Exports the data in xml format. (xml is a generic framework for storing any amount of text or any data. Its primary purpose is to facilitate the sharing of structured data across different information systems, particularly via the internet.)

Export to .csv	Exports the data in csv format. If you do not have a copy of MS Word, this file could be used, for example, as a hit file to create a mail merge (either to letters or labels) in another word processing package that supports mail merge.
Excel Sheet	Exports the results and displays them in MS Excel.

Electronic Output – See separate section on Text Messaging overleaf.

WORD MAIL MERGE FACILITIES

FROM STANDARD REPORTS

One of the options when producing **Cancellation/Reminder, Failed to Attend, Aged Debt** and **Recall** reports is to export the results directly to Microsoft Word and carry out a mail merge, ie produce a run of letters for each patient included on the report. Sample templates for these reports are installed on your C Drive\Shire Dental Documents\Templates in the relevant folders, ie Recall_Run, Aged _Debt, App_Reminders-Cancellations and Failed_Attend. These can, of course, be edited as required.

CREATING MS WORD TEMPLATES

For this you would need to produce a template in MS Word which contains tokens that allow you to determine where the patient details are to be inserted into the document as well as the standard non-variable text. There will already be examples of templates stored on your server and these should be edited to your own requirements before attempting the merge.

NOTE: Templates used in the standard reports for mail merge, ie reminder letters, etc should be saved as Word 97 – 2003 Documents (*.doc). The templates for use with the DI tab should be saved as standard Word Documents (*.docx).

The method for inserting tokens into Word varies according to the version of Word that you are using, but in Word 2010 the option for doing so is outlined below. If you are using a different version of Word, contact us for assistance if required.

- Click in the document where you want the token to be inserted.
- Click on the **Insert tab**.
- In the **Text section** of this tab, click **Quick Parts** and select the **Field** option.
- In the **Categories section**, select **Mail Merge**.
- In the **Field Names section**, select **MergeField**.
- In the **Field Name box** type in the name of the token (no spaces).
- Click **OK** to insert the token.

You can also add a token that will insert today's date into the letter. This can be automatically updated each time that letters are produced. To do so:

- Click in the document where you want the date token to be inserted.
- Click on the **Insert tab**.
- In the **Text section** of this tab, click **Date & Time** and select your preferred format for the date from the list offered.
- Click the **Update Automatically box** and click **OK**.

General Report/Labels Tokens

Title	Address1 (no space)	Forename	Address2
Surname	Address3	Address4	Postcode

Report Specific Tokens

Report	Token	Displays
Appointment Reminders/Cancellation Rpt	**AppDate**	Date and time of appointment
Failed to Attend Report	**AppDate**	Date and time of failed appointment
Recall Run	**RecallDate**	Date of recall due
Aged Debt Report	**Balance**	Patient Account Balance. (You can insert a pound sign in front of this when adding the token by ticking the box alongside the **Text to be inserted before:** option in the **Field options** section and typing a £ sign in the text box.)

Labels

Most practices position the text of the letter so that the letters fit into window envelopes, but you can also mail merge these reports to a label template – for example, you can run the report once for a letter and, using the same **Patient and Date** selection options, once more for a label for each of those letters.

There are already label templates stored on the system in the **Labels** folder within each template report folder. These have been set up to print onto A4 Avery Labels – product numbers L7160 (3 columns x 7 rows of labels per page) and/or L7161 (3 columns x 6 rows of labels per page). If you wish to use this facility then make sure that you buy labels that are compatible with these Avery product numbers and select the relevant template for your labels when running the report.

TO CARRY OUT THE MAIL MERGE

1) Select the report that you require from the **Reports** menu and specify the **Patient and Date Selection** requirements for the report.

2) Then click:-

Cancellation/Reminder Report	**Letters** or **Labels** button
Failed to Attend Report	**FTA Letters** or **Labels** button
Recall Report	**Letters** or **Labels** button
Aged Debt Report	Having run the report, click the **Word Merge** button – there are more detailed notes in the **Reports** section of the **User Manual**.

3) Browse for and select the template either by double-clicking it or single clicking it and clicking **Open**.
4) Older versions of Word/Windows will open the document automatically when the merge is complete. With more recent versions, the mail merge will be generated and a Microsoft Word icon will appear on the Windows task bar at the bottom of the screen. Click this icon to view the mail merged letters.
5) This will produce a separate Word document which contains one letter per patient and can be printed onto your own letterheads and saved using the usual print/save facilities in Word. The original template is a different document and will remain untouched in the Templates folder.

FROM THE PATIENT'S DI TAB

Consent Forms/Information Sheets/Referral Letters

You can also merge directly from the DI tab on a patient's record into previously saved Microsoft Word templates. This feature can, therefore, be used to produce and save customised referral letters, consent forms, general letters to the patient and information sheets etc.

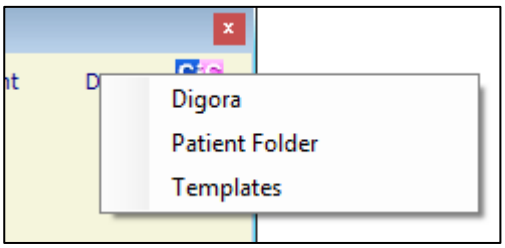
In recent versions MS Word (2007 or later), it is possible to produce a protected form as a template, whereby you can include checkboxes and/or combo selection boxes as part of the document.

Documents produced from the DI tab can be edited manually as they are produced and will be saved automatically in the Patient Folder on the DI tab, from where they can be viewed later. Additionally, a link is created in the patient's journal and double clicking this link will also display the saved document.

Example templates are installed for new systems on the C Drive\Shire Dental Documents\DI_Templates. These can be edited as required. The tokens available for these templates are listed overleaf – see page 106 for instructions on inserting these tokens into templates.

When you click the DI tab you will be presented with a menu of available options. One of these will be the **Patient Folder** and all mail merge generated correspondence will be stored in this folder.

Depending upon how your system has been configured, your DI menu might be displayed as follows:-



- Everything except the **Patient Folder** is a link to either a template (or a digital x-ray machine).
- Once merged, the documents and digital X-rays will be stored in the **Patient Folder**.

Browse for and select the template required. However, you should be aware that as soon as a template has been selected from the DI tab, then the merged document is automatically saved against that record in the Patient Folder. If

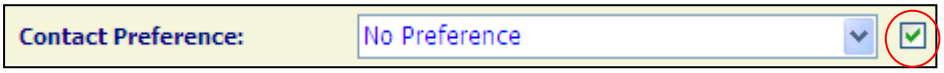
you make any changes to the merged document, you should click the **Save** button before exiting the document for your amendments to be saved, or select the **Save** option when prompted as you close the document, otherwise the base document only will be saved.

DI Tab Mail Merge Tokens

PatientID	Surname	Forename	PreviousName
Salutation	Address1	Address2	Address3
Address4	PostCode	HomePhone	WorkPhone
MobilePhone	EmailAddress	DOB	GeneralNotes
NI_Number	NHSNumber	DefaultFeeScale	DefaultDentistID
RecallPeriod	Registration_Date	RecallDate	HygenistRecallDate

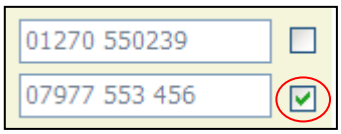
TEXT MESSAGING

Please note that, **if the box alongside the Contact Preference field on the Patient Details Screen is not ticked, and you select Obey Patients' Contact Preferences when running a report, then the patient will not be included at all in any reminder run, electronic or otherwise, ie this is your option for excluding patients who do not wish to receive any reminders.**



Your system needs to be configured to send text messages before this option is first used. There is a minimum charge (currently £10 per month), which includes up to one hundred texts and the method of payment is by direct debit. If you use more than one hundred texts, we will invoice you for these at our prevailing rate (currently 10p per text). Please note that unused texts from your monthly allowance cannot be carried forward to the following month. Contact our Support Department for further details.

RECALL RUN - ELECTRONIC NOTIFICATION



Recall reminders can be sent by text message for those patients who have elected to receive reminders in this way. For those patients who wish to be sent text message reminders, you should tick the box alongside the home or mobile telephone number on their **Patient Details Screen**.

You can choose to:-

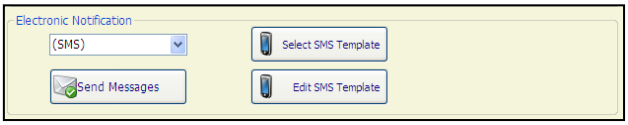
send either a text message or a printed reminder; or
send both a text message and a printed reminder

If you have selected the option to **Exclude patients who will receive SMS** in the **Patient and Date Selection** section when printing your recalls, you can subsequently choose to send SMS text messages to those patients who have been excluded from the print run. You could, of course, choose to send SMS text messages as well as printed reminders by not excluding them from the initial printout.

1) Once your system has been configured, select **Recall Run** from the **Reports Menu**.

2) Select your Patient and Date options in the usual way – see your user manual for more details regarding these options. We would recommend that you print a report at this stage and check that the output selection is correct before continuing to send the texts.

3) In the **Electronic Notification** section, select the **(SMS)** option from the drop down menu.



4) Click the **Select SMS Template** button and select the template required – see notes below.

5) Click the **Send Messages** button.

> **NOTE:** This will send a text message to those patients where the box alongside the **Mobile** field on the **Patient Details** screen is ticked. You can also send a text message to a home number if no mobile number exists providing the box alongside the **Home Phone** field is ticked. If the boxes alongside both the home and mobile number are ticked, only one message will be sent – to the mobile number.

SMS TEMPLATES

From: This will be your practice name, as configured during setup.

Subject: Not applicable for Text Messages.

Body: This box should contain the text message that you wish to send to your patients. The default message can be edited and the text can contain the field tokens listed below.

Tokens for Electronic Output

The following tokens can be embedded in the text of SMS templates. When SMS messages for recall reminders are sent, the following data will be inserted in place of these tokens.

PATIENT NAME	Patient's title followed by patient's surname
DUE	Recall date – as displayed on the **Patient Detail** screen
DATE	Today's date

Select SMS Template

The SMS template file is called SMS.xml. There will already be a default template in existence for each type of report and, where possible, the recall template will be displayed ready for selection. This template will be used by default if you run the recalls without selecting a template at all. It can be edited, if required, using the **Edit SMS Template** option described below.

Edit SMS Template

> **The system will allow you to type 500 characters into a template. You should bear in mind, however, that there is a maximum of 160 characters per text message and, if you exceed this character length, then you risk sending two (or even three) messages to each patient which, of course, will double (or even treble) your costs. The character count should include the number of characters that will be imported in place of any tokens that you may have built into the template.**

1) To edit the SMS template, click this button and double click the template to be edited. Edit the text displayed in the **Body** section of the template - the approximate character count is displayed at the bottom of the screen.

