THE READERS' CORNER

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(Editor's Note: The Readers' Corner is a quarterly feature of JCO in which orthodontists share their experiences and opinions about treatment and practice management. Pairs of questions are mailed periodically to JCO subscribers selected at random, and the responses are summarized in this column.)

1. Please check the types of diagnostic records you use. (Respondents were asked to indicate which pretreatment, progress, and post-treatment records were used routinely and which were used occasionally.)

Few clinicians obtained full-series x-rays on a routine basis either before, during, or after treatment. They were used occasionally, however, by 40% of the respondents pretreatment and by 8% post-treatment.

Bite wings were rarely used routinely, but were used occasionally in the pretreatment and progress phases. No clinician reported taking bite wings during the post-treatment phase.

Panoramic x-rays appeared to be the most standard radiographs, being used routinely by nearly all respondents before, during, and after treatment. Slightly more clinicians used them pretreatment than at other times.

Pretreatment lateral cephalograms were taken routinely by nearly all respondents, while 16% routinely obtained progress films and 65% routinely took post-treatment films. Fifty-one percent of the respondents occasionally obtained progress lateral cephalograms, and 18% occasionally took them after treatment.

More than 80% of the clinicians routinely traced their headfilms prior to treatment, about 40% routinely traced them after treatment, and 18% routinely traced progress headfilms. Another 32% made occasional progress tracings; pretreatment and post-treatment tracings were made occasionally by about 15% each.

Frontal cephalometric films were rarely obtained on a routine basis before treatment (8%), and never on a routine basis during the progress or post-treatment phases. Frontal films were utilized more on an occasional basis during all three phases of treatment: by 42% of the respondents before treatment, 19% during treatment, and 19% after treatment.

Submental vertex cephalograms were only occasionally obtained before treatment (20%). These films were rarely taken, even on an occasional basis, during the progress or post-treatment phases.

Laminagrams were the least utilized record on the list. No clinician reported routinely using laminagrams, and only a few used them occasionally before treatment.

Wrist x-rays were primarily used on an occasional basis, by 34% of the respondents before treatment and less than half that percentage in the progress phase. Only one clinician occasionally utilized wrist x-rays post-treatment.

Transcranial TMJ x-rays were rarely used routinely, but were taken occasionally for some clinicians' pretreatment records. Only a few clinicians obtained them occasionally for progress or post-treatment records.

Occlusograms were not utilized routinely during any phase, but were used by a smattering

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of the respondents on an occasional basis before treatment.

Intraoral and extraoral photographs were the most consistently used of any records. More than 90% of the clinicians reported taking intraoral and extraoral photographs routinely before and after treatment. Fewer than one-third routinely took progress photographs, but most of the respondents said they took photos occasionally during treatment.

How much do medicolegal considerations influence your decision?

Fully half of the respondents indicated that medicolegal considerations strongly influenced their record-taking decisions, while 38% said their decisions were slightly influenced. Only 12% indicated that medicolegal considerations had no effect on their records regimens.

Elaborate on any specific types of cases for which you would change your normal record-taking routine.

Respondents most often altered their normal routine when surgery was involved, occlusal or facial asymmetries were noted, orofacial anomalies such as cleft lip and/or palate were present, or signs or symptoms of TMD were evident prior to treatment or developed during treatment. In these cases, the additional records included mounted models, frontal cephalometric x-rays, and TMJ films (primarily tomograms). Additionally, many clinicians thought periapical x-rays were warranted in cases exhibiting periodontal disease or extensive restorations, or when panoramic films made them suspicious of root resorption.

There were a few clinicians who deleted some items from their routine records procedure in certain instances. Some reported they did not take full records on partial treatment cases.

Interesting comments included:

• "If I detected a problem with the case proceeding according to plan, I would take progress records. I would take the final models on a case that was interesting and that I may want to show to dentists or patients in the future. If I felt a patient had a litigious bent, I would take more progress records. If there was a significant oral hygiene problem, I would document it with additional photographs."

• "I take more records in growing Class II cases where excessive or asymmetric mandibular growth is affecting treatment. And in any case where unexpected skeletal changes appear to be occurring, I will take progress cephalometric films."

• "I may ask for PA x-rays on a patient with short roots as seen on a panoramic x-ray."

• "I do not take cephalometric films on skeletal Class I cases."

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2. What is your usual procedure for answering patients' or parents' initial telephone calls to your office?