2) Tokens can be included in the template to automatically display patient data. Remember to allow adequate characters to display the imported data.

3) Click the **Save** button.

To Create a New Template

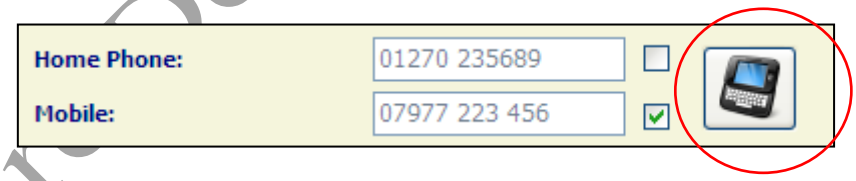
If you wish to create an alternative recall template, say for a different dentist if you are filtering by dentist, click the Edit SMS Template button and copy and paste the existing template into the same location. Right click and rename the copy (don't rename the default template – this needs to exist) and double click the new template and edit the existing text. Click the **Save** button.

TEMPLATES ARE STORED IN THE FOLLOWING LOCATIONS:-

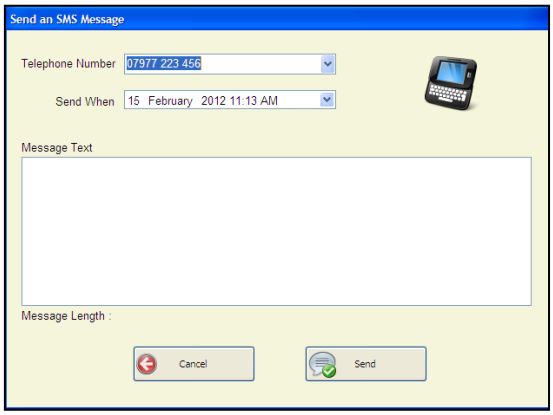
Appointment Cancellations	**C:\shire dental documents\xml\ app_reminders_cancellations\ sms\cancel**
Appointment Reminders (Manual) :	**C:\shire dental documents\xml\ app_reminders_cancellations\sms\reminder**
Appointment Reminders (Automatic) :	**C:\shire dental documents\xml\ app_reminders_cancellations\sms\auto**
Recall Reminders:	**C:\shire dental documents\xml\recall_run\sms**

ONE-OFF TEXT MESSAGES

Once text messaging has been enabled, you can send a one-off text message to a patient providing the mobile or home phone box is ticked on the **Patient Details Screen**. There is a mobile phone icon alongside the telephone numbers on the **Patient Details Screen** - this will become enabled if the mobile or home phone box is ticked.



1) Click this icon to send a text message to that patient (if text messaging has not been enabled on your system a message warning that this is the case will be displayed). The following screen will be displayed.



2) **Telephone Number**: select the number to which the text message is to be sent.

3) **Send When**: select the date and time to send the message – it defaults to today's date and the current time, but these can be edited.

4) Type your text into the **Message Text** box – the message length will be displayed as you type.

5) Click **Send** and the message will be sent to the number, and on the date and at the time, that you have specified.

APPOINTMENT REMINDERS/CANCELLATIONS

This option allows you to identify patients who have appointments booked and send them a text message reminder for that appointment. Alternatively, you could also use the same option to advise them that their appointment has been cancelled by the practice and send a text message to ask them to rebook. This works in the same way as for recalls but the token **DUE** in this option will include the date and time of the booked appointment. Select **Appointments** – **Appointment Reminders/Cancellation Notification** – from the **Reports Menu**.

Default reminder and cancellation templates will be installed which can be edited in the same way as the recall template. **As this report has two functions, you will need to select the required template each time that you run this routine. There can be no default option since the system has no way of knowing whether you are sending appointment reminders or cancellation notifications.**

AUTOMATIC APPOINTMENT REMINDERS

There is also an option to send or schedule automatic text reminders at the point that the appointment is booked. An option has been added to the existing appointment booking screen to schedule an SMS reminder **Now**, the **Day Before**, the **Week Before** and the **Month Before** (or combinations of). These options can either be selected at the time of booking or set as defaults in **Application Preferences** (Administration Menu/System Maintenance). The template for automatic appointment reminders is different to that for manual appointment reminders – see previous page for template locations.

FAILED TO ATTENDS

This option allows you to identify patients who have failed to attend an appointment on a specified date and send them a text message to rebook. This works in the same way as for recalls but the token **DUE** in this option will include the date and time of the failed appointment. Select **Appointments** – **Failed to Attend Report** – from the **Reports Menu**.

A default failed to attend template will be installed which can be edited in the same way as the recall template. The system will use this default template, even if you do not click the **Select SMS Template** button each time that you run the routine.

OUTPUT TO SMS – SUMMARY NOTES

APPOINTMENT REMINDERS

Text messages can either be sent manually or scheduled automatically at the point the appointment is booked.

Telephone numbers need to be updated before you can start sending any text messages. Don't tick any of the text reminder indicators unless the numbers are correct.

IMPORTANT - see separate notes re maximum message length per text for all SMS transmissions.

Automatic SMS Appointment Reminders

- By far the easiest option but needs constant internet access and the server left running at all times.
- Reminders are scheduled when the appointment is booked by clicking the relevant box.
- If the appointment is cancelled or cancelled and rebooked, the schedule is amended.
- In Application Preferences (Administration Menu, SMS tab) you can set the preferred default auto schedule option selection on the appointment booking screen.
- **Template location**: C drive\Shire Dental Documents\xml\ Appointment_Reminders_Cancellations\SMS\Auto.

All manually run reports listed below can also be output to labels, letters or a printed list.

Manual SMS Appointment Reminders

Note: Appointment Reminder and Cancellation Notification reports are generated from the same menu option but output to different SMS templates. Depending upon what the report is being used for, just select the relevant template before you send the texts.

- Select **Appointments - Appointment Reminders/Cancellation Notifications** from the **Reports Menu** and choose the **Reminder** template.
- Internet access is required for SMS output at the time that the report is run until the messages have been transmitted.
- If you are using both auto and manual SMS appointment reminders, you should ensure that these two templates are identical to reduce the possibility of duplicate texts being sent.
- **Templates location:** C drive\Shire Dental Documents\xml\ App_ Reminders_ Cancellations\SMS\Reminder.

CANCELLATION NOTIFICATION REPORT

- Select **Appointments - Appointment Reminders/Cancellation Notifications** from the **Reports Menu** and choose the **Cancellation** template.
- **Templates location:** C drive\Shire Dental Documents\xml\App_Reminders_ Cancellations\SMS\Cancellation.

FAILED TO ATTEND REPORT

- This can be run daily – the day following the missed appointments.
- Select **Appointments** – **Failed to Attend** from the **Reports Menu**.
- **SMS Template Location** - C drive\Shire Dental Documents\xml\Failed_Attend\SMS.

RECALL REPORT

Note: The appointment reminder options outlined above will pick up those patients who already have an appointment. The Recall Run report will pick up those patients who are due a recall but who do not already have an appointment. This depends, of course, upon the recall date being updated. (For the Reception module, recall dates have to be maintained manually but for the Billing or Charting modules, however, these recall dates will be updated automatically as the treatment is entered.)

- Using the Recall Run option, you can send text reminders to those patients who haven't already got an appointment booked and who are set up to receive texts.
- Select **Recall Run** from the **Report Menu**.
- **SMS Template Location** - C drive\Shire Dental Documents\xml\Recall_Run\SMS.
- A report or letters can be printed for those patients who have not already got an appointment booked and who are not set up to receive texts.

ONE-OFF SMS

For those patients who are set up to receive text messages, click the text message button on the patient details screen. Type in the message and press **Send**. No template or tokens are available for this option. Internet access is required for this option at the time the message is sent.

SMS REPORT

You can print a status report of texts sent in a date range from the Ad-hoc Reports option (see page 117) on the Reports Menu. Open SMS Delivery Report in the SMS folder and execute. The results can then be printed or exported to Excel. User permission applies.

SMS messages from our system are delivered to the recipient's mobile by passing the message from one network to another. We pass your messages to our SMS gateway, and they route the message to the recipient through the appropriate network. Unfortunately, delivery of the message cannot be not guaranteed, as multiple networks are involved, and any one of those networks may drop it – or, of course, the mobile may be turned off or the

telephone number may not be a valid/active number. Unfortunately, this is beyond our control.

The status on the SMS delivery report will show either:-

Delivered,
Sent or
Expired.

Sent means that the message has been sent but not yet delivered. Attempts to deliver the message will continue for a while but, if unsuccessful, the status will eventually change to Expired, and there will be no further attempts to deliver it.

AD-HOC REPORT GENERATOR

STRUCTURED QUERY LANGUAGE

SQL stands for Structured Query Language which is a language that allows you to search your records for data. The Shire Dental System supports SQL and ad-hoc reports can be generated, saved and run to query your dental database. The Ad-hoc Reports option is accessed from the Reports Menu.

SQL QUERIES

You can write your own queries or copy and paste an existing query into the report generator. To make your queries more flexible, you can build tokens into a report to prompt for variable criteria each time that the report is run.

Once a query has been saved, it can be recalled and run as often as required. The results can be previewed on the screen, printed, exported to Excel or saved to a list.

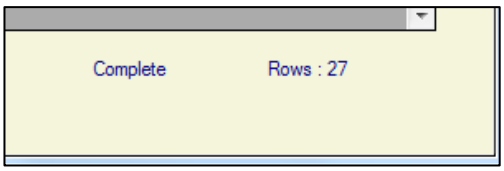
TO EXECUTE (RUN) AN EXISTING QUERY:

1) Click the **Open** button.

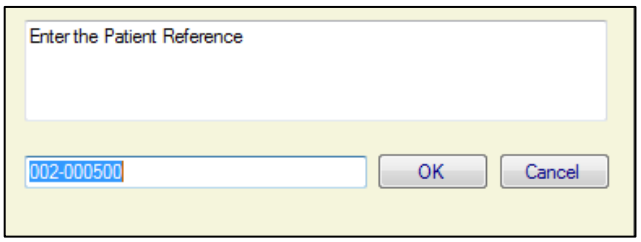
2) Browse for the report in the Shire Dental Documents\Ad-Hoc Reports folder on your C: drive and click the relevant query from the list displayed in the **Open** box and click **Open**.

3) The query will be displayed in the query text box (at which point it can be edited, if required).

4) Click the **Execute** button to display the results on the screen. Once the query has been run, the results will be shown on the bottom half of the screen. The records that meet the criteria will be counted and the number displayed in the bottom right hand corner of the screen.



5) Some queries require the user to enter variable values upon which the query is based. If this is the case, the values should be added at this point. When you run such a query, the following prompt screen will be displayed.



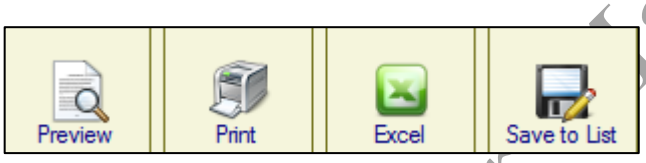
- Default entries for prompted data may be embedded in the script itself. If so, and this is the correct value, then click **OK** to select. Overwrite and click **OK** if a different value is required.
- Dates should be selected using the calendar.

- If the **Like** operator has been used in the query, this means that part of the value can be typed in – the % symbol can be used as a wildcard (ie a special symbol that stands for one or more characters) before and/or after the text.
- If the **Equals** operator is used, then the exact value needs to be added.
- In setting values, generally 1=Yes and 0=No although in some tables True and False is used in place of these numbers.

To Stop a Query from Running

You can stop a query from running by clicking the **Stop** button on the toolbar. You will be prompted that the execution has been cancelled and only the records that were selected up until the **Stop** button was pressed will be displayed on the screen.

PRINTING AND EXPORTING SQL QUERIES



The results of the query can be previewed, printed, exported to Excel or saved to a list. Execute the query and select one of the following options:-

Print Preview

Execute the script and click the **Preview** button on the toolbar. Confirm that the correct printer is selected and press **Print**. The preview will be displayed on the screen.

The results can be printed from here if required by clicking the print option in the top left hand corner.

Print

Once the script has been executed, the results can be printed directly to the printer by clicking the **Print** button on the toolbar. Confirm that the correct printer is selected and press **Print**.

Export to Excel

Execute the script and click the **Excel** button on the toolbar. The results will be copied and pasted into a new Excel document.

NOTE: MS Excel decides whether to interpret data that has been pasted into the spreadsheet as dates and we have little control over this interpretation. Reformatting the cells is usually, but not always, enough to correct the display if the dates are displayed incorrectly.

Save to a List

Make sure that the patient ID is included in the **Select** clause and then execute the script and click the **List** button on the toolbar.

BUILDING YOUR OWN QUERIES

It will be helpful when building your own queries if you understand the structure of the database that stores your data.

Database Structure

Database	A database stores data in tables and can be a collection of tables.
Table	A table consists of a list of records with each record having the same structure. Records are displayed in rows in a table.
Field	The data relating to each record is stored in 'fields'. Each record has a fixed number of fields of a specific type. Fields are displayed in columns in a table.

A database most often contains more than one table. Each table is identified by a name (eg Patients). Each field is identified by a unique name within each table. This is preceded by the table name with a full stop separating the table and field names. There are no spaces in table and field names.

Patients.Surname is the surname field in the Patients table.

Fields contain the same type of data for every record.

The Patient table below displays five records (one row for each record) and six fields (one column for each field).

FamilyID, FamilyName, PatientID, Active, Surname, Forename.

FamilyID	FamilyName	PatientID	Active	Surname	Forename
050-000002	Evans	050-000023	1	Evans	John
050-000002	Evans	050-000024	1	Evans	Michelle
050-000002	Evans	050-000025	1	Evans	Michael
050-000003	Dodd	050-000026	1	Dodd	Daisy
050-000004	Kelly	050-000027	0	Kelly	Alice

Most of the data in the dental system is stored in a database called DentalSystem. The ad-hoc report generator can only be used to directly query the DentalSystem database. There is, however, a separate database called DentalSystem_EDI which stores most of the data relating to EDI transmissions. We have, therefore, written Views that link both databases for general EDI queries

Tables can be joined for the purpose of extracting data, providing there is a common field in both tables linking the relevant record(s) in one table to the relevant record(s) in another. Such tables are called related tables. If you want to base your query on more than one table, then you will need to include a join in the query (see page 132 for instructions on adding

joins). The type of join will vary according to how the data is linked. With this in mind, we have created some views that link tables for you – see Tables/Views list overleaf.

To Build a Query

The first step in building a query is to determine which Table(s)/Views contain the data that you wish to query.

Selecting Table(s)/View(s)

1) Click the **Build** button on the toolbar. This will display the query builder screen.

2) On the left-hand side of the screen is the **Tables/Views** selection tool. This comprises of a choice between **Tables** and **Views**.

3) Click the plus sign to the left of either the Tables or Views to display a list of Tables or Views that are available for selection.

There are many tables in the DentalSystem database. Tables/Views that you are most likely to want to query are as follows:-

Most Commonly Used Tables/Views

NAME	TABLE OR VIEW	DESCRIPTION
Apps	Table	This table contains a record of all appointments currently stored in your appointment book, together with all Emergency, Break, Lunch Break and Meeting Slots 1. If an appointment has been cancelled, it is moved from the Apps table to the AppsHist table.
AppHist	Table	This table contains a record of all cancelled/restored patient appointments.
Cashbook	Table	This table contains a record of all payments and refunds.
FeeCodes	Table	This table contains a record of all fee codes for every fee scale. The table includes fees that have been deleted and marked as disabled even though these are not offered for selection when entering treatment.
Invoices	Table	This table contains a record of all treatment invoiced. Deleted invoices are moved from this table to the ArchivedInvoices table.
ArchivedInvoices	Table	This table contains a record of all deleted invoices.
Journal	Table	This table contains a record of every journal entry for every patient.

Patients	Table	This table contains a record of all patients, active and inactive.
TreatmentCourse	Table	This table contains extra details about the courses of treatment. It mainly relates to transmission details for NHS courses of treatment. There is one entry in the table per course of treatment.
Chart_Lines	View	Use this view for charting queries – it is a combination of several tables with automatic joins built in.
NHS_EDI_Messages	View	This view stores a course reference for NHS transmitted courses of treatment and displays the EDI claim reference and file reference numbers for each of these courses.
NHS_EDI_Schedl_Responses	View	This view stores a course reference for schedule responses for NHS transmitted courses of treatment and displays the confirmed patient charge and number of UDAs.

GETTING STARTED

Queries comprise of various clauses and these clauses have to be constructed in a pre-determined format. A very basic query comprises of at least the following two clauses:-

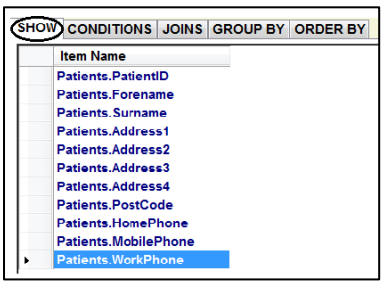
The SELECT clause (which specifies what data will be displayed for each record selected in your query; and

The FROM clause (which specifies in which Table/View that data is stored).

THE SELECT CLAUSE

1) Decide which Table or a View you wish to query and click the plus sign alongside that Table or View. This will display a list of fields within that Table or View.

2) Drag those fields that you wish to display on your report (preferably in the order that you want to display them) and drop them into the **Show** box in the query builder.



3) Once the fields are displayed in the **Show** box, you can change the order in which they are displayed by dragging them from one position and dropping them into another. If you wish to remove a field from the **Show** box, drag it out of the box again.

4) As you select the fields you will see that the query is being built automatically and is displayed on the bottom half of the screen. The SELECT clause comprises of the fields displayed in the SHOW box. You will see that the fields are separated by commas with no comma after the last fieldname.

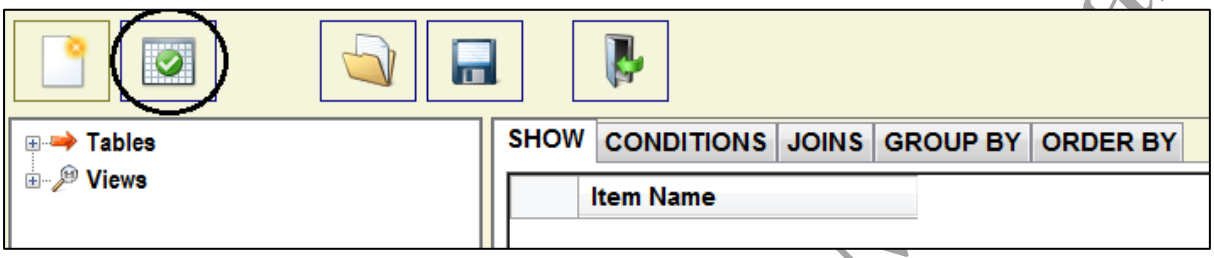
THE FROM CLAUSE

The FROM clause will also be generated automatically depending upon from which table or view you have selected your SELECT data.

If your query comprises of only these two clauses, then every record will be displayed from the specified table.

TO SAVE THE QUERY

1) Click the **Write Query** button and the query will be exported to the Ad-Hoc Reports



screen.

2) You can write comments at the top of the query before you save it. General comment (for example the report name or a brief description of the report) should be preceded by two dashes, as follows:

   --Active Patient Report

   The two dashes effectively instruct SQL to ignore the comments on that line and not attempt to process them. A hard return (ie pressing the **Enter Key)** will end the comments line.

3) Click the **Save** button on the **Ad-Hoc Reports** screen.

4) SQL scripts should be saved in the Reports folder in the Shire Dental Documents folder on your C drive. You can create sub-folders if you wish. Select the folder in which you want to save the report, name the report and click **Save**.

THE FOLLOWING CLAUSES ARE OPTIONAL

THE WHERE CLAUSE

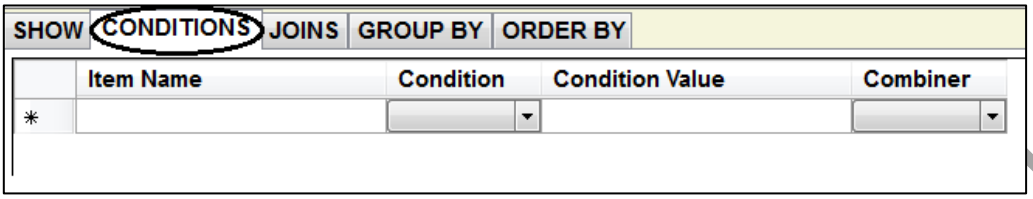
It is possible to place conditions upon which records are selected by adding a WHERE clause, which allows you to select the records that meet specified conditions. You can select any of the fields contained within the tables upon which the query is to be based and specify the conditions that apply to the selection of the records you wish to retrieve, ie you can compare the value stored in the field in the database against the value for which you are searching. You need to specify:

- the **field** upon which the condition is to be placed (this doesn't have to be a field that is included in the SELECT clause, it can be any field in the table or view);
- a **condition** (comparison operator); and

- the **search value**.