Eighty percent of the respondents indicated that their receptionists answered the telephone. Although 18% said any staff member who happened to pick up the phone would answer it, they generally added that all staff were familiar with the accepted protocol of answering initial telephone calls and that the calls were routed to designated staff members.

Describe your usual procedure for responding to an initial telephone call from a prospective patient.

Nearly all respondents recorded basic information—name, age, address, and referral source—and gave general instructions such as directions to the office and how long the visit would last. Many clinicians also requested insurance information or advised the patient or parent to bring insurance data to the appointment. The caller was usually informed about what would take place during the initial visit and what fee would be charged, if any. A few clinicians thought it was important to inform the patient if there would be no fee for the visit.

After the initial contact, many offices sent a thank-you letter to the referral source. Many also sent an information packet to the patient, with the standard AAO Health Questionnaire often

included.

There were some comments to the effect that the initial phone contact should be just that—a contact—and limited to obtaining pertinent information. These respondents believed that insurance details, dental history, previous opinions, and other details should be recorded at the appropriate time by the responsible staff member or the doctor.

Individual replies included:

• "Usually, our receptionist answers the phone and records the information. However, the entire office staff is trained to welcome new patients and take all the pertinent information."

• "After obtaining basic information, we ask what is the chief complaint and if the family has ever seen another orthodontist and if records were taken. Then we inform the caller that we will schedule an initial exam consisting of records, oral exam, and a short conference with the doctor to discuss the initial findings. If the patient is an adult, we inquire if they are interested in the Invisalign system."

• "Allow the patient to express the reason for the call. Use a script to enter information into the computer program including the patient's chief concern; send a follow-up introductory brochure and letter. Also, send medical/dental history forms to be completed and brought to the initial appointment. If it's a child patient, send a letter to them and a 'Getting to know you' form also."

Do you have a script for answering initial telephone calls?

Sixty-five percent of the respondents did not use a script to answer initial telephone calls. Most of the scripts used by the remainder were designed to obtain only basic information. A few were much more specific, however, requesting detailed insurance, health, and personal information.

Some interesting remarks were:

• "I have found that scripts advocated by practice management gurus do very little to help in the development of our practice. Staff often complain that these scripts sound bogus."

• "Our script is very basic—i.e., 'Welcome to our office; let me take information for our computer [name, address, referral source, etc.]; what day and time is most convenient?' and then make appointment; quote fee for initial appointment; inform the caller that we will send them information about the office, such as a medical history and an insurance worksheet. And finally, we tell the caller that we are looking forward to their visit."

What methods have you found particularly effective in answering calls?

The most frequent response to this question involved conveying a friendly and concerned attitude to the prospective patient. Many also commented that a trained staff member should answer the initial call, and that the initial appointment should be scheduled as soon as possible at a time that was convenient for the patient and parent.

Approaches to resolving questions the caller might ask about fees were varied. A few clinicians advocated being open about the total treatment fee, but most thought it would be best for the fee to be discussed after the initial examination.

Some clinicians felt the information gathered on the initial call should not be too extensive to avoid giving the impression that an initial exam was being conducted over the phone.

One respondent outlined the procedure as follows:

• "Isolate the employee who is taking the call so no interruption occurs. Don't rush the caller, and don't place them on hold. If it is inconvenient for them to talk, offer to call back for additional information. It is important to know the chief concern (TMJ problems, surgery, child, facial deformities, etc.) so an appropriate time can be scheduled."

What methods have you found particularly ineffective in answering calls?

The most frequently mentioned mistake was getting too involved in obtaining details such as insurance, health, and personal information. A related observation was that rushing the call to

gather too much information was inefficient.

Putting the caller on hold was another commonly noted error. Several respondents also mentioned that being too rigid in setting an initial examination time can create unnecessary conflict with the responsible party's schedule.

Comments included:

• "Don't allow untrained staff to take the initial call, and make the appointment within 7-10 days if possible. Also, it's best to get insurance information so we can determine the benefits. Otherwise some patients cannot make a decision to initiate treatment on the day of the visit."

• "Giving the patient too much information. It is appropriate that certain information should be obtained by the doctor at the time of the visit. Also, we try not to give any kind of fee schedule over the phone. We tell the caller that each case is different and therefore fees are varied."

• "Having clinical rather than administrative staff answer the phone, and putting the caller on hold."

Have one or more of your staff members received any of the following forms of training in answering initial telephone calls?

All respondents checked off multiple training methods, the most universal being one-on-one training. Following this, in order of frequency of replies, were office training manuals, practice management consultants, other written material, and audiovisual material.

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