Selecting the Field

1) Click the **Conditions** tab on the query builder screen.



2) Drag the field upon which the condition is to be placed into the **Item Name** box.

Adding a Condition

3) Click on the arrow to the right of the **Condition** box and select an **operator**. The available choices are as follows:-

=	Equal to	Will search for data exactly equal to the specified value. The value can be alphabetical or numerical or a combination of the two.
!=	Not equal to	Will search for data not equal to the specified value.
>	Greater than	Will search for data greater than the specified value but will not include the specified value. The data can be numerical or in date* format.
>=	Greater than and equal to	Will search for data greater than or equal to the specified value. The data can be numerical or in date* format.
<	Less than	Will search for data less than the specified value but will not include the specified value. The data can be numerical or in date* format.
<=	Less than and equal to	Will search for data less than or equal to the specified value. The data can be numerical or in date* format.
In	In	See page 126 for an explanation of how these two operators can be used.
Not in	Not in	
Like/Not like	Like and Not like	You can use the Like and Not Like operators to find values in a field that match, or do not match, a pattern (text string) that you specify. These operators can be used in conjunction with wildcard characters to make the search more flexible:- • % The percentage symbol matches any character string. (It resembles * in DOS applications). • _ The underscore symbol matches any single character. These wildcard characters can be used either before or after the text string – or both, if relevant.

		For example, you could use the condition LIKE 'Smith%' . This could return all patients with a surname of Smith and Smithson. Whereas, LIKE 'Sm_th' could return all the patients with a surname of Smith and Smyth and LIKE 'Sm_th%' could return all patients with a surname of Smith, Smyth, Smithson and Smythson.

* When used with dates > means after, >= means on or after, < means before and <= means on or before the specified date.

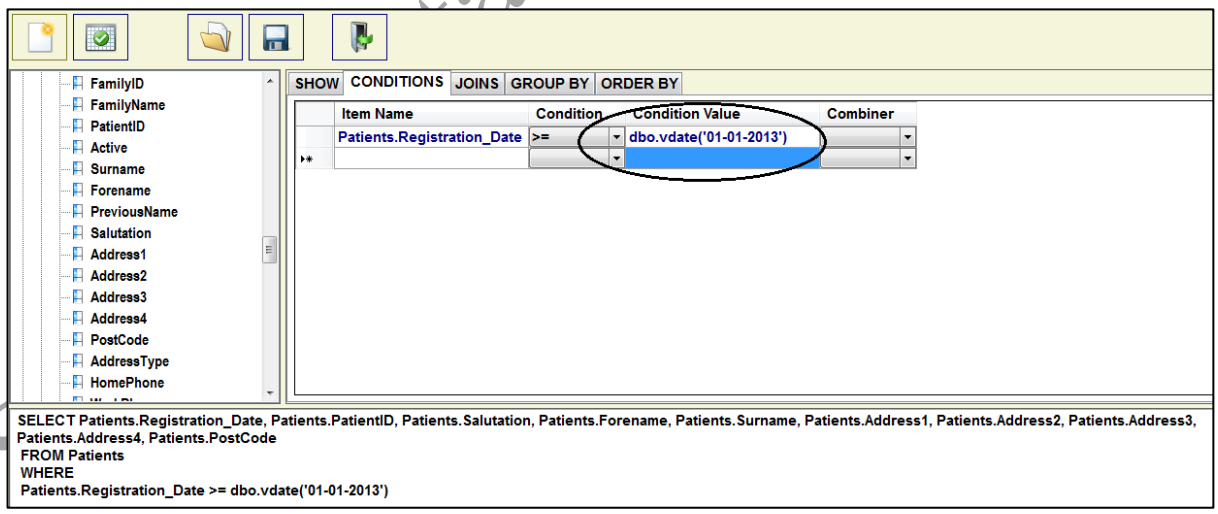
Specifying the Condition Value

4) Click on the **Condition Value** box and type in the text with which you wish to compare the data entries and press the **Enter Key** to refresh the script. Please note that, a value should always be entered with single quotes around it. The search is not case sensitive, ie data in both upper and lower case will be included.

Using Dates as Condition Values

A function has been written for use in the builder, called **dbo.vdate.** This ensures that all dates are formatted consistently, irrespective of how they have been entered, and it should be used around each date value in the query. It can be used in the SELECT clause, if required, but it is more important in a WHERE clause to ensure the correct selection of data.

The syntax (ie the rules for the structure of the queries) for using this function is as follows:-



In the above example, the patient registration date has been used in the WHERE clause to select all patients who have registered after a specific date. The date registered is a value that is stored in the table but is not displayed on the **Patient Details** screen.

Other built-in, mathematical functions can be used in SQL scripts – these are described later in these notes on page 127.

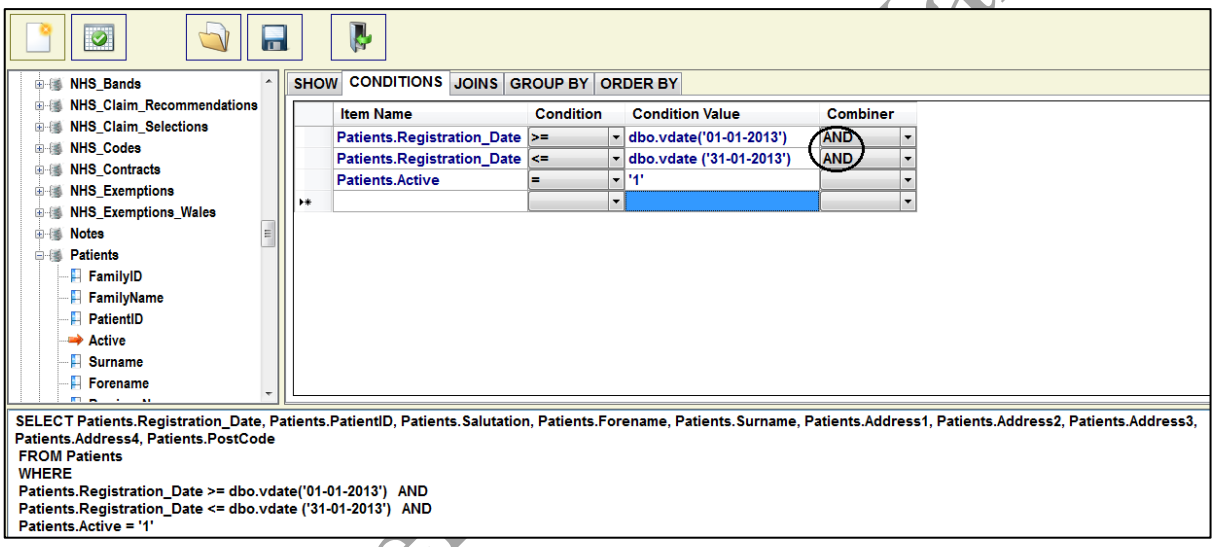
Multiple Conditions

There is no limit to the number of simple conditions that can be present in a single SQL query. The operators AND and OR join two or more conditions in a WHERE clause.

- The AND operator displays a result if ALL conditions listed are true.
- The OR operator displays a result if ANY of the conditions listed are true.

NOTE: Combinations of both AND and OR can be included in a single query but, when doing so, more care needs to be taken with the syntax of the script to ensure that the correct data is selected. A detailed explanation of how to combine these two operators into a single query can be found on the following page.

To add a second condition to a script, click the arrow to the right of the **Combiner** column and select your required operator and then add your next condition on the line below. Continue on this way until all of your conditions have been entered.



In the above example, the patient registration date has been used in the WHERE clause to select all patients who have registered between specific dates and an additional condition has been added to select only those patients who have a tick in the **Active Patient** box on the **Patient Details Screen** (a value of 1 usually indicates a tick in a box). You could use this query, for example, to generate a hit file that could be used in a mail merge each month to write to your newly registered patients and welcome them to your practice.

Combining AND/OR Connectives

When a query has multiple conditions in the WHERE clause and those conditions combine AND and OR connectives, the order in which the conditions are evaluated can affect the results of the query. By default, all of the AND conditions are evaluated before any OR condition.

This is not a problem if only AND or OR connectives are used, just if there is a combination of the two. You can change the order in which they are evaluated, however, by adding brackets around particular search conditions. For example, you may want to create a query where you selected all active patients whose default fee scale was one of two possible scales. If you constructed your query as follows:

```
WHERE
  Patients.Active = 1 And
  Patients.DefaultFeeScale = 'Private'   Or
  Patients.DefaultFeeScale = 'Independent'
```

The conditions would be evaluated in the following order.

```
Patients.Active = 1 And
Patients.DefaultFeeScale = 'Private'
(which would return all of your active patients whose default fee scale is Private)
```

Or

Patients.DefaultFeeScale = 'Independent' (which would return all or your patients whose default fee scale is Independent – whether they were active patients or not.

This could be prevented by putting brackets around the OR condition as follows. The brackets would need to be added manually to the script before saving.

```
WHERE
 Patients.Active = 1 And

 (Patients.DefaultFeeScale = 'Private'   Or
 Patients.DefaultFeeScale = 'Independent')
```

This forces SQL to perform the selection based upon the fee scale first and then check for whether the patients are active.

A less complicated way to construct your query, however, would be to use the IN or NOT IN clause.

THE IN/NOT IN CLAUSES

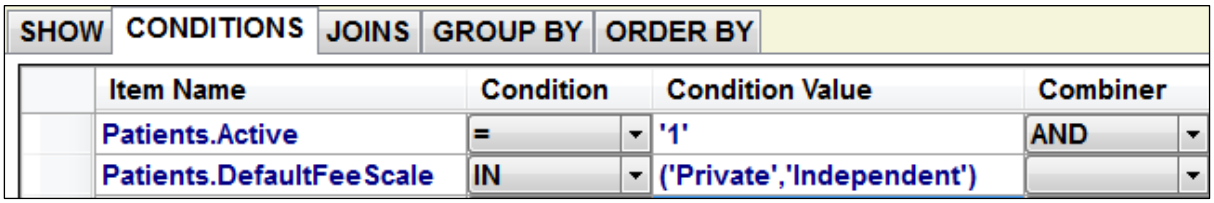
The IN clause selects a record if a specified value matches any value in a list.

NOT IN clause selects a record if a specified value does not match any value in a list.

The syntax for these clauses is as follows:-

```
WHERE
  Patients.Active = 1 And
  Patients.DefaultFeeScale IN ( 'Private' ,'Independent')
```

- The list is enclosed in brackets.
- The individual values within the list are enclosed in single quotes and separated by commas.



Nested (or Sub-Queries)

The IN and NOT IN clauses can also be used for nested queries. A nested query is a query statement tucked (or nested) inside an existing query - ie, it is possible to run a query based upon the results of another query. We will not be covering nested queries in this manual, however, as this is an advanced feature that requires a more in-depth knowledge of SQL.

THE GROUP BY CLAUSE

This can be used in queries where you wish to summarize data. For example, you may wish to produce a list of all patient families. Producing a report to list all of the family IDs* and family names in the Patients table without using a GROUP BY clause – see example script below, would result in each family member appearing on the report, ie if a family comprised of 3 family members, then that same family ID and name would appear three times in the report.

* Family IDs are stored in the Patients table but are not displayed on the Patient Details Screen. Each family member would have the same Family ID and this is not to be confused with the Patient ID which is unique per patient)

Example:

```
SELECT Patients.FamilyID, FamilyName
FROM Patients
WHERE Patients.Active = '1'
```

If you wanted the forenames and surnames of each family member to be included in the report, then this would be correct. However, if you were to GROUP BY the SELECT fields FamilyId and FamilyName, then the ID and the name would only ever appear once in the report. You are effectively saying that where the family ID and family name are exactly the same, then only display the record once in the report.

If you use a GROUP BY clause in your script, then you can only include in the SELECT clause those fields that also appear in the GROUP BY clause, ie you cannot list individual family surnames if you have used GROUP BY as the family ID appears only once.

Note: Bear in mind that every patient record is allocated a family id, even if no other family members are added. We will be explaining later in these notes how, if you have used a GROUP BY clause, you can count how many family members are in each family and how to display only those families who have more than one family member.

THE FORMULA FUNCTIONS

This option allows you to add a formula to perform mathematical calculations on the results of a query - such as counting or adding them up or calculating their average value - and include the answer in the SELECT clause. SQL has several such arithmetic (aggregate) functions.

The most commonly used are:

- SUM – totals all non- null numeric values in a specified field.
- COUNT – counts the occurrences of all non- null values in a specified field.
- AVG – returns the average value of all non- null numeric values in a specified field.
- MIN – returns the lowest non-null numeric value in a specified field.
- MAX - returns the highest non-null numeric value in a specified field.

It performs these calculations on the number of entries in each group and the correct syntax (format) of these formulas is as follows:-

COUNT (*)

For any function other than the **Count** function, you should edit the function and replace the * within the brackets with the field name upon which the formula is to be based.

To Add a Formula Function to your Query

In the query builder, on the **Show** tab, drag the relevant function from the list on the far right hand side of the screen onto the **Formula** section and replace the * with an actual field name if the function is anything other than **Count**.

For example, if you had generated a query that displayed family IDs and family names, and you had used a GROUP BY clause to list each family only once, you could add the COUNT function onto the FORMULA tab which would add this calculation to the SELECT clause and would result in the following script being generated. An extra column would then be displayed showing how many patients there were in each family

```
SELECT Patients.FamilyID, Patients.FamilyName, Count (*)
FROM Patients
WHERE Patients.Active = 1
GROUP BY Patients.FamilyID,Patients.FamilyName
```

Formula functions do not need to be included in the GROUP BY phrase as the value is not a stored value but a calculated value.

This script would return results such as:

FamilyID	FamilyName	
002-000840	Adams	1
002-000131	Agar	3
002-000519	Akhtar	1
002-000842	Alexander	1
002-000809	Ali	2
002-000509	Ally	1
002-000223	Amery-Cook	1
002-000837	Andrews	1
002-000692	Appleton	2

Creating Your Own Column Headings

You will note that the column displaying the number of family members has no heading. That's because there is no field name in the database that stores this data – it is calculated. You can, however, define a column heading. To do so, type in the heading you require immediately after the field name in the SELECT clause, eg

SELECT Patients.FamilyID, Patients.FamilyName, Count(*) 'No of Family Members'

If you use more than one word for the heading, you will need to put single quotes around it, as above. This would return:

FamilyID	FamilyName	No of Family Members
002-000840	Adams	1
002-000131	Agar	3
002-000519	Akhtar	1
002-000842	Alexander	1
002-000809	Ali	2
002-000509	Ally	1
002-000223	Amery-Cook	1
002-000837	Andrews	1
002-000692	Appleton	2

You can add your own headings in the same way to any field in the SELECT clause (by default, these are headed with the database field name). The following script would add your own column headers for each field.

```
SELECT Patients.FamilyID 'Family ID', Patients.FamilyName 'Family Name',
Count(*) 'No of Family Members'
FROM Patients
WHERE Patients.Active = 1
GROUP BY Patients.FamilyID,Patients.FamilyName
```

Using a Formula Function without a GROUP BY Clause

You can use a formula function in a query without using a GROUP BY clause if the only entry in the SELECT Clause is one or more formula functions. If you wanted to just count the number of active patients in a table, for example, you could construct a script that would return the following results:

```
SELECT Count(*) 'No of Active Patients'
FROM Patients
WHERE Patients.Active = '1'
```

No of Active Patients
2868

There are no facilities for constructing a script with only a formula function in the SELECT Clause in the SQL builder, however, so you would need to type this directly into the Ad-hoc Reports screen.

THE HAVING CLAUSE

This clause is reserved for formula functions only. It allows you to specify a selection condition based upon the results of such functions. The WHERE clause cannot be used in these circumstances as this can be used to query only actual values stored in a table and not calculated values.

The syntax for this is as follows:-

```
HAVING Count(*) > '1'
```

The following script would limit the results to only those families where there is more than one member with user-defined headings.

```
SELECT Patients.FamilyID 'Family ID', Patients.FamilyName 'Family Name',
Count(*) 'No of Family Members'
```

```
FROM Patients
WHERE Patients.Active = '1'
GROUP BY Patients.FamilyID,Patients.FamilyName
HAVING Count(*) > '1'
```

THE TOP CLAUSE

This clause needs to be typed manually into the script but it can potentially be very useful when constructing and checking a query that takes a while to run. Until you are satisfied that the query is accurately returning the results that you are looking for, you can specify that you want it to stop running after it has selected the top so many records. You will need to remember to remove this clause, of course, before you run and save the completed version of the script.

It also gives you the ability to filter for your top spending patients if you use it on a query that has been ordered by the value that the patients have spent with you in a specified date range (see also the following notes on the **ORDER BY** Clause).

You can also use it to display, say, the top 50 records in any table so that you can see the type of data that is stored in that table.

The syntax for this clause is as follows:-

```
SELECT Top 50 * from Journal
( ie it is positioned immediately after the word SELECT and before the first field name)
```

In this script, the * is used instead of specifying every field individually, ie it means **all fields in the table.** It will select and display all of the fields in the top 50 records in the Journal table. You can substitute any table for the Journal to find out how the table is constructed and what sort of data is stored in that table.

THE ORDER BY CLAUSE

You can specify the order in which the results are displayed (if no sort order is specified, the data will usually be displayed in the order that the data appears in the table.) **This must always be the last clause in a query**, ie you must always specify what records you want to select before specifying in what order you want them displayed. You can specify as many secondary sort fields as you wish.

```
SELECT Patients.Surname Surname, Patients.Salutation Title, Patients.Forename
Forename, Patients.Address1 'Address 1', Patients.Address2 'Address 2',
Patients.Address3 'Address 3', Patients.Address4 'Address 4', Patients.PostCode
Postcode
FROM Patients
WHERE
Patients.Active = '1'
ORDER BY Patients.Surname,Address1,Patients.Forename
```

In the example above, the patient records will be sorted firstly into alphabetical order of the patients' surnames. Having specified that the Address line 1 is the secondary sort order, patients with the same surname living at the same address are grouped together. The final sort order is in forename order.

NOTE: The data can be sorted in either ascending or descending order. By default, the data in a query generated using the SQL Builder will be displayed in ascending order – ie alphabetical fields will be displayed in alphabetical order and numerical fields will be displayed from lowest to highest. Once the query has been exported to the Ad-hoc Reports screen and before saving it, you can add the word DESC to the ORDER BY clause to display the data in descending order, eg

ORDER BY Patients.Surname,Address1,Patients.Forename DESC

VARIABLE VALUES

Instead of embedding an actual value in a **WHERE** clause, it is possible to replace the value with a token and prompt for the value each time that the query is run. This will make your queries more flexible and prevent other users from having to edit the actual query themselves if they want to search for a different value.

Note: The value of the **LIKE** operator cannot be used as a prompted token, as the LIKE operator would be overwritten by the = operator in SQL.

Creating Tokens

THERE ARE 3 STEPS TO CREATING TOKENS:-

1) Make up a name for the token.

2) Embed the token in the query in place of the value.

3) Prompt for the value of the token.

Name the Token

Give the token a relevant name which should be preceded with an @ symbol, ie @FeeScale

- Do not include spaces
- Do not use an actual field name

Embed the Token

Embed the token in the query in place of the actual value , as follows:-

WHERE Patients.DefaultFeeScale = '**Private**' AND Patients.Active = '1'

becomes

WHERE Patients.DefaultFeeScale = **@FeeScale** AND Patients.Active = '1'

Prompt for the Value

Enter a command line for each token that will prompt for the value when the query is run.

--Ask,Enter the Fee Scale,@FeeScale VarChar (20), 'PRIVATE'

The command line comprises of the following different settings, separated by commas.

--Ask	Activates the prompt
Enter the Fee Scale	Is the text that will appear as an entry prompt when the query is run
@FeeScale	Identifies the token
VarChar(50)	Specifies the format of the data and the maximum number of characters to be entered when prompted – see overleaf for the most common format settings
'PRIVATE'	Default value

Data Entry Format Settings

DATES: **DateTime** – Use this format for all dates.

TEXT: **VarChar(50)** - where (50) represents the maximum number of character spaces that will be required to type in the variable value when the query is run. (Please note that if you type in more than the maximum number of characters specified, the entry will be truncated.

NUMBERS: **Decimal(10,2)** - where 10 represents the total number of digits, and 2 represents the number of decimal places.

MULTIBLE TABLES

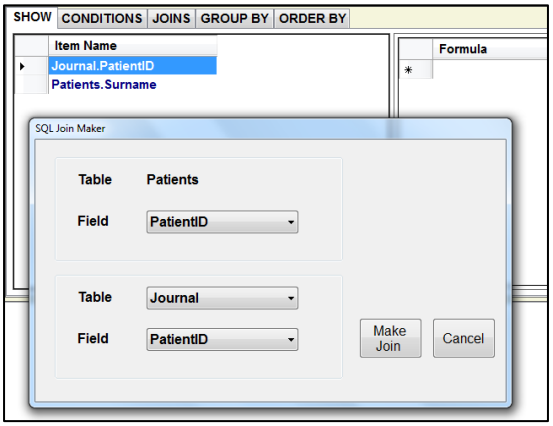
It may be necessary to base your query upon more than one table (ie if the data that you wish to select is saved in more than one table). Tables can only be joined if there is a common entry in both tables. The fields do not have to be called the same name, it is the data stored in those fields that has to be identical so that records in one table can be matched to records in the other.

You should bear in mind that you may join a table with one entry per patient to a table with more than one entry per patient. This is called a one-to-many relationship.

For example, the patient's name is not stored in the Journal, only the patient ID. If you want to display the patient's name on your report, you will need to link the Patients table to the Journal table. The common field in these two tables is the Patient's ID. When you link these two tables, for each entry in the Patients table there will be many entries in the Journal table which means that the patient's name in your report will be repeated for each line of journal entry.

JOINING TABLES

If you select a field from more than one table in the SQL Builder, you will be prompted for the common field.



Select the common field from both tables and click the **Make Join** button.

Example

On the SQL Join Maker screen, by selecting PatientID from the Patients table and PatientID from the Journal table, the following join is generated.

```
SELECT Journal.PatientID, Patients.Surname
FROM Journal
JOIN Patients ON Journal.PatientID = Patients.PatientID
```

NOTES ON THE STORAGE OF DATA IN THE MOST COMMONLY USED TABLES

Most of the data stored in tables is self-explanatory but to assist you in the construction of queries we have included some useful notes regarding the way that data is stored in those fields where this is not so obvious.

Appendix I – The Apps Table

Appointment Categories

Category 1 relates to appointments booked for patients – **Type 1** is an individual patient appointment and **Type 2** is a family appointment.

Note: If a Category 1 appointment is booked into an emergency slot, then the **Emergency** field will have a value of 1, if not then it will have a value of 0.

Category 2 relates to Emergency slots. The Type field for this category always has a value of 0.

Category 8 relates to Breaks/Lunch Breaks. The Type field for this category always has a value of 0.

Category 9 relates to Meeting slots. The Type field for this category always has a value of 0.

Subject stores the **Appointment Category** selected at the time of booking.

AppDetails stores the **Additional Information** text entered at the time of booking.

Patient stores the patient ID but this is followed by the symbol 002-000547º. Also, family appointments will contain more than on patient ID. This means that you are unable to accurately use the **Equals** operator to select all appointments for a particular patient. You can, however, use the **Like** operator combined with the patient ID immediately preceded and followed by a percentage symbol which acts as a wild card, eg **Like '%002-000547%'**.

Attended and **Completed** fields have values of either 1 or 0, where 1=yes and 0=no.

BookedBy/Last ModifiedBy fields store the User ID of the person who booked/last modified the appointment.

NOTE: The name of the user is not stored in the Apps table – this is stored only in the User table. So, to display the name on your report instead of the id, you would have to join these two tables or, alternatively, you could run a separate script that lists the IDs and names of all of your users.

Custom Status (Status_Spade, Status_Heart, etc) have values of either True or False.

Appendix II – The Cashbook Table

cbDate records the date and time that was selected on the **Record Payment** screen.

cbDone records the actual date and time that the payment was recorded.

cbPrinted records the date that the transaction was marked as printed when cashing up.

cbTakenByUser records the id of the user who was logged onto Shire Dental when the payment was recorded.

cbTakenByStaff records the id of the user who was selected in the **Taken By** field on the Record Payment Screen.

cbPayStaff records the id of the user to whom the payment was assigned.

Appendix III – The Fee Codes Table

Enabled - It is possible to disable a fee code in a fee scale as opposed to deleting it. This field record a value if 1 or 0, where 1 = True and 0 = False.

FeeIndex records the order that the fee codes are displayed for selection when entering treatment.

Deleted - Deleted fee codes are not removed from the table, they are just marked as deleted**.** This field records a value of 1 or 0, where 1 = True and 0 = False.

Price records the basic Item Price (Individual Price).

Price2 records the subsequent price – if applicable.

MaxPrice - records the maximum price, if applicable.

SecondaryAnalysisCode records what has been entered into the **Fee Type** field on the **Fee Code Maintenance** screen.

AnalysisCode records what has been entered into the **Analysis** field on the **Fee Code Maintenance** screen.

Appendix IV – The Invoices Table

iDate records the invoice date.

iEValue records the invoice value.

iInvoiceNum records the invoice number.

iPatient records the patient id for whom the invoice was raised.

iNarrative records the narrative, which will be one of the following:-

TRANSACTION TYPE	NARRATIVE
Invoice or credit note raised manually	Treatment
Invoices raised automatically	[Auto Invoice]
NOTE: The Auto Invoice option should only be activated for those practices that record payments but do not enter any billing information. The invoice can be raised automatically in those circumstances to keep the patient's financial tab reconciled. **Do not activate this option if you are using the system for billing or charting purposes, otherwise duplicate invoices will be raised each time that you record a payment**.	
Invoice has been raised for stock items only (ie using the work code STK).	Stock Sale
Auto credit note has been raised by using the right click option on the financial tab.	Credit

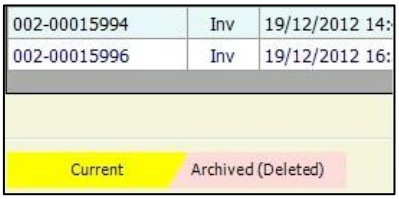
Appendix V – The ArchivedInvoices Table

This table contains the same fields as the Invoices table, with the addition of the two extra fields below.

DeletedBy records who was logged on when the invoice was 'deleted'.

DeletedAt records the date and time that the invoice was 'deleted'.

'Deleted' invoices are not actually deleted but are moved from the Invoices table to the ArchivedInvoices table. They can be accessed from the **Patient Details** screen by clicking the Archived (Deleted) tab.



Appendix VI – The Journal Table

All journal entries for every patient are stored in the Journal table. The journal entries for a specific patient are identified by the PatientID field.

ID: Every journal entry has its own unique ID and this is stored in this field.

Line Type: Entries in the journal have different line types, depending upon the type of entry. The line types currently in use are:-

1 = Charting entry

2 = Linked images/xrays

4 = Medical history

5 = Linked document

Note: Lines of medical history are stored in the journal table but are not displayed by default in the View Journal option. They are displayed in the Medical History option. They can be viewed in the journal, however, by removing the tick from the Exclude Medical History box.

Notation records the tooth notation for this entry.

Performer records the user assigned to the entry.

UserID records the actual user who was logged on at the time the entry was recorded.

PatientID records Patient ID

Visible: Most entries in the journal are visible, by default, from the **View Journal** option. However, there are some instances where entries are stored in this table but are not visible to the user, for example if you edit a journal entry, the original entry is stored but is not visible. Also, if you remove the tick box from the **Review Journal Entries for this Session** screen, then those deselected entries are also stored in the table but are not visible.

In the table, those entries that are visible have a value of 1 and those entries that are not visible have a value of 0.

Appendix VII – The Patients Table

ID Fields: Each patient record stores a family id, family name, patient id and surname. Each member of a family has the same family id and family name and each member of the family has an individual patient id.

Active: This indicates whether the patient is active or not. Active patients have a value of 1 and inactive patients have a value of 0.

AddressType: A home address has a value of **h** and a work address has a value of **w**.

ExpressRegistered: Patients added as express patients have a value of 1 and fully registered patients have a value of 0.

RecordComplete: This field will store a value of 1 if the record is complete and 0 if the record is incomplete.

See following table for patient status entries:

Patient Status	ExpressRegistered Value	RecordComplete Value
Express registered patients – incomplete record	1	0
Express registered patients – completed record	1	1
Fully registered patients	0	1

Contact_Home: If the box alongside the **Home Telephone Number** is ticked, this field will have a value of 1 and, if it is unticked, it will have a value of 0.

Contact_Mobile: If the box alongside the **Mobile Telephone Number** is ticked, this field will have a value of 1 and, if it is unticked, it will have a value of 0.

Contact_Work: If the box alongside the **Work Telephone Number** is ticked, this field will have a value of 1 and, if it is unticked, it will have a value of 0.

Contact_None: Opposite to the above, however, if the box alongside the **Contact Preference** is not ticked, this field will have a value of 1 and, if it is ticked, it will have a value of 0.

Appointment/Payment Required: These two fields store a value against the patient depending upon what has been ticked on the **Payment** or **Appointment Required** fields on the charting **Session Finalisation** screen. If either of these options were ticked, then a value of 1 will be stored, if not, then a value of 0 will be stored.

Appendix VIII – Tables Storing Details of Courses of Treatment

Data relating to courses of treatment is stored in the following tables:-

The Chart Work Header and **Chart Work Lines Tables**

NOTE: There is a view, called the **Chart_Lines** view, that links the above two tables and incorporates an automatic join. As the tables will need to be joined to query patient treatment data, using this view instead of the individual tables will avoid having to create a manual join.

There is one entry per item of treatment so each course of treatment for a patient may have multiple entries, depending upon how many items of treatment have been carried out.

The Treatment Course Table contains extra details about the courses of treatment. It mainly relates to transmission details for NHS courses of treatment. There is one entry in the table per course of treatment. The following fields are stored in this table and are self-explanatory:

CourseID, PatientID, DefaultFeeScale, Dentist, DateofAcceptance, DateofExamination, DateofCompletion, EstimatedCharge, VisitsMade, CourseNotes, NHSExemption, MaxNHSCharge, ClaimProcessed, NHSSupportingDetails.

If you wish to include these details in your query, you will need to join the table to the **Chart_Lines** view.

Treatment Course Table

Most of the fields in this table are self-explanatory – eg course ID, patient ID and course acceptance and completion dates. The dentist ID and patient ID only is stored and not the dentist and patient names.

Chart-Lines View

This table stores the individual items of treatment included in each course.

Work Ref: Each item of treatment has a unique work reference. This is comprised of the patient ID followed by the Course Reference followed by a reference for line of treatment.

TN: Is the tooth number and is used internally in the application – it is not applicable to any queries that you might write and, therefore, should not be used in any queries that you build.

Notation: Identifies the tooth applicable to the item of treatment carried out. Use this field in your queries if you are searching for work on a particular tooth.

Deciduous: This field will have a value of 0 if work has been carried out on a permanent tooth and a value of 1 if the tooth is deciduous.

Charge Code: This is the fee code allocated to the line of treatment.

Fee Scale: This is the fee scale from which the fee code was selected – which may be different to the Default Fee Scale stored in the Treatment Details Table.

Status: Is the Work Code.

Surface: This relates to fillings only and identifies which surfaces have been filled.

Material: Displays the material associated with the item of treatment.

Visit: This is the visit number on the course. It is applicable only if additional visit headers have been added to the treatment plan for appointment booking purposes.

Index in Visit: This identifies the order in which the items of treatment are displayed.

Booking Interval/Length: These two fields relates to the booking interval and appointment length if a visit header has been added to the treatment plan for appointment booking.

Price Estimate: This is the price per item of treatment.

Invoice: If the treatment has been invoiced, an invoice number will be displayed in this field.

Secondary Analysis: This is the **Fee Type** allocated to the **Charge Code** (ie Fee Code).

Analysis Code: This is the Analysis code allocated to the Charge Code.

Unit Qty: For unit price fees, this field displays the unit quantity charged.

ChartSessionID: This is the course reference.

PatientID: This is the Patient ID for whom the line of treatment was added.

DateCharted: This is the date and time that the work was charted as pending. A date of 01-01-1900 will be displayed if this is still pending and once complete it shows the date and time of completion.

DateDone: This is the date and time that the work was completed.

DentistID: This is the ID of the dentist who charted the work.

NHS - ELECTRONIC TRANSMISSION

PROVIDER DETAILS

Before printing any forms or processing any claims for the first time, make sure that the **Provider Details** option on the **Administration** menu has been completed for each dentist for whom you wish to print forms.

1) The dentist must be added as a user before provider details can be completed. Select the dentist's username from the drop down box of **Registered Users**.
2) Tick the **Use Practice Address** box.
3) Type in the **Performer Number**, **Contract Tag** and **Location ID** in the boxes provided. If the dentist is an associate dentist, just enter the dentist's performer number in the **Provider Number** box and leave the other sections of the contract number blank.
4) The **EDI PIN** will be added later for those practices intending to use the WebEDI transmission module.
5) Click **OK**.

FP17 FORM PRINTING

If you do not plan to transmit claims via WebEDI, you can:-

k) print the form header only (provider/performer and patient details) and manually add the claim details after the form has been printed; or

l) produce the entire form manually by adding the claim details on the screen before the form is printed; or

m) if you are using the system to enter clinical records, print the fully completed form. The form details can be viewed and edited before printing if required.

Printing the FP17 Form Header

1) Select **Form Printing and UDAs/FP17 Form Header (NHS)** from the **Reports** menu.
2) Provider Details
   - If the dentist who carried out the treatment is also a provider, then leave the tick in the **Performer Number Same as Provider** box.
   - If the dentist who carried out the treatment is not a provider, then click on the **Performer Number Same as Provider** box to remove the tick and select the relevant performer from the drop down list.

     Note: If the practice is the provider, then the **Provider** box on the **Practice Details** screen should be ticked and the relevant contract details added – see page 5.

     The provider's name, address and contract number will be displayed on the screen.
3) Patient Selection
   - Click the Search for Patient Record link.
   - Search for and select the patient for whom the claim is to be submitted.
   - The patient's details will be displayed on the screen.

4) Click the **Print** button.

Manually Completing and Printing the FP17 Form

1) Select **Form Printing and UDAs/Manually Produce FP17 Form (NHS)** from the **Reports** menu.

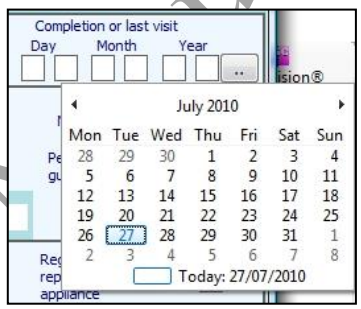
2) Complete items 2) and 3) above (for printing the form header).

3) Click the **Next** button to display and fill in the claim details section of the form.

4) **Claim Details**

The following edit options are available for completing the claim details.

- Click on a box to add a cross in the box – click again to remove the cross.
- On a date field, click on an individual date section and type in the date or click the **Browse** button to display a calendar for selection.
- On any other sort of data entry box, click on the box and type in the data.



5) Click the **Print** button to print the form.

Note: It is not necessary for each letter to line up exactly with each box provided on the form, as long as the first letter is lined up properly in the first box on each line.

Printing a Completed FP17 Form

1) Select **Form Printing and UDAs/ FP17 Pending Claims (NHS)** from the **Reports** menu.

2) All pending claims will be displayed on the **Unprocessed** tab. Select the form to be printed by double clicking the relevant record or single clicking and clicking the **Process Selected** button.

3) Complete the provider/performer section as outlined in item 2) on page 142 for printing the form header.

4) The patient details will be already displayed – click the **Next** button to display the claim details section of the form.

5) Check the details to confirm that they are correct and edit any that you wish to change by clicking on that section of the form and overwriting the default entries. All default entries will be coloured in yellow (if you change any of the pre-selected boxes, the original box will remain in yellow).

6) Click the **Print** box to print the form.

7) The claim details will be removed from the **Unprocessed** tab and can be viewed on either the **Processed by Date** or **Processed by Patient** tabs.

NHS - WEBEDI TRANSMISSIONS

REGISTRATION AND CONFIGURATION

WebEDI allows you to send secure NHS claims between your dental system and the NHS Business Services Authority Dental Services Division (DSD) via the internet. Before you can begin transmitting Web-EDI claims, you need to apply for a site number (application form – CGDP 8). The NHSDSD will then send your site number.

When you have your site number, you should register at http://ebusiness.dpb.nhs.uk and keep a secure note of the passwords and usernams issued (a printed version of this is recommended to ensure that no mistakes are made when configuring your system). The NHSDSD will process your application and send a confirmatory email that you are able to begin transmitting claims via WebEDI. Each dentist will be issued with a PIN (Personal Identification Number) which will be sent by post in a security envelope to your practice address.

Useful contacts: **DSD External Access Support Team** **01323 433560**
Email: edisupport@dpb.nhs.uk

DSD Helpdesk **01323 433550**
Email: helpdesk@dpp.nhs.uk

NHSBSA Dental Services Division
Compton Place Road
Eastbourne
East Sussex
BN20 8AD

Once your account has been activated, you should then contact our Support Department so that your software can be configured ready to begin transmitting claims. We will need your Site Reference Number, the Username and Password. The PIN for each dentist will need to be entered onto the system – this can either be done by the Support Department at the same time as setting up but the PIN can be entered by yourselves. This is stored on the **Provider Details** screen and will be encrypted, for security purposes, as it is entered.

PR forms can be obtained from your local Primary Care Trust – you are required to complete this form for each patient.

NHS FEE SCALE

An NHS fee scale should already exist on your system. A new scale should be created each time that the banding prices are adjusted. You should identify the active (current) NHS fee scale from the **Administration** menu - **System Maintenance**/**Application Preferences**/**NHS** tab.

EXEMPTION/REMISSION

Exemptions added to the patient details screen will default onto the course information screen when opening a new NHS course. These can be overwritten where necessary when entering course details.

PROCESSING CLAIMS

To transmit WebEDI claims you can process by one of the following two methods:

n) **Manual** – by completing a claim form on screen manually (see notes on page 143 – Manually Completing and Printing the FP17 Form) and choose to **Queue** the claim for transmission instead of printing the form; or

o) **Auto** – by entering the treatment details using the system (with or without the charting module), whereby the system will complete the claim details for you. The completed claim form will be displayed on the screen for you to accept - or edit if you wish to do so. You can then choose to **Queue** the claim for transmission instead of printing the form (see notes on page 143 – Printing a Completed FP17 Form).

Unprocessed Tab

This tab displays all of the completed NHS courses, which will remain on this tab until they have either been transmitted or printed. These claims can be filtered by dentist - by selecting the relevant dentist from the drop down list - and should be checked and marked as ready for transmission – ie queued for transmission. You will be prompted for your PIN each time that you queue a claim.

If you prefer, you can view and queue a claim as the course is completed. You will be prompted for your PIN as you complete the course and queue the claim. Each time that you enter your PIN, the system will validate your entry. If the PIN is not correct, you will be prompted to re-enter it.

> **NOTE:** There is an option to remember the PIN – you can click this if you do not want to have to enter the PIN each time that a subsequent claim is queued for transmission.

Queued for Transmission Tab

This tab displays all of the claims that are queued ready for transmission, either from the completion. The claims need to be built into a file before they can be transmitted to the DSD. There is a tick box beside each claim – tick the claims to be included and click **Transmit Selected**.

The file will then be built and the claims transmitted. How often you transmit these claims is up to you – WebEDI is normally accessible 24 hours a day.

NOTE: The DSD recommends that you arrange the timing of transmissions to suit your working practice but that you should not send batches of more than 500 claims at a time. They recommend that claims are sent at least 10 days prior to your schedule processing date to ensure that they meet your NHSDSD payment date.

Awaiting Acknowledgment/Reject Claims Tab

Once a file has been transmitted, the individual claim details will be moved from the **Queued for Transmission** tab to the **Claim Reconciliation** tab and the file details will be displayed on the **Awaiting Acknowledgment/Rejected Claims** tab**.** The status indicator alongside the filename appears green to show that the file has been successfully delivered. If the status indicator is red, please contact us for advice.

Detailed validation of individual claims contained in the file will then be carried out by the NHSDSD and this will generate an acknowledgement of the file and an electronic response for any rejected claims.

Each time that you connect to transmit a file, the system will check for any responses and download them as they become available.

Once a response has been received to acknowledge that the file has been processed, it will be removed from the **Awaiting Acknowledgement** section and any individual rejected claims from that file will be displayed on the **Rejected Claims** section of this tab.

NOTE: Any file that remains displayed in the **Awaiting Acknowledgement** section for an unusual length of time, therefore, should be queried with the DSD and, if applicable, retransmitted - right click to retransmit the file.

Once acknowledged, any rejected claims will be transferred to the **Rejected Claims** section on the bottom half of the screen. Individual courses can be edited to generate a correct claim, or the claim form itself can be edited, before re-transmission.

Valid claims will automatically be passed to the NHSDSD payment process and details of those claims will be remain on the **Claim Reconciliation** tab until payment for the claim is included on your schedule, which will be automatically uploaded as it becomes available.

All claims included in your schedule will be removed from this tab, and only then, will they be moved to the **Processed by Date/Processed by Patient** tabs and the **UDA Information** tab updated accordingly, ie

- acknowledged claims not yet included in your schedule will be stored on the **Claim Reconciliation** tab and
- acknowledged claims that have been included in your schedule will have been moved to the **Processed by** tabs.

Therefore, UDAs for any claims still displayed on the **Claim Reconciliation** tab after your schedule has been processed have not yet been paid and the claim details will not be available to view in the **Processed by** tabs.

UDA Data

Once the contract details have been stored in the system, data transmitted by the NHSDSD regarding UDAs can be viewed from the **UDA Information** tab on the **NHS Treatment**

Course Processing screen. You can use the filter controls to display graphs showing the **Average Targeted** and **Achieved UDAs** in a date range.

You can also use the **Forecast** button to compare the achieved UDAs to the required UDAs.

Contract Details

For each performer:

- Select the **NHS Contracts** option from the **Maintenance Menu**.
- Enter a **Contract Reference** number – free text entry.
- Select an individual performer, specify the contract dates and confirm the expected number of UDAs for that performer.
- Select **Add** as the mode and click the **Add** button.

GUIDANCE NOTES ON NHS CLAIMS

Individual items of treatment on the NHS fee scale, when added to the estimate, determine the banding of the course and which options are selected on Part 5a – the Clinical Data Set. The following options, however, need to be added to the estimate manually.

PART 5 - TREATMENT CATEGORY		
CATEGORY	**WORK CODE**	**FEE CODE**
Band 4	.XM	Treatment urgently required for acute condition
Band 5 – Regulation 11	A (Artificial)	Regulation 11 Replacement Upper/Lower Appliances
Band 6 Prescription only with no antibiotics Prescription only with antibiotics	OT (Other Treatment)	Prescription Only – No Antibiotics Prescription Only + Antibiotics (Type in the number of antibiotics at the time of entering – defaults to 1)
Note: For prescription supplied as part of a course with no antibiotics use fee code Prescription as Part of a Course (work code OT). If antibiotics prescribed – also add fee code Antibiotic Items Prescribed (work code OT) and type in the number of antibiotics prescribed – defaults to 1).		
7 – Denture Repairs	A (Artificial)	Repair of Upper/Lower Denture
8 – Bridge Repairs	B (Bridge Retainer)	Repair of a Bridge
9 – Arrest of Bleeding	POC (Post-operative Care)	Arrest of Abnormal Haemorrhage
A – Removal of Sutures	POC (Post-operative Care)	Removal of Plugs/Sutures
PART 5a – CLINICAL DATA SET		
G – Referral for Advanced Mandatory Services	OS (Other Services)	Referral for Advanced Mand Services
L – Best Practice Prevention	OHI (Oral Hygiene Instruction)	Oral Hygiene Instruction

PART 6 - OTHER SERVICES		
Treatment carried out On Referral	OS	Treatment on Referral
Free Repair or Replacement	OS	Free Repair/Replacement
Further treatment required within 2 months	OS	Further treatment within 2 months
Domiciliary Services Supplied	DOM	Domiciliary Visit
Sedation Services	SED	Sedation Services

Referral for Advanced Mandatory Services

The NHS rules specify that where a dentist refers a patient to another dentist for a specific item of treatment, each dentist will be credited for UDAs for only the treatment that they actually provide. The collection of patient charges are the responsibility of the referring dentist to collect the charge, which should be based on the charge band for the entire course of treatment.

There is a right-click option on the treatment plan screen to **Mark as Referred for AMS.** You should chart the treatment for the course, including the treatment to be referred. You should then right click on the treatment to be referred and select **Mark as Referred for AMS**.

- This option allows you to complete the remainder of the course without completing the referred treatment.
- At the same time, when you click **Save & Continue**, it also automatically calculates the correct band for the treatment being carried out by the referring dentist, which is then transmitted with the claim.
- The band for the treatment to be referred will also be automatically calculated and displayed, as is now required, in the **Referred for Advanced Mandatory Services** section of the claim (instead of just an X as it did previously).
- The journal will be updated accordingly.
- If you decide upon a referral after the band has already been applied and invoiced, you can still mark the pending treatment as **Referred for Advanced Mandatory Services** but the band will need to be changed. You should right click on the band and select **Delete Invoice and Mark Line Pending**. Once the band is pending, you can right click and remove it. Then when you click **Save & Continue**, the correct band for the remaining treatment will be recalculated and applied. The deleted invoice will be stored on the patient's financial record in the **Archived Invoices** tab and a new invoice generated.

  Marking Referred Treatment as Complete

  1) All referred treatment will be carried through on the chart to the next course of treatment – coloured in red, but opaque. It is not classed as pending for the referring dentist - just that it has been referred - but you can update the chart to show that it has been completed, as outlined below, in order to update the chart history.

  2) You can add fee codes to the relevant work codes for referred treatment (eg **Root Treatment** and **Extraction)** in the 2014 NHS fee scale, with a zero price called, say,

Referred Root Treatment or **Referred Extraction**. Just make sure that when you are creating the fees, you do not add an NHS code or band to them so that there will be no impact upon any subsequent NHS claim.

3) You can also create a material called **Referred**, add a unique colour to it and link this material to the new fees so that any completed referred work will be displayed in that colour.

4) This fee can then be charted as pending and complete on the next course.

Completing NHS Courses with Treatment Pending

There is an option on the dental system toolbar – **View Open Treatment Plans** – which lists all open courses of treatment, both private and NHS, and totals up the value of outstanding work. You can export this data to MS Excel for accounting purposes.

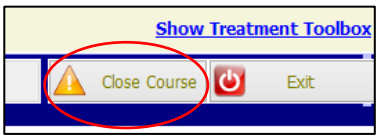
From this list, you can also right click and navigate to the patient's record from where you can complete the course with pending treatment if applicable.

It is also possible to run an ad-hoc report and export the results to Excel or to a list and from which you can navigate to the patient's record. The ad-hoc report can filter for a specific dentist and for patients who do not have a future appointment.

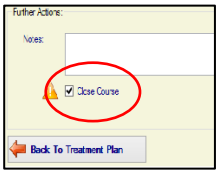
If you do close an NHS course with treatment pending, you should keep the original band on the course as this is what generates the band for Part 5 of the claim. You do need to edit the price for this band where applicable, however, otherwise the patient charge would be incorrect, so you might end up with a band two (for the planned treatment) priced at £18.50 (actual treatment). The price would already be set at zero for exempt patients so no editing would be necessary if this were the case.

If the fee has already been invoiced and you need to edit the price, you should right click on it and select **Delete Invoice and Mark Pending**. You can then double click, edit the price and recomplete. The deleted invoice will be stored on the patient's financial record in the **Archived Invoices** tab and a new invoice generated.

- There is an option to close the course with treatment outstanding on the **Treatment Plan** screen if no changes have been made to the plan, ie if you have not had to change the price on the original treatment band.



- For those courses where the original invoice has been deleted and the patient charge amended, the **Close Course** option will not be available on the **Treatment Plan** screen. You should click **Save & Continue** as normal and, at the warning prompt that the patient charge may need to be re-evaluated, click **No**. Then click the **Close Course** option on the **Session Finalisation** screen.



  - The system calculates the band that is transmitted in **Part 3 – Incomplete Treatment and Treatment Dates** from the treatment that has been completed on the course.
  - The **Patient Charge** in Part 4 is determined by the patient charge on the course (exemption rules still apply).

- The band on the course determines what is transmitted in **Part 5 – Treatment Category**
- The completed treatment determines what is transmitted in **Part 5a – Clinical Data Set**.

DENTAL SYSTEM BACKUP

FULL SYSTEM ARCHIVE

A FULL SYSTEM BACKUP IS USUALLY SCHEDULED TO RUN TO YOUR USB HARD DRIVE, WHERE THIS IS AVAILABLE, ONCE A WEEK AUTOMATICALLY – MOST COMMONLY AT MIDNIGHT ON A SUNDAY. **IF YOU TURN OFF YOUR COMPUTER OVER THE WEEKEND, PLEASE CONTACT OUR SUPPORT DEPARTMENT SO THAT THE BACKUP SCHEDULE CAN BE AMENDED.**

THIS FULL SYSTEM BACKUP IS SCHEDULED TO TAKE PLACE, BY DEFAULT, OUTSIDE OF NORMAL HOURS AS THERE CAN BE SOME IMPACT ON THE PERFORMANCE OF THE SERVER WHILE THE BACKUP IS RUNNING.

Please note that it is your responsibility to check that these backups are running.

NOTE: We would normally recommend that you leave the USB hard drive permanently connected to your server. If you prefer, and depending upon your backup schedule, you can remove the USB hard drive overnight and reconnect it when you are next at the practice. However, be aware that if the backup utility is due to run and it cannot detect the hard drive, then as soon as you reconnect it, Windows will immediately begin the full system backup and this could result in your system running slowly until the backup is complete. Also, by removing it from site, you run the risk of not reconnecting it in time for the next scheduled backup.

DAILY DATA BACKUP

As the full system archive is run only once a week, a **daily** data backup should be run every day with the data being copied firstly to the C: drive but also to some form of external media (usually memory sticks) so that this data can be removed from site for extra security. This daily data backup is run as outlined below.

There should be a backup utility installed on your server before it is delivered to site and a shortcut created on all of your desktops. This is called **Shire Dental Backup**. Double click this shortcut to start the backup wizard. (The utility can also be found in **All Programs** on the Windows **Start** button.)

You will be taken through a series of configuration screens the first time that the backup is run, but you will normally be guided through this with our trainer on site. Once the utility has been configured, you will be prompted to proceed as follows:-

STEP 1- What to Backup

We recommend that you leave the tick in the **Backup All My Daily Dental Records** box.

STEP 2 – Where to Backup

Leave the location blank and the backup will be saved to the default location on your hard drive, ie C:\DentalBackup.

Click **Start Backup.**

The status bar at the bottom of the backup screen will show you the progress of the backup and a message will be displayed when the backup is complete. Click **OK.**

COPYING THE DATA BACKUP TO YOUR MEMORY STICKS

This daily data backup will be overwritten the next time that you carry out the above routine, so each day you should either copy that day's data backup onto your preferred external media (ie memory stick) or run the routine again and this time choose your external media as the backup location at **STEP 2** by clicking the **Choose Location** button.

You should also copy the Shire Dental Documents folder (on your server's C drive) onto your memory stick. This is particularly important as it includes all of your report layouts and everything saved in patient folders, ie letters, x-ray images, etc.

ONLINE BACKUP

There is also the facility to backup your daily data online. It is not a replacement for a volume archive but can be used as well as the daily data backup to memory sticks. We can include specific document folders in this backup - please contact us for more details